

Employer Complaint Form

Today's date: Click or tap to enter a date.

THIS IS A REPORT OF

<input type="checkbox"/> Unprofessional Conduct <input type="checkbox"/> Termination <input type="checkbox"/> Suspension Days Click or tap here to enter text.	<input type="checkbox"/> Fitness to Practice <input type="checkbox"/> Resignation Please attach relevant discipline letter to this form
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REGISTRANT'S INFORMATION

First and Last Name of Registrant			
CARNA Registration Number			
Length of time Registrant was in the position at the time of 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):	
<input type="checkbox"/> Full Time <input type="checkbox"/> Casual <input type="checkbox"/> Temporary <input type="checkbox"/> Probationary	<input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Multiple Employers <input type="checkbox"/> Unknown	<input type="checkbox"/> Staff Nurse <input type="checkbox"/> Charge Nurse <input type="checkbox"/> Educator/ Instructor/ clinical	<input type="checkbox"/> Manager <input type="checkbox"/> Administrator <input type="checkbox"/> Other: Click or tap here to enter text.
Type of setting where incident(s) occurred (Choose one):			
<input type="checkbox"/> Hospital <input type="checkbox"/> Assisted Living <input type="checkbox"/> Medical Clinic/Primary Care Network <input type="checkbox"/> Mental Health/Psychiatry <input type="checkbox"/> Social Media <input type="checkbox"/> Homecare <input type="checkbox"/> Occupational Health and Safety <input type="checkbox"/> Other (Describe other):		<input type="checkbox"/> Long-term Care / Nursing Home <input type="checkbox"/> Private Residence / Group Home <input type="checkbox"/> Palliative Care / Hospice <input type="checkbox"/> Remote Work Setting <input type="checkbox"/> Community <input type="checkbox"/> Cosmetic Clinic/ Service <input type="checkbox"/> Public Health Clinic	

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

How the incident came to your attention (Select all that apply):

- Direct Observation
- Patient/family report
- Registrant self-report

- Co-worker/colleague report
- Review of audit report
- Review of incident report

Characteristics of Patient: (if any apply):

- Child/ Infant
- Mental Illness/ Limitations
- Living Alone

- Physical Limitations
- Cognitive Decline
- Terminally Ill/ Palliative

Other: [Click or tap here to enter text.](#)

Did the action / inaction of the Registrant in this incident result in harm to anyone?

Yes No

Who was harmed?

Patient

Member of the Public

Co-worker

What harm was done?

Did you complete an investigation or formal review?

Yes No

What was the outcome of the investigation or formal review?

Were there any factors other than the practice concerns of the Registrant reported that were determined to have contributed to the incident (equipment failure, product labeling, workload on the unit?)

Yes No

Comment:

REMEDATION IN WORKPLACE

Is there a plan in place to remediate the Registrant's practice/behavior that contributed to the incident?

Yes No

Comment:

Description of the Registrant's Response to employer action:

Did the Registrant accept responsibility for actions/practice/behavior?

Yes No

Comment:

Briefly describe Registrant's history of similar practice/behavior concerns and performance management and/or discipline rendered.

Names of other agencies that were informed of the incident:

COMPLAINANT CONTACT INFORMATION

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 CARNA will notify the Registrant as named above of my complaint and provide a copy of my complaint to the Registrant.

Date:	Signature:
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