Employer Complaint Form

Today's date:

THIS IS A REPORT OF

☐ Unprofessional conduct ☐ Termination ☐ Suspension of days	☐ Fitness to practice ☐ Resignation **Please attach relevant discipline letter to this form**

REGISTRANT'S INFORMATION

First and Last Name of Registrant			
CRNA 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):	
☐ 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 incident(s) occurred (Choose one):			
☐ Hospital ☐ Assisted living ☐ Medical clinic / Primary Care Network ☐ Mental health / Psychiatry ☐ Social media ☐ Homecare ☐ Occupational health and safety ☐ Other (describe other):		☐ Long-term care / Nursing home ☐ Private residence / Group home ☐ Palliative care / Hospice ☐ Remote work setting ☐ Community ☐ Cosmetic clinic / Service ☐ 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 Other:	☐ Physical limitations ☐ Cognitive decline ☐ Terminally ill / palliative

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:	

REMEDIATION 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 the CRNA will notify the registrant as named above of my complaint and provide a copy of my complaint to the registrant.

Date:	Signature: