Appendix 6 – CMMOTA Complaint Form

Information Page

The Canadian Massage & Manual Osteopathic Therapists Association takes your complaint seriously and will follow the steps laid out in the CMMOTA *Discipline for Complaints Policy* to resolve the complaint. It is important to note that often the process can take 3-6 months to complete depending on the complexity of the complaint.

Conduct Justifying a Complaint:

Any person may make a complaint against a Member regarding any conduct of a Member that:

1. Violates any provision in the Code of Ethics, Standards of Practice, Scope of Practice, CMMOTA Bylaws, or CMMOTA Policies; and/or
2. Is detrimental to the best interests of the public; and/or
3. Harms or tends to harm the standing of the profession generally; and/or
4. Displays a lack of knowledge, skill, or judgement in the practice of the profession.

To initiate a formal inquiry into your complaint, please:

- Complete the CMMOTA Complaint Form in its entirety. A completed form is necessary to initiate a formal inquiry into your complaint(s).
- Forward the completed forms to the CMMOTA office. You can send it to info@cmmota.com or fax them to 403-517-7675.

Upon receiving a formal written complaint CMMOTA will follow the process located in the CMMOTA *Discipline for Complaints Policy*

*If you have any questions or require assistance to complete this form, please contact the CMMOTA office at 403-356-1160 or info@cmmota.com.

Please note:

- Although the CMMOTA seeks to resolve conflicts between clients and our Members to the satisfaction of all parties involved, the purpose of the complaints process is to reduce the risk of recurrent conduct that prompted the initial complaint.
- The Canadian Massage & Manual Osteopathic Therapists Association cannot award financial compensation.

OFFICE USE ONLY – COMPLAINT FILE NUMBER_____-_____.

Information of Person Registering Complaint

Ms. /Mrs. /Mr. /Dr. _____

Email Address: _____

Mailing Address: _____

City, Province: _____ Postal Code: _____

Telephone:

(home)_____(work)_____(cell)_____

- If you are not the client, please describe your relationship to the client and provide details about the client below. If you are the client, please provide Date of Birth and then proceed to **Therapist Information.**

Relationship to Client: _____ Date of Birth: _____

- Please note that if you are making a complaint on behalf of a client, consent from the client or the client's legal representative to release medical information will be required.

Client Information

Ms./Mrs./Mr./Dr. _____

Mailing Address:_____

City, Province: _____ Postal Code:_____

Date of Birth:(D/M/Y) _____ Telephone:_____

Date of Death:_____ Telephone (W):_____

Telephone (C): _____

Therapist Information

Therapist's Name: _____

Clinic Name: _____

Clinic Address: _____

City, Province: _____ Postal Code: _____

Clinic Telephone Number: _____

Therapist Membership Number: _____

OFFICE USE ONLY – COMPLAINT FILE NUMBER_____-_____.

Witness Information

Provide the name(s) of any other individual(s) and the details of the information they may have pertaining to the complaint (i.e. physician, other health professionals). By including an individual on this list, you are confirming that they have agreed to provide information regarding your complaint should they be contacted as a witness through the investigation process.

Name: _____ Telephone Number: _____

Relationship to the client: _____

Information pertaining to complaint: _____

_____

Name: _____ Telephone Number: _____

Relationship to the client: _____

Information pertaining to complaint: _____

_____

Name: _____ Telephone Number: _____

Relationship to the client: _____

Information pertaining to complaint: _____

_____

- If there are additional witnesses, please provide them on an additional piece of paper. Thank-you.

Has this complaint been registered with local law enforcement, another organization, or another agency or association? _____Y _____N

If so, please complete the following:

Organization Name: _____

Contact Name: _____ Telephone Number: _____

File Number (if applicable): _____

Organization Name: _____

Contact Name: _____ Telephone Number: _____

File Number (if applicable): _____

OFFICE USE ONLY – COMPLAINT FILE NUMBER_____-_____.

Details of Complaint

Date(s) of Treatment: _____

Body Location or Type of Treatment: _____

Provide a brief and clear description of the complaint(s) you have about the Massage Therapist named in this submission. Include examples where appropriate (e.g. if you are alleging rude behavior provide examples). Please provide as much details as possible.

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(if more room is needed, please provide additional information on another sheet)

OFFICE USE ONLY – COMPLAINT FILE NUMBER_____-_____.

What is your expected resolution following the investigation of this complaint?

PLEASE NOTE The Canadian Massage & Manual Osteopathic Therapists Association cannot award financial compensation.

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Please note, all information received is treated and considered as CONFIDENTIAL. It is solely intended for the use of the CMMOTA Complaint Review Process laid out in the *Discipline for Complaints Policy* and the Member that the complaint has been filed against, or entity to who this correspondence is addressed. All other recipients are prohibited from disclosing, copying, using, distributing, or taking any action in reliance of the contents.

DECLARATION OF ACURRACY: I understand that providing false statements may open me to civil liability for defamation and I attest that the above information provided is accurate to the best of my knowledge.

_____ _____

Signature of person making complaint Date

_____ _____

Signature of client (if applicable) Date

STATEMENT OF CONSENT

I, _____, hereby authorize the Canadian Massage and Manual Osteopathic Therapists Association to both proceed with an investigation into the complaint that I have made within the next 10 business days, and to adjudicate the matter based on the results of their investigation as per the CMMOTA *Discipline for Complaints Policy* document. I understand that although the CMMOTA seeks to resolve conflicts between complainants and its members to the satisfaction of all parties involved, the purpose of the complaints process is to reduce the risk of recurrent conduct that prompted the initial complaint. I also understand that the Canadian Massage & Manual Osteopathic Therapists Association cannot award financial compensation.

I, (clients name) _____, hereby authorize (name of therapist)_____ and/or (name of clinic) _____ _____ to allow access to all my personal information that they are retaining including, but not limited to my treatment records, to the Canadian Massage and Manual Osteopathic Therapists Association (CMMOTA) and their representatives. I also grant permission for the CMMOTA to obtain copies of this information for the purposes of investigation and adjudication of a complaint of which I am a part. I also grant permission for the CMMOTA to retain the obtained information as part of the Complaint File for as long as they deem necessary.

I attest that I am providing this statement of consent of my own free will.

Name of Complainant _____

Signature of Complainant _____

Name of Client (if different than complainant) _____

Signature of Client _____

Date (YYYY/MMM/DD): _____