COMPLAINT FORM

First Name	Last Name	Date

Address	City

Province	Postal Code	Phone	Fax

E-mail	Preferred Method of Contact

Names of the Individual(s) Involved

Date/Time/Location of Incident	Did You Report or Attempt to Resolve the Issue

Witnesses - Please provide their names and contact details below (Note: by providing this information you consent to Benchmark IME to contact them)

Specific Details and Nature of Complaint:

Efforts Taken to Resolve the Complaint and/or Previous Resolution Attempts:

Requested Resolution to the Matter:

Please complete this form, include any additional documentation, and send to:

Email: complaints@benchmarkime.com

Fax: 905.827.6085

Mail: Attn: Manager of Clinical Services
Benchmark Independent Medical Examinations Inc.
303 – 165 Cross Ave.
Oakville, ON L6J 0A9

Place and Date

____

(Signature)

____

Name