



Saskatchewan Association of Medical Radiation Technologists

Complaint Form

Complainant

Mr. Ms. Surname _____ Given Name(s) _____

Mailing Address _____

Telephone (_____) _____ Alternate Telephone (_____) _____

Email _____

Complaint

Name of Medical Radiation Technologist _____

Date(s) of occurrence _____

Name, address and telephone number of facility where events occurred:

Name(s) of other individual(s) (i.e. other health professionals) and details of information they may have about the complaint:

Name	Address	Telephone	Details of information they may have

Provide a clear description of the complaint about the Medical Radiation Technologist, including as much detail as possible. *This section must be completed.*

Signature: _____ Date: _____