

Complaints Form

This is a fillable form. Please type along the lines to enter your information.

Complainant information

Name: _____

Mailing address: _____
Street number Street

City Province Postal code

Telephone number: _____

Email address: _____

Are you the patient/client?

Yes No

If no, please provide the name of the patient/client: _____

Is the patient/client aware you are making this complaint?

Yes No

Information about the kinesiologist (Please provide as much information as you are able)

Name: _____

Company name: _____

Practice address: _____

Registration number: _____

Details of the complaint

Date of incident(s): _____

Location(s) of incident(s): _____

Names of other healthcare professionals you have spoken to about the incident(s):

Specific concerns:

Any other additional Information:

Please complete the form and send:

By email: complaints@coko.ca

OR

By mail: Registrar c/o Professional Conduct Department
College of Kinesiologists of Ontario
160 Bloor Street East, Suite 1402
Toronto, ON
M4W 1B9

OR

By fax: (416) 961-7009