



Massage Therapy Association of Manitoba, Inc. Complaints Investigation Application Form

The Massage Therapy Association of Manitoba (MTAM) 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 MTAM Office.

Upon receiving the forms, MTAM 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 MTAM Office at 204-927-7977 or toll free at 1-866-605-1433.

A. Person Registering Complaint

Prefix/Title: _____ 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

Prefix/Title: _____ First Name: _____ Last Name: _____

Mailing Address: _____

City, Province: _____ Postal Code: _____

Date of Birth: _____ Telephone (Home): _____

Telephone (Work): _____

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.

C. Therapist Information

Therapist First Name: _____ Therapist Last Name: _____

Clinic Name: _____

Clinic Address: _____

City, Province: _____ Postal Code: _____

Clinic Telephone Number: _____

Therapist Registration Number: _____

Provide the name(s) of any other individual(s) and the details of the information they may have which pertains 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 "Yes", please complete the following:

Organization Name: _____

Contact Name: _____ Telephone Number: _____

Organization Name: _____

Contact Name: _____ Telephone Number: _____

D. Details of Complaint

Date(s) of Treatment: _____

Body Location or Treatment Type: _____

Provide a brief and clear description of the complaint(s) you have about the Massage Therapist named in this submission. Include examples where appropriate (e.g., if you are alleging unprofessional behavior provide examples).

What is your expectation from the investigation of this complaint?

- Although MTAM seeks to resolve conflicts between patients and Massage Therapists to the satisfaction of all parties involved, the purpose of the complaint resolution process is to reduce the risk of recurrent conduct that prompted the initial complaint.
- The Massage Therapist Association of Manitoba 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 MTAM 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: _____

Relationship of complainant to patient: _____

Signature of patient (if possible): _____

Date: _____

Return to:
C/O Executive Director
Massage Therapy Association of Manitoba Inc.
175 Marion Street
Winnipeg, Manitoba
R2H 0T3
tweid@mtam.mb.ca