INQUIRIES DIVISION
1250, René-Lévesque Blvd. W., Suite 3500, Montreal (Quebec) H3B 0G2
Tel.: 514 933-4441 or 1 888 633-3246
Fax: 514-933-2291 | deonto@cmq.org

COLLÈGE DES MÉDECINS DU QUÉBEC

Inquiries Division
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. Please do not hesitate to contact us if you have any questions.

If your inquiry request concerns a resident or a fellow, the information you provide may be forwarded to the university authorities for analysis.

A – Your contact information

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

Pronouns used: ☐ She ☐ He ☐ Other ☐ Prefer not to answer

Surname: _____ First name: _____

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

City: _____ Province : _____ Postal code: _____

Home phone: _____ Cell phone: _____

Email: _____

Preferred method of communication: ☐ Mail ☐ Secure 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 this person 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's contact information (do not complete if identical to Section A)

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 person.

Surname: _____ First name: _____

Specialty: _____

Where did the consultation with this person take place?

☐ Hospital ☐ Office (clinic) ☐ Walk-in clinic

Other, specify: _____

Name of the clinic or health care facility: _____

Address (no.): _____ Street: _____ City: _____

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

D - Description of your concerns

Provide a description of the situation including, if possible:

- the nature of your complaint or dissatisfaction;
- the reason(s) why you consulted this person;
- where the consultations or events took place;
- the dates on which the consultations or treatments took place;
- if you refer to care provided by other physicians in your request, even if you do not have any criticisms against them, please tell us their names and where the consultations 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 complete your description on the pages provided for this purpose in Appendix A of the form. Attach a copy of any documents relevant to the examination of your request (**including any recordings**).

Signature : _____ Date : _____

APPENDIX A