



## Massage Therapist Association of Alberta Complaint Submission Form

The Massage Therapist Association takes your complaint seriously and will investigate, however it is important to note that often the process takes several weeks to complete depending on the complexity of the complaint.

### To begin a formal inquiry into your complaint, please:

- Complete this form. A completed form is necessary to initiate a full investigation of your complaint.
- Forward the completed submission and authorization forms to the MTAA Office.

### Upon receiving the forms, the MTAA will:

- Contact the Massage Therapist in question and provide them with a summary of the complaint.
- Contact those individuals who may have information relevant to the complaint.
- Review all information. Further communication with the parties involved may be necessary.
- Inform the complainant and Massage Therapist in writing of the results of the review.

***If you have any questions or require assistance to complete this form, please contact the MTAA Office at 403-340-1913.***

### A. Person Registering Complaint

Ms/Mrs./Mr./Dr. \_\_\_\_\_  
First Name Last Name

Mailing Address: \_\_\_\_\_

City, Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone (Home): \_\_\_\_\_

Telephone (Work): \_\_\_\_\_

Telephone (Cell): \_\_\_\_\_

***If you are not the patient, please describe your relationship to the patient and provide details about the patient below. If you are the patient please proceed to section C.***

### B. Patient Information

Ms/Mrs./Mr./Dr. \_\_\_\_\_  
First Name Last Name

Mailing Address: \_\_\_\_\_

City, Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone (Home): \_\_\_\_\_

Date of Death: \_\_\_\_\_ Telephone (Work): \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ Telephone (Cell): \_\_\_\_\_

***Please note that if you are making a complaint on behalf of a patient, consent from the patient or the patient's legal representative to release medical information will be required.***



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### C. Therapist Information

Therapist Name \_\_\_\_\_

First Name

Last Name

Clinic Name \_\_\_\_\_

Clinic Address: \_\_\_\_\_

City, Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Clinic Telephone Number: \_\_\_\_\_

Therapist Membership Number: \_\_\_\_\_

***Provide the name(s) of any other individual(s) and the details of the information they may have pertaining to the complaint (i.e. physician, other health professionals)***

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Information pertaining to complaint: \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Information pertaining to complaint: \_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Information pertaining to complaint: \_\_\_\_\_

\_\_\_\_\_

***Has this complaint been registered with any other organization or agency?  Yes  No***  
*If so, please complete the following:*

Organization Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Organization Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_





## Massage Therapist Association of Alberta Complaint Submission Form

What is your expectation from the investigation of this complaint?


- Although the Complaints and Discipline Committees seek to resolve conflicts between patients and Massage Therapists to the satisfaction of all parties involved, the purpose of the complaints resolution process is to reduce the risk of recurrent conduct that prompted the initial complaint.
- The Massage Therapist Association of Alberta cannot award financial compensation.
- Please note, all information received is to be treated and considered as CONFIDENTIAL. It is solely intended for the use of the MTAA Complaints and Discipline Committees and the Massage Therapist that the complaint is against, or entity to who this correspondence is addressed. All other recipients are prohibited from disclosing, copying, using, distributing or taking any action in reliance of the contents.

\_\_\_\_\_  
Signature of person making complaint

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient (if possible)

\_\_\_\_\_  
Date

**Return to:**  
**Massage Therapist Association of Alberta**  
**#2, 7429 – 49 Ave..**  
**Red Deer, AB**  
**T4P 1N2**  
**Fax: 403-346-2269**

**Date Received into MTAA Office:** \_\_\_\_\_

**Via:**  Mail  
 Fax

**Signature of Staff Receiving Complaint:** \_\_\_\_\_

**Date Submitted to Complaints Committee:** \_\_\_\_\_ **File #:** \_\_\_\_\_