

Patient Information

Name: _____

Address: _____

City: _____ Postal Code: _____

Telephone: (_____) _____ * Please provide best number to reach you at

Email: _____

Practitioner Name: _____

Clinic Name and Address: _____

City: _____ Telephone: (_____) _____

Nature of Complaint: (including dates if known and pertinent details)

Attach additional information if warranted

I provide the Saskatchewan Association of Optometrists authority to investigate this complaint and to view my eye health records if required.

Patient Signature: _____

Please complete this page and return via fax or email at [306.652.2642](tel:306.652.2642) | ed@saosk.ca

Please contact us if you have any questions

Phone: [306.652.2069](tel:306.652.2069) | Toll-free: [1.877.660.3937](tel:1.877.660.3937)

102-202 Wellman Crescent | Saskatoon, SK | S7T 0J1

For Office Use Only:

Date Received: _____

Mediator: _____