

Dental Board of New South Wales

COMPLAINT FORM

If you are thinking about making a complaint it may be useful for you to contact the Dental Board at the number on page 4 to discuss your complaint, or seek assistance before lodging it with the Board.

I wish to lodge a complaint with the Dental Board of New South Wales

MY PERSONAL DETAILS

Mr/Mrs/Ms (Other) First Name Last Name

Address

..... Postcode

Date of Birth / /

Telephone (business hours) (after hours)

Mobile email address

My preferred language other than English is

The best way to contact me is

I have spoken to the Dental Board before lodging this complaint YES NO

PATIENT DETAILS (if you are NOT the patient but are making this complaint about the care of another person)

The person who received the dental care service was

Mr/Mrs/Ms (Other) First Name Last Name

Address

..... Postcode

Date of Birth / / Telephone

My relationship to the person is (e.g. sister, parent, carer)

Is the person aware you are complaining on their behalf YES NO

COMPLAINT SUMMARY

What are your main concerns?

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.....
.....
.....

DESIRED RESULT

What do you want as a result of your complaint?

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.....
.....

ACTION ALREADY TAKEN

Was the Dental Service Provider approached about your concerns? YES NO

If YES, what was the outcome?

.....
.....
.....

Have you complained to another organisation about the same matter YES NO

If YES, which organisation and what was the outcome?

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.....
.....

I UNDERSTAND THAT

- The Dental Board will normally release to the Dental Service Provider or other people dealing with this complaint, a copy of my complaint.

If you have any concerns about this, please specify –

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Signature Date

Please forward the completed form and any documents you want to send with this complaint to:

Registrar
 Dental Board of New South Wales
 P O Box K1116
 Haymarket
 Sydney, NSW 1240

Telephone: (02) 9281 0835
 Facsimile: (02) 9211 3606
 Website: www.dentalboardnsw.org.au

Remember:

- To attach copies of any documents that you want the Dental Board to see. Please do not send the original written or typed documents
- Keep a copy of your complaint
- Please send in any original x-rays which will be returned to you upon completion of the complaints process
- **Your complaint may require you to have an independent assessment by another dentist recommended by the Dental Board. Any further treatment should be postponed until a decision is made in this matter.**

Please be advised that a person who provides to the Dental Board information that is false or misleading may be guilty of an offence.

AUTHORITY FORM

I, (name)

of (address)

hereby authorise officers of the Dental Board to have access to all information, medical or otherwise, relating to my care and treatment

by (Dentist)

of (address)

Relationship to Complainant:

Particulars

Full name of complainant:

Date of birth:

Address:

Address at time of treatment:

Date of treatment: From To

.....

(Signature)

.....

(Date)