

Today's Date:

This is a report of:		
<input type="checkbox"/> Unprofessional Conduct	<input type="checkbox"/> Termination	Please attach relevant employer letter to this form.
<input type="checkbox"/> Fitness to Practice	<input type="checkbox"/> Resignation	
<input type="checkbox"/> Suspension Days -		

Regulated Member Information	
Full Name	Click here to enter full name.
Registration #	Click here to enter registration #.
Length of time Regulated Member in position held at the time of the incident:	
Click here to enter length of time.	

Regulated Member's Employment Status at the time of the incident <i>(select all that apply)</i>	Regulated Member's Role at the time of the incident <i>(select all that apply)</i>
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Casual <input type="checkbox"/> Self Employed <input type="checkbox"/> Temporary Position <input type="checkbox"/> Multiple Employers <input type="checkbox"/> Probationary <input type="checkbox"/> Unknown	<input type="checkbox"/> Staff Nurse <input type="checkbox"/> Charge Nurse <input type="checkbox"/> Educator/Instructor/Clinician <input type="checkbox"/> Manager <input type="checkbox"/> Administrator <input type="checkbox"/> Other:

Type of setting where incident occurred: <i>(Choose one)</i>	
<input type="checkbox"/> Acute care	<input type="checkbox"/> Long term care/Nursing home
<input type="checkbox"/> Assisted living	<input type="checkbox"/> Palliative care/Hospice
<input type="checkbox"/> Clinic/Primary Care Network	<input type="checkbox"/> Private residence/Group home
<input type="checkbox"/> Remote work setting	<input type="checkbox"/> Other:

Level of Supervision in the workplace:		
<input type="checkbox"/> No supervision (works independently)	<input type="checkbox"/> Usually under supervision but periods of no supervision	<input type="checkbox"/> Unknown
<input type="checkbox"/> Limited supervision (works nights/weekends only)	<input type="checkbox"/> Under supervision at all times	

<p>If you are submitting this complaint because of the requirement to report to CARNA any discipline, termination or resignation of a Regulated Member that involves unprofessional conduct, do you consider this matter to be sufficiently managed in the workplace?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Comment</p>	
<p>Were there any factors other than the practice concerns of the Regulated Member reported that were determined to have contributed to the incident (equipment failure, product labeling, workload on the unit)?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Remediation in Workplace</p>	
<p>Is there a plan in place to remediate Regulated Member practice/behavior that contributed to the incident?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Comment:</p>	
<p>Description of Regulated Member Response to employer action:</p>	
<p>Did the Regulated Member accept responsibility for actions/practice/behavior?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Comment:</p>	
<p>Briefly describe Regulated Member history of similar practice/behavior concerns and performance management and/or discipline rendered?</p>	
<p>Names of other agencies that were informed of the incident:</p>	

Characteristics of Patient: (if any apply)		
<input type="checkbox"/> Infant or child	<input type="checkbox"/> Living alone	<input type="checkbox"/> Cognitive decline
<input type="checkbox"/> Mental illness / limitations	<input type="checkbox"/> Physical limitations	<input type="checkbox"/> Terminally ill / palliative
Other		

Complainant Contact Information
Name
Position / title
Name of facility / agency / employer
Department
Street Address
City
Postal Code
Phone Number(s)
Fax Number
E-mail Address

Acknowledgement

I have read and understand CARNA will notify the Regulated Member as named above of my complaint and provide a copy of my complaint to the Regulated Member.

Please date and sign the complaint.

Date:	Signature: