

Employer Complaint Form

THIS IS A REPORT OF

Unprofessional conduct	Fitness to practise
Termination	Resignation
Suspension of ____ days	
Please attach relevant discipline letter to this form.	

REGISTRANT INFORMATION

First and Last Name of Registrant			
CRNA Registration Number			
Length of time registrant was in the position at the time of the incident			
Registrant's employment status at the time of the incident (select all that apply)		Registrant's role at the time of the incident (select all that apply)	
Full time Casual Temporary Probationary	Part time Self-employed Multiple employers Unknown	Staff nurse Charge nurse Educator / Instructor / Clinical	Manager Administrator Other:
Type of setting where the incident(s) occurred (choose one)			
Hospital Assisted Living Medical Clinic / Primary Care Network Mental Health / Psychiatry Social Media Homecare Occupational Health and Safety Correctional Facility Other (please describe):		Long-term Care / Nursing Home Private Residence / Group Home Palliative Care / Hospice Remote Work Setting Community Cosmetic Clinic / Service Public Health Clinic Virtual Health	

Level of supervision in the workplace (choose one)

No supervision (works independently)
 Limited supervision (works nights / weekends only)
 Unknown

Under supervision at all times
 Usually under supervision but periods of no supervision

REPORT OF INCIDENT

Date of Incident(s)

Facility or Location of Incident(s)

Briefly describe the incident(s) that occurred on the reported date(s) and who was involved.

How did the incident come to your attention? (select all that apply)

Direct observation
Patient / family report
Registrant self-report

Coworker / colleague report
Review of audit report
Review of incident report

Who was harmed?

Patient

Member of the Public

Coworker

No Harm

What harm was done?

Did you complete an investigation or formal review?

Yes

No

What was the outcome of the investigation or formal review?

REMEDICATION IN THE WORKPLACE

List supports, remediation, training, etc. that have been provided to the registrant prior to or following the incident that occurred.

Comments

Description of the registrant's response to employer action

Did the registrant accept responsibility for their actions/practise/behaviour?

Yes No

Comments

Briefly describe the registrant's history of similar practise/behaviour concerns and performance management and/or any discipline rendered.

Names of other agencies that were informed of the incident

COMPLAINANT CONTACT INFORMATION

First and Last Name

Position / Title

Department

Name of Facility / Agency / Employer

Street Address

City / Postal Code	
Phone Number(s)	
Fax Number	
Email Address	

ACKNOWLEDGEMENT

I have read and understand the CRNA will notify the registrant, as named above, of my complaint and provide a copy of my complaint to the registrant.

Your typed or electronic signature is considered as legally valid as your handwritten signature on this form.

First and Last Name	
Signature	
Date	