COLLÈGE DES MÉDECINS
DU QUÉBEC

Inquiries Division
1250, René-Lévesque Blvd. West, Suite 3500
Montreal, QC H3B 0G2
Tel.: 514 933-4787 or 1 888 633-3246, ext. 4787
Fax: 514-933-2291
info@cmq.org

Inquiry request form

If you wish, you can use this form to submit a request for an inquiry regarding one or more physicians.

Fill out the form on screen or print it out and fill it out by hand. Then send it to the Inquiries Division at the above address. Do not hesitate to contact us if you have any questions.

A - Contact information of the person requesting the inquiry

Please note that the contact information you provide is the contact information the Collège des médecins will use to reach you.

Mr. ☐ Ms. ☐ Surname: First name:

Address (no.): Street: Apartment no.:

City: Province: Postal code:

Home phone: Cell phone:

Email:

If you are the patient, please indicate your:

Date of birth: Health insurance number (letters and numbers):

If you are not the patient, please indicate your relationship to the patient and provide their contact information in Section B.

In addition, if you are submitting your **request on behalf of an organization or company**, please complete the additional fields below.

Organization or company:

Title or function:

B - Patient contact information (do not complete if identical to Section A)

Mr. ☐ Ms. ☐ Surname: First name:

Address (no.): Street: Apartment no.:

City: Province: Postal code:

Home phone: Cell phone:

Email:

Date of birth: Health insurance number (letters and numbers):

C - Contact information of the physician concerned by your request

Provide as much information as possible to help us identify the physician.

Surname: First name:

Specialty:

Where did the consultation with the physician take place?

Hospital ☐ Office (clinic) ☐ Walk-in clinic ☐ Other, specify:

Name of the clinic or health care institution:

Address (no.): Street: City:

If your request concerns other physicians, please indicate this on a separate page.

D - Description of your concerns

On the next page, provide a description of the situation including, if possible:

- the nature of your complaint or dissatisfaction;
- the reason(s) why you consulted the physician;
- where the consultations or events took place;
- the dates on which the medical consultations or treatments took place;
- if you refer to care provided by other physicians in your request, even if you have nothing to criticize these physicians for, please tell us their name and where the consultation took place (we may need to see your medical record kept by these physicians);
- your expectations with respect to the inquiry request.

If necessary, you can add one or more pages. Attach a copy of any documents relevant to the review of your request **(including any recordings)**.

Signature **Date**

D - Description of your concerns