Public Complaint Form

Today's date:

REPORT OF INCIDENT

First and Last Name of Nurse	
Date of Incident	
Facility or Location of Incident	

Briefly describe the incident(s) that occurred on the reported date(s)

Type of setting where incident(s) occurred:
(Choose one)

☐ Hospital	☐ Long-term Care / Nursing Home
☐ Assisted Living	☐ Private Residence / Group Home
☐ Medical Clinic/Primary Care Network	☐ Palliative Care / Hospice
☐ Mental Health/Psychiatry	☐ Remote Work Setting
☐ Social Media	☐ Community
☐ Homecare	☐ Cosmetic Clinic/ Service
☐ Occupational Health and Safety	☐ Public Health Clinic
☐ Other	
Describe other:	

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?

ACKNOWLEDGEMENT

I have read and understand the following:

☐	CRNA will notify the Registrant as named above of my complaint **and provide a copy of my complaint to the Registrant with my contact information redacted.**
☐	CRNA will obtain the patient's personal health information, such as diagnostic, treatment and patient care information when relevant and if this matter is investigated.
☐	Any information collected during an investigation will be used for the CRNA conduct process.

Please date and sign the complaint below (Required)

Print Name	
Signature	
Date	

REPORTER CONTACT INFORMATION (CONFIDENTIAL)

Name	
Full Mailing Address	Street, City, Province, Postal Code
Email Address	
Phone Number(s)	

I am a:

☐ Patient	☐ Family of Patient
☐ Co-worker	☐ Friend of Patient
☐ Other Describe other:	

Have you spoken to anyone to try to resolve your complaint?

Nurse involved	☐ Yes ☐ No
Manager **Enter the date reported if applicable:** **Describe the managers response and outcome of your report of incident:**	☐ Yes ☐ No
Health Service Provider (Patient Relations or Patient Concerns) **Enter the date reported if applicable:** **Describe the Health Service Provider's response and outcome of your report of incident:**	☐ Yes ☐ No
Another Agency (PPC, OIPC, RCMP, EPS, CPS) **Enter the name of the agency involved:**	☐ Yes ☐ No
Have you contacted CRNA before about your Complaint?	☐ Yes ☐ No

What do you hope will happen as a result of your complaint?

☐ Education	☐ Apology	☐ Investigation
☐ Other Describe other:		