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 date on which the person aggrieved first 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 first point of 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
### PERSONAL INFORMATION OF COMPLAINANT

<table>
<thead>
<tr>
<th>Name of HCE</th>
<th>Unit Ward of Posting/Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### A. Personal details

<table>
<thead>
<tr>
<th>Title (Tick the relevant box)</th>
<th>□ Mr.</th>
<th>□ Mrs.</th>
<th>□ Ms.</th>
<th>□ Other</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>First &amp; Last Name of Complainant</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of HCE</th>
<th>Unit Ward of Posting/Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Father’s/Husband’s Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CNIC Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of HCE</th>
<th>Unit Ward of Posting/Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### B. Contact details

<table>
<thead>
<tr>
<th>Current residential address</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Write postal address (if different from residential address)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Email address (If any)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Telephone number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Preferred contact method</th>
<th>Landline</th>
<th>Mobile</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Title (Tick the relevant box)</th>
<th>□ Mr.</th>
<th>□ Mrs.</th>
<th>□ Ms.</th>
<th>□ Other</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>First &amp; Last Name of Person</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Father’s/Husband’s Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Current residential address</th>
</tr>
</thead>
</table>

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
Current residential address

Email address (If any)

Telephone number

Landline

Mobile

Your Relationship with the aggrieved HCSP

□ Parent
□ Guardian
□ Spouse
□ Friend
□ Other (Please Specify)

Is this person deceased?

□ Yes
□ No

SECTION 2

FIRST POINT OF COMPLAINT

Did you lodge a complaint about this event with the healthcare establishment, where this event happened?

□ Yes /
□ No (if “No” then go to next question)

If yes, mention date.

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

To whom:

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

□ Yes / 
□ No (if “No” then go to next question)

Did you lodge your complaint with any other agency?

□ Yes
□ No (if “No” then go to next question)

If yes, mention date.

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

To whom:

Sindh Healthcare Commission

Quality Care for All

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
Did you lodge a complaint about this event with SHCC before?

Yes [ ]

No [ ] (if “No” than go to next question)

Date of incident:

[ ] Yes [ ] No / (آیا کوئے کسے نے اسے پکھا؟)

د (جیسے شوہر، دوست، یا چند افراد)

If yes, mention date. / (اگر ہاں، تاریخ کی ذیلی ذکر کریں)

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

لاکھ ہسپتال کی سرگرمیؤں میں مذکور کی گئی کی روز

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

کیا مشکل کی وجہ سے شدید مشکل کے دھارے میں نہیں بنے جس جدوں (جیسے ضروری جمی ڈرائی ڈینسیتی نہیں سکی؟)

A [ ] Healthcare Service Provider (HCSP) / Co-worker

B [ ] Healthcare Establishment (HCE)

شرکاء کے ہم کار

A. Healthcare Service Provider (Include details and use extra paper sheets if required)

<table>
<thead>
<tr>
<th>Name of Patient / Patient Carer</th>
<th>CNIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>مرضیہ جگنیال جو ہسپتال / توبہ کار / (اس کے ہم کار)</td>
<td>شفیعی آباد، جو ہسپتال / توبہ کار</td>
</tr>
</tbody>
</table>

Contact #: 

Address:

B. Healthcare Establishment

Name of Manager/Administrator:

Name of Organization/Hospital/ Centre/Individual Owner:

Type of service provider

<table>
<thead>
<tr>
<th>Doctor</th>
<th>Nurse</th>
<th>Dentist</th>
<th>Other (Please specify)</th>
</tr>
</thead>
</table>

Telephone number:

<table>
<thead>
<tr>
<th>Landline</th>
<th>Mobile</th>
</tr>
</thead>
</table>

Address:

Directorate of Complaint SHCC
Type of Healthcare Establishment

Specify:

Alamat:

Telephone number

Landline

Mobile

Address

SECTION 4

MY COMPLAINT

a) 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.

b) Nature of harm experienced by the HCSP

(Kindly tick the relevant box(s))

☐ Death / موت

☐ Unconsciousness / سیطیس

☐ Impairment or loss of mental functions / حسرت جسمی یا جسمانی که بررسی خواهد یافت یا دلایل مثبت دارد
□ Extreme physical pain / جسمي شداید
□ Protracted and obvious disfigurement / گرازه‌های مداوم و واضح
□ Physical Assault / اضطراب بدنی
□ Fraud/Forgery / داده‌های تقلبی
□ Harassment/Violence / هدایات و نژادپرستی
□ Administration/Financial Loss/Job Loss / طرفداری از وام و اقتصادی
□ Impairment or temporary loss of the function of a bodily member/organ. / خسارت وقوعی در عملکرد توده بدنی
□ Bodily injury which involves a substantial risk of death / خسارت بدنی با خطر مرگ‌بار
□ Permanent loss of bodily function / خسارت کارکرد بدنی دائمی
□ Other (Specify): / دیگر (مشخص کردن)

b) Do you have any 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 the HCSP / HCE, Patient / Patient Caretaker although 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 aggrieved HCSP so that the SHCC can collect the required information to assess the complaint. (Please select the following one of the options that apply to you.)


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

B. I am the next-of-kin/guardian of the person HCSP aggrieved and authorize the SHCC to access his/her personal information for the purpose of handling this complaint.

C. If you are making this complaint on behalf of someone else, please have them sign by that person and complete the following:

I understand that (complainant name) is making a complaint for me and authorize the SHCC to access my personal information for the purpose of handling this complaint.

Signature

Thumb Impression

Agrohi Gujar Khan / Additional Commissioner

Directorate of Complaint SHCC

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AKNOWLEDGEMENT

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

Before sending this form, kindly check that you have:

- Included as much as relevant information as possible.
- Given details of HCSP/HCE/patient/patient carer you are complaining about.
- Clearly identified your concern.
- Answered Section 5: Authority and Section 6: Accessing Health Information.
- Attached 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)
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/=

Note: If the complaint is not addressed within 14 days, the person may file a complaint with the District Health Authority or the UHC Authority.
ACKNOWLEDGEMENT SLIP

Complaint number: 

Date: 

The SHCC acknowledged the complaint submitted by Mr./Mrs./Ms S/D/W/O

The SHCC will update you regarding actions on your complaint.

Assistant
Directorate of Complaint
SHCC

OFFICE USE ONLY

Complaint reference No.: 

Date: 

Type of Complaint: 

□ Service Provider
□ Health Establishment

□ Managerial

□ Treatment

□ Behaviour

□ Online

□ In writing

□ In person

Category of Complaint: 

□ Service Delivery

□ Health Establishment

□ Managerial

□ Treatment

□ Behaviour

□ Online

□ In writing

□ In person

Notes: 

Directorate of Complaint SHCC