College of Registered Nurses of Alberta

Public Complaint Form

REPORT OF INCIDENT

First and Last Name of Nurse	
Date(s) of Incident(s)	
Facility or Location of Incident(s)	

Briefly describe the incident(s) that occurred on the reported date(s).
If extra space is required, please provide additional information as a separate attachment. Please do not attach patient records.

Type of setting where the 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
☐ Correctional Facility	☐ Virtual Health
☐ Other (please describe)	

Who was harmed?

☐ Patient	☐ Member of the Public	☐ Coworker	☐ No Harm

What harm was done?

ACKNOWLEDGEMENT

I have read and understand the following:

☐	The 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**.
☐	The 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)

Your typed or electronic signature is considered as legally valid as your handwritten signature on this form.

First and Last Name	
Signature	
Date	

REPORTER CONTACT INFORMATION (CONFIDENTIAL)

First and Last Name	
Mailing Address	
Email Address	
Phone Number(s)	

I am a:

☐ Patient	☐ Family of Patient
☐ Coworker	☐ Friend of Patient
☐ Other (please describe)	

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

Nurse involved	☐ Yes ☐ No
Manager **Enter the date reported**, if applicable: **Describe the manager's response and the outcome of your report of the 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 the outcome of your report of the incident**:	☐ Yes ☐ No

Another Agency (PPC, OIPC, RCMP, EPS, CPS) **Enter the name of the agency involved**, if applicable:	☐ Yes ☐ No
Have you contacted the CRNA about your complaint before?	☐ Yes ☐ No

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

☐ Education	☐ Investigation
☐ Other (please describe)	