YOUR EXPECTATIONS

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User's signature: _____

_____

Date: _____

Signature of user's representative, if applicable:

_____

Date: _____

SEND US YOUR FORM BY:

1. MAIL
   SERVICE QUALITY AND
   COMPLAINTS COMMISSION
   1215 CHEMIN DU TREMBLAY
   SUITE 220, ROOM 2270
   LONGUEUIL QC J4N 1R4

2. EMAIL
   plaintes.cisssme16@ssss.gouv.qc.ca

3. FAX
   450 468-8261

FOR INFORMATION:

Phone: 450 468-8447
Toll freee: 1 844 302-8447

Centre intégré
de santé
et de services sociaux
de la Montérégie-Est

Québec

2102 (100-3487)

SERVICE QUALITY AND
COMPLAINTS COMMISSION

COMPLAINT FORM

"IMPROVING THE QUALITY OF SERVICES: OUR MAIN CONCERN!"

Québec

USER IDENTIFICATION (PATIENT/RÉSIDENT)*

First and last names:

FIRST NAME FAMILY NAME

Maiden Name (if applicable)

Full address:

Telephone (between 8:30 a.m. and 4:30 p.m.):

(_____) _____

Cell phone:

(_____) _____

Email:

Date of Birth: _____ / _____ / _____

YYYY MM DD

File Number (if available)

Complainant: ☐ User ☐ User's representative

Date and time of event:

_____ / _____ / _____ / _____ CHECK ☐ A.M. ☐ P.M.

YYYY MM DD TIME

*Personal information provided is confidential

LOCATION WHERE THE EVENT TOOK PLACE (CHECK AND NAME)

☐ Hospital ☐ CHSLD ☐ CLSC ☐ Intermediate resource ☐ Protection and Rehabilitation Centre for Troubled Youth
☐ Family-type resource

DESCRIBE THE EVENT