



CHSLD juif de Montréal

Jewish Eldercare Centre

COMPLAINT FORM

USER IDENTIFICATION

Last name : _____ First Name : _____
Telephone # : _____
Address and postal code : _____
Room Number (if applicable) : _____ File Number : _____

FACILITY OR RESOURCE IN QUESTION

Hope Pavilion Kastner Pavilion

IDENTIFICATION OF THE PERSON MAKING THE COMPLAINT ON BEHALF OF THE USER (if applicable)

Last name : _____ First Name : _____
Telephone # : _____ Work Telephone # : _____
Address and postal code : _____
Relationship to the User : _____ Legal Representative : _____

IDENTIFICATION OF THE PERSON OR ORGANIZATION ASSISTING THE USER (if applicable)

Last name : _____ First Name : _____
Organization : _____ Telephone # : _____
Address and postal code : _____
Relationship to the User (if applicable) : _____

INFORMATION ABOUT THE COMPLAINT

Please indicate, if possible, the date, time, place and the person or service affected

Date of Event : _____ Time : _____
Place : _____
Person and service affected : _____

(Continued on back)

