CENTRE D'AIDE ET DE LUTTE CONTRE
LES AGRESSIONS À CARACTÈRE SEXUEL
DE LA VALLÉE-DE-LA-GATINEAU

COMPLAINT FORM
STEP 2

Identification of the user (*REQUIRED)

*Full name: _____ *Telephone: ( ) ____ - _____

*Birthday date: _____-_____-_____

*Adress: _____*Code postal_____

Current location (if applicable): _____

Complainant information *(If different from user)*

☐ Representative
(*with user's authorization)

☐ Other (your link) _____
(*with user's authorization)

Full name: _____ Telephone: ( ) _____ - _____

Adress: _____ Code postal _____

Reason of representation (Why are you representing): _____

Kinnship (*If applicable*): _____

Complaint *(If more space is needed, attach extra sheets)*

☐ Right to participate ☐ Right to consideration ☐ Right to protection

☐ Right to privacy ☐ Right to information

☐ Right to compensation and restitution of property ☐ Right to support and guidance

Employee name : _____ Job title : _____

Where did the incident occur? (ex. Hospital, CLSC) : _____

Department? : _____

Date of incident : _____

Description of incident (please be as specific as possible and include: time, location, date, physical descriptions) : _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Complaint (continued)

State your expectations in the treatment of this complaint (*REQUIRED)

***DIVULGATION AUTHORIZATION**: ☐ YES

I hereby authorize the Service Quality and Complaints Commissioner to divulge this complaint to the Head of the concerned Department, only for its examination. Strict confidentiality will be upheld during the entire length of the examination process.

Signature of the user — Date

Signature of legal representative — Date

This duly completed and signed complaint form must be sent to the CALACS Vallée-de-la-Gatineau coordinator in person or by email at :

Coordonnatrice : contact@calacsvg.com
Carole St-Amour : carolestamour@videotron.ca
Carole Beaudin : carolebeaudin19@gmail.com

MAXIMUM TIME OF 30 DAYS FOR A FOLLOW-UP