Saskatchewan Association of Optometrists

Patient Information

Name: _____

Address: _____

City: _____ Postal Code: _____

Telephone: (_____)_____ 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 306.652.2642 or email ed@saosk.ca

Please contact us if you have any questions
Phone: 306.652.2069 | Toll-free: 1.877.660.3937
102-202 Wellman Crescent | Saskatoon, SK | S7T 0J1

For Office Use Only

Date Received: _____

Mediator: _____