TO: THE REGISTRAR, P O BOX 205, Pretoria, 0001

553 Madiba Street, Arcadia 0083; Legalmed@hpcsa.co.za; Tel: 012 338 9300; Fax: 012 328 4895

COMPLAINT FORM	
1. DETAILS OF COMPLAINANT / REPRESENTATIVE	
Title & Full names of complainant	
Identity / Passport number	
Postal Address	
Physical Address	
Cellphone number	
Landline number	
Fax number	
E-mail address	
Power of Attorney must be attached if complainant is a representative.	
2. DETAILS OF THE PATIENT IF THE PATIENT IS NOT THE COMPLAINANT	
Title & Full names of the patient	
Identity number / birth date / Passport number	
Postal Address	
Physical Address	
Cellphone number	
Landline number	
Fax number	
E-mail address	

3.	DETAILS OF PRACTITIONER
Name of Practitioner	
Physical Address (not PO Box)	
HPCSA Registration Number	
Practice Number	
Cellphone number	
Telephone Number	
Fax Number	
E-mail address	

4.	DETAILS OF COMPLAINT (or attach to this form)
5. List of documents relevant to complaint attached to this form (if any)	

E.g. Medical reports, x-rays, hospital records, statement of account, affidavit/ confirmatory statement of patient above 12 years of age, etc.	
6. What outcome do you expect for this complaint? (Acknowledgment letter will be sent within 7 days. **Financial compensation** is through Courts, not HPCSA)	
7. Date	
8. Place	
9. Signature of complainant	

10. CONSENT BY PATIENT
(compulsory if above 12 years old on date of Complaint)

I hereby grant consent to my treating practitioner to disclose my confidential medical information to the HPCSA and/or to my treating practitioner's legal representative in the course of addressing my complaint lodged with the HPCSA if necessary.

Signature……

Date ……

11. CONSENT BY NEXT OF KIN
(if patient is deceased or cannot consent)

I hereby grant consent to the practitioner who treated the patient to disclose the patient's confidential medical information to the HPCSA and/or to the treating practitioner's legal representative in the course of addressing my complaint lodged with the HPCSA if necessary.

Signature……

Date……..

LETTER OF CONSENT FOR HOSPITAL RECORDS (IF APPLICABLE)

I, the undersigned,

…..……..……

do hereby grant the Health Professions Council of South Africa and/or their authorised agent(s), the treating practitioners and their legal representatives **consent** to inspect and/or request and/or obtain copies of the medical records, bed-letters and/or x-rays, clinical reports from the doctors, relating to the treatment received by (**patient's name, not doctor's name**):

…..……..……..……

at…… **HOSPITAL** during the period ……..……..

Hospital file number: …..…….....

Address of Hospital: ……..

Tel Number of Hospital: …… Fax Number …….…….

Identity / Passport Number of the person who was admitted at the hospital: ……..

(PLEASE ATTACH PATIENT'S COPY OF ID / PASSPORT / BIRTH CERTIFICATE)

ID No of person responsible for payment of the hospital account:

…….……..

Medical Aid No: ……..

_____

SIGNATURE

Date:…….