

Public Complaint Form

Today's date:

Report of Incident

First and Last Name of Nurse:

Date of Incident:

Facility or Location:

Description of Incident(s) that occurred on the reported date(s):

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

- Yes
- No

Who was harmed?

- Patient
- Member of Public
- Co-Worker

What harm was done?

ACKNOWLEDGEMENT I have read and understand the following:

- CANNN will notify the Nurse as named above of my complaint and provide a copy of my complaint to the Nurse with my contact information removed.
- CANNN 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 CANNN conduct process.

Please date and sign the complaint below (Required)

Name

Signature

Date

REPORTER CONTACT INFORMATION (CONFIDENTIAL)

Name

Full Mailing Address

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

- Yes
- No

Enter the date reported if applicable:

Describe the managers response and outcome of your report of incident:

Health Service Provider (Patient Relations or Patient Concerns)

- Yes
- No

Enter the date reported if applicable:

Describe the Health Service Provider's response and outcome of your report of incident:

Have you contacted CANNN before about your Complaint?

Yes

No

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

Education

Apology

Investigation

Other Describe other: