



*Health Professional Councils Authority*

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## Section 1

### Your details - Part A

I am a

If relative or friend  
(please specify)

of the patient / person receiving the service  
of the health practitioner

If treating practitioner  
(please specify)

of the patient / person receiving the service  
of the health practitioner

If education provider (please specify)

Organisation Name

Position Title

If Other - please specify

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Title

First Name

Middle Name

Last Name

Gender

Male

Female

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### Contact details - Part B

E-mail Address

Preferred daytime  
phone number

Mobile number

Apartment / unit/ house number

Street Name

City

Postcode

State

Country

## Part C

I am making this complaint on behalf of:

Myself (please go to Section 2)

Another person (complete this section below with their details)

What is your relationship to them

Is the person deceased ?

Yes (if Yes, complete Part D)

No (if No, complete Part E)

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Part D - If you answered yes to the above question please complete this section

Date of Death

Their Title

Their gender

Male

Female

Their First Name

Their Last Name

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Part E - If you answered no to the above question please complete this section

Does this person know you are making this complaint?

Yes

No

Does this person require assistance to communicate with the Council?

Yes

No

Is the person of Aboriginal or Torres Strait Islander descent?

Yes

No

Does this person have a disability /special needs?

Yes

No

If yes  
(please  
specify)

May we discuss your complaint with this person?

Yes

No

Are you able to provide the name and contact details for the person

Yes

No

**If you can provide details for the person please do so below:**

Their Title

Their gender

Male

Female

Their First Name

Their Last Name

Preferred daytime phone number

Mobile number

Email address

Apartment / unit / house number

Street name

City

Postcode

State

Country

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## Section 2

### Practitioner details

**Please include as much information as possible about the practitioner that your complaint or concern is about**

Please select the health profession your complaint relates to

#### Health practitioner's personal details (f known)

Title

First name

Last name

Gender

Male

Female

Health practitioner's contact details (if known)

Contact number

Place of Work

Apartment / unit / house number

Street name

City

Postcode

State

Country

AHPRA Registration number (if known)

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### Section 3

#### Complaint details

Is the person you are complaining about  
a health practitioner or student

Practitioner

Student

**Provide a short summary of your  
complaint. It is useful to include what  
happened, when it happened and who  
was involved**

**The main issues I am concerned about  
are:**

**As a result of my complaint, I want:**

**Please attach supporting documents relating to your complaint**

Have you approached the practitioner about your concerns

Yes

No

Have you made a complaint or raised a concern about the health practitioner to any other organisation?

Yes (If yes please specify below)

No

If you answered yes to the above please  
provide details

How did you hear about us?

Internet search

HPCA website

Family/friend

Health service provider

I have previously complained

Other

**It would assist us to have your consent to access your medical records for the purpose of assessing this complaint.**

I authorise the Health Care Complaints Commission to access my personal health records for the purpose of handling this complaint.

Yes

No