Ancient Rivers
FAMILY HEALTH TEAM

Ancient Rivers Family Health Team Complaint Form

Name of Person Submitting Complaint	**Daytime Phone**	**Alternate Phone**
Street Address		
City	**Province**	**Postal Code**
Name of Client for whom you are filing this complaint (if you are not filing for yourself)		**Relationship to Client**
Email Address		
Name of person against whom you are making this complaint:		
Identify the grounds upon which the complaint of discrimination or alleged discriminatory practice or harassment is being made:		
Narrative description of your complaint: Describe the factors and issues that caused you to file this complaint and what happened – include when and where it happened and who was involved. If possible, include the full names of any individuals involved. If possible, attach copies **(do not send originals)** of any relevant documents.		
What would resolve this complaint to your satisfaction?		

Signature: _____ Date: _____