



COLLEGE OF NURSES OF THE NORTHWEST TERRITORIES AND NUNAVUT

COMPLAINT FORM

YOUR DETAILS

Today's Date:

Name:

Mailing Address:

Community/City: Postal Code:

Telephone Number:

Email address:

I am a:

- Patient
- Employer
- Colleague
- Other

For Employers:

Employer Name:

Title of person submitting the complaint:

Employers and Registrants have a mandatory duty under the *Nursing Profession Act, Nursing Professions Act* and *Code of Conduct* to report unprofessional conduct of a registrant to the College of Nurses of the Northwest Territories and Nunavut. For more information visit [our website](#).

INSTRUCTIONS:

- Complete all relevant sections of the Complaint Form, sign and submit to intake@cannn.ca.



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- Attach any information (eg. Papers, forms, pictures, documents) that may be related to your concerns outlined in your complaint details.
- If your complaint is about more than one Registrant, please fill out one form per registrant.

ACKNOWLEDGEMENT

Your name and a copy of the complaint will be sent to the Nurse you identified in this form. Rest assured, your contact information will remain confidential and will not be disclosed or shared with the Registrant.

I have read and understand the following:

- I am making a complaint against the Nurse named in this Complaint Form;
- If my complaint is investigated, CANN will obtain my personal health information, such as my patient chart, interview persons who may have observed what happened or know information related to the complaint, and request information from other relevant persons or organizations;
- Any relevant information collected during an investigation and used for the CANN conduct process will be provided to the Nurse;
- If the complaint proceeds to a Board of Inquiry, information related to the complaint will be required to be presented at the Board of Inquiry and I may be called as a witness to speak at the Board of Inquiry;
- My name and a copy of the complaint details will be sent to the Nurse;

Signature:

Print Name:

Date:



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COMPLAINT DETAILS

Date of Incident:

Time of Incident:

Location of Incident (eg. hospital, health centre):

Name of Nurse:

Registration Number:

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

(if you require more space, please attach, and refer to the attachment in the space below)

Did the action or inaction result in harm to anyone?

- Yes
- No



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Who was harmed?

What harm was done?

Witnesses:

(Persons who saw the complaint or have information related to the complaint)

Provide names of all individuals who may have direct knowledge or information regarding the complaint. Please include how they are involved and what information they can provide. These individuals may be contacted as part of any investigation CNNN conducts.

Name of Witness	Contact Information	What they saw or know related to the complaint.



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What do you hope will happen because of your complaint?



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FOR COMPLETION BY EMPLOYERS

This is a report of:

- Unprofessional Conduct
- Termination
- Suspension
- Fitness to Practice
- Resignation

**Please attach relevant disciplinary letter to this form*

Nurses Employment Status:

- Full time
- Part time
- Casual
- Locum
- Agency; Agency Name:

Nurse Role:

Date of Hire:

How did the incident come to your attention?

Did you complete a formal investigation?

- Yes
- No

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

- Yes
- No



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Comment:

Is there a plan to remediate the Nurse's practice/behaviours that contributed to the incident?

- Yes
- No

Did the Nurse take responsibility for their actions or behaviours?

- Yes
- No

Comment:

Other information relevant to the Complaint



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