COMPLAINT FORM **– Please enter the necessary details and mail ORIGINAL form to our office at the below mentioned address. Kindly affix signature at the bottom of complaint form. Please note that complaints will only be addressed when the ORIGINAL complaint is received. A complete account of events can be attached as an appendage.**

FULL NAME OF THE COMPLAINANT: _____

CONTACT DETAILS OF COMPLAINANT
(Mailing Address): _____

_____

(Telephone Contact):_____

FULL NAME OF MEDICAL PRACTITIONER
COMPLAINT IS BEING MADE AGAINST: _____

CONTACT DETAILS OF MEDICAL PRACTITIONER
(Mailing Address & Telephone Contact): _____

_____

DETAILS OF ALLEGED INCIDENT(S)
(Kindly ensure that details are not vague/nebulous/hazy): _____

_____

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DATE OF ALLEGED INCIDENT(S): _____

TIME OF ALLEGED INCIDENT(S): _____

PLACE OF ALLEGED INCIDENT(S): _____

DATE OF ALLEGED INCIDENT(S): _____

TIME OF ALLEGED INCIDENT(S): _____

PLACE OF ALLEGED INCIDENT(S): _____

Signature of Complainant:_____

Mailing Address: The Secretary
Medical Board of Trinidad and Tobago
Eric Williams Medical Sciences Complex
Uriah Butler Highway, Champs Fleurs, TRINIDAD, W.I.