The Sindh Healthcare Commission

In pursuance of Sindh Healthcare Commission (SHCC) Act 2013, the SHCC is an autonomous body dealing with regulation and quality of health services provided in both the public and the private sector in the province of Sindh. The SHCC deals with complaints about health services affecting the clinical management or care of a patient, professional conduct of a health practitioner/healthcare establishment, and risks to the health and safety of the public.

Making a Complaint
Any person or his/her legal representative can lodge a complaint. The complaint must be in writing using this form. It is important to include all relevant information and any relevant additional documents may be attached to this form.

First point of making a Complaint
An aggrieved person/client or his/her legal representative shall first make a complaint to the owner/manager of the healthcare establishment (HCE) within (30 days) from the day on which the person aggrieved frist had the notice of the matter alleged in the complaint. A complaint should only be lodged with the SHCC if HCE is unable to resolve the issue or concern at point first-point the HCE.

Assistance required while making a Complaint
If you have difficulty in writing the complaint, the SHCC helpline can be reached at number(s) 0800 07422.

The Complaint Process
When a complaint is lodged, the complainant will receive an acknowledgement receipt from the SHCC. Complaint will be assessed and reviewed and if it is accepted for investigation then, the SHCC will inform the complainant to provide facts before the investigation team. Every complaint is investigated on a case-by-case basis and decision will be informed in writing.

Appeal against Decision
The complainant has the right to appeal against the decision within 30 days before the district/session judge.

Directorate of Complaint SHCC

Address: 2nd Floor, Block C, Finance Trade Center (FTC), Shahrah-e-Faisal, Karachi.

+92 21 38656000, info@shcc.org.pk www.shcc.org.pk
## SECTION 1  
### PERSONAL INFORMATION OF COMPLAINTANT

<table>
<thead>
<tr>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Healthcare Establishment</td>
</tr>
<tr>
<td>Name of Owner of Healthcare Establishment</td>
</tr>
<tr>
<td>CNIC number of owner</td>
</tr>
<tr>
<td>First &amp; Last Name of Complainant</td>
</tr>
<tr>
<td>CNIC number of Complainant</td>
</tr>
<tr>
<td>Postal address of Healthcare Establishment</td>
</tr>
<tr>
<td>Email address (If any)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Landline</td>
</tr>
<tr>
<td>Mobile</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preferred contact method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone</td>
</tr>
<tr>
<td>Mobile</td>
</tr>
<tr>
<td>Letter</td>
</tr>
<tr>
<td>Email</td>
</tr>
</tbody>
</table>

## SECTION 2  
### FIRST POINT OF COMPLAINT

<table>
<thead>
<tr>
<th>Did you lodge your complaint with any other agency?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes / No (if “No” then go to next question)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If yes, mention date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day---------- Month-------- Year-----------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To whom:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Write outcome/result of that complaint (Use Additional sheet if required)</th>
</tr>
</thead>
</table>
Did you lodge a complaint with SHCC before?

☐ Yes ☐ No (if “No” than go to next question)

If yes, mention date:

Day---------- Month---------- Year----------

To whom:

Write outcome/result of that complaint (Use Additional sheet if required).

SECTION 3

A. Healthcare Service Provider (HCSP)

B. Healthcare Establishment (HCE)

C. Patient or his/her carers (HCP)

Name of service provider:

Registration Number:

Name of Organization/Hospital/ Centre/Individual Owner:

Type of service provider

☐ Doctor ☐ Nurse ☐ Dentist ☐ Other(Please specify)

Telephone number

Landline / Mobile

Address

B. Healthcare Establishment

Outline as much as details possible:

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### Name of Manager/Administrator:

Name:

### Name of Organization/Hospital/ Centre/Individual Owner:

Name:

### Type of Healthcare Establishment

- **Specify:**
  - **Specify:**
  - **Specify:**
  - **Specify:**

### Telephone number

- **Specify:**
- **Specify:**
- **Specify:**

### Address

- **Specify:**
- **Specify:**
- **Specify:**

### C. Patients or his/her carers (include as much as possible)

- **Specify:**
- **Specify:**
- **Specify:**

### Patient Name:

- **Specify:**
- **Specify:**

### CNIC Number:

- **Specify:**
- **Specify:**

### Unit/Ward of Patient

- **Specify:**
- **Specify:**

### Telephone number

- **Specify:**
- **Specify:**

### Address

- **Specify:**
- **Specify:**

### SECTION 4 MY COMPLAINT

- **Specify:**
- **Specify:**

### a) Type of Complaint (tick the relevant box(s))

- [ ] Harassment/Violence
- [ ] Damage of property
- [ ] Others (Specify)

### Directorate of Complaint SHCC

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(b) Kindly provide a short summary of your complaint. It is useful to include what happened, when it happened and who was involved. If you need more space, please attach separate page to the back of this complaint form. Please attach any relevant documents.

(c) What is your specific request to Sindh Healthcare Commission (SHCC)?

SECTION 5
AUTHORITY

The SHCC is required to give the information about the name of the complainant and nature of your complaint to the HCE/HSCP/Patient / patient Carealthough in special circumstances the commission may withhold this information, if there are valid reason for doing so. If you have any concern about the release of your name and/or complaint, please mention the reasons.
SECTION 6

ACCESSING HEALTH INFORMATION

It will assist the SHCC to have the consent of the owner of the healthcare establishment who experienced that event so that the Commission can collect the required information to assess your complaint.

☐ I am complaining and authorize the SHCC to access my personal information for the purpose of handling this complaint.

Signature

Thumb Impression

ACKNOWLEDGEMENT

All the information provided above is true and correct to the best of my knowledge.

Signature

Date

Thumb Impression

Directorate of Complaint SHCC

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Before sending this form, kindly check that you have:

- Included as much as relevant information as possible.
- Given details of HCSP / HCE, you are complaining about.
- Clearly identified your concern.
- Answered Section 5: Authority and Section 6: Accessing Health Information.
- Submitted copies of CNIC and copies all supporting documents (Please do not send original documents).
- An Affidavit (Accepting responsibility that the information provided is true)

Please send complaint and supporting information to:
The Chief Executive Officer (CEO)
The Sindh Healthcare Commission
Address: 2nd Floor, Block C,
Finance Trade Center (FTC), Shahrah-e-Faisal, Karachi.
For online submission of complaint form, Go to SHCC Web page: www.shcc.org.pk

Please Note:
It is an offense for a person to provide false information to the Sindh Healthcare Commission. In such a case, that person will face a penalty of up to Rs. 200,000/=

Directorate of Complaint SHCC
**ACKNOWLEDGEMENT SLIP**

<table>
<thead>
<tr>
<th>Complaint number:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>شكاوى رقم:</td>
<td>تاريخ:</td>
</tr>
<tr>
<td>S/D/W/O</td>
<td></td>
</tr>
</tbody>
</table>

The SHCC acknowledged the complaint submitted by Mr./Mrs./Ms. ___________________________ regarding ___________________________.

The SHCC will update you regarding actions on your complaint.

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**OFFICE USE ONLY**

<table>
<thead>
<tr>
<th>Complaint reference No.:</th>
<th>Date:</th>
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</thead>
<tbody>
<tr>
<td>شكاوى رقم:</td>
<td>تاريخ</td>
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<tr>
<td>S/D/W/O</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Complaint:</th>
<th>Service Provider</th>
<th>Health Establishment</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>طبي عمل</td>
<td>مريض</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Complaint:</th>
<th>Service Provider</th>
<th>Damage of property</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>براندين / كفر / هراسان طرف</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Complaint lodged:</th>
<th>Online</th>
<th>In writing</th>
<th>In person</th>
</tr>
</thead>
<tbody>
<tr>
<td>ذاكرة كم طريقي كن / ذاكرات تدخل طبي</td>
<td></td>
<td>الكرنكر / نَتَوي</td>
<td></td>
</tr>
</tbody>
</table>

Notes: ___________________________