

Mandatory Report

Instructions

This form is for use by employers, organizational leaders, and licensees submitting a mandatory report about a nurse or midwife.

Please review the information outlined in the BCCNM [Mandatory Report Guide](#) prior to completing this form.

Note: All sections of the form must be completed unless otherwise specified. However, peer reporters may complete this form to the best of their knowledge. Sections relating to employment actions, human resources processes, or internal investigations may be left blank if the reporting individual does not have access to that information.

Part A1 – Reporting party and organization information

Role: Direct supervisor/manager HR representative
 Professional practice leader Peer
 Other: _____

Full name: _____ Pronouns (optional): _____

Title/position: _____ Organization: _____

Email: _____ Phone: _____

Indigenous self-identification (optional):

I identify as Indigenous (First Nations, Inuit, Métis). I understand that this information will be used to ensure culturally safe support is available.

Part A2 – Contact person for this report (required only if different from Part A1)

Role: Direct supervisor/manager HR representative
 Professional practice leader Peer
 Other: _____

Full name: _____ Pronouns (optional): _____

Title/position: _____ Organization: _____

Email: _____ Phone: _____

Indigenous self-identification (optional):

I identify as Indigenous (First Nations, Inuit, Métis). I understand that this information will be used to ensure culturally safe support is available.

Part B – Patient/client/resident information (if applicable)

Full name: _____ Pronouns (optional): _____

Date of Birth or personal health number: _____

Was the client harmed? Yes No Unknown

Is the client aware that the concern has been reported to BCCNM? Yes No Unknown

Has the patient/client/resident/client been informed of the care issue or concern itself? Yes No Unknown

Has a Patient Care Quality Office (PCQO) complaint been made regarding this matter? Yes No Unknown

Multiple clients were affected

Indigenous self-identification (optional):

The patient/client/resident identifies as Indigenous (First Nations, Inuit, Métis). I understand that this information will be used to ensure culturally safe support is available.

Part C – Mandatory reporting basis

This report is being submitted because evidence exists indicating that one or more of the following circumstances apply and employment action has occurred or was intended (check all that apply):

Lack of competence (knowledge, skills, or judgment) resulting in significant risk to patient/client/resident/client

Health condition unduly impairing safe practice and resulting in significant risk to patient/client/resident/client

Sexual misconduct or sexual abuse

Discrimination (conduct adversely affecting others based on a protected personal characteristic)

Resignation or dissolution of partnership in circumstances where termination, suspension, or restriction of employment was intended

Other statutory reporting obligation (please specify): _____

Part D – Employment action related to this report

This section captures whether employment or professional action has occurred, is underway, or was intended as a result of the circumstances identified in Part C.

Status of employment or professional action (check all that apply):

Termination of employment

Suspension (paid or unpaid)

Restriction of duties or scope of practice

Administrative leave

Medical leave

No employment or professional action taken to date

Resignation or dissolution of partnership where termination, suspension, or restriction was intended

Employment or professional action pending or under consideration

Other (please specify): _____

Effective date(s) or anticipated date(s) (mm/dd/yy): _____

Part E – Licensee information

Complete the following information for the nurse or midwife being complained about.

Full name: _____ Pronouns (optional): _____

BCCNM ID: _____

License type: LPN NP RN RPN Midwife

Workplace setting (if known): Hospital Long-term care Mental health facility
 Community Virtual health Other (specify): _____

Care setting (unit, program, or practice area, e.g., emergency department, mental health and substance use (MHSU) program, residential care): _____

Date of hire (mm/dd/yy): _____

Licensee's employment status at time of incident: Full-time Part-time Casual
 Agency Other: _____

Length of time Licensee was in the position at time of incident: _____

Licensee's role at time of incident: Staff nurse Charge nurse Nurse educator
 Manager Other: _____

Licensee's Level of Supervision at time of incident: Supervision at all times
 Limited supervision (nights/weekends)
 No supervision
 Other: _____

Was the Adverse Event Decision Pathway (AEDP) used to support the reporting decision? Yes No

If yes, which category best reflects the licensee's conduct? Human error
 At-risk behaviour
 Reckless behaviour¹
 Intent to harm patient/client/residents/clients¹

¹ Reckless behavior and intent to harm trigger mandatory reporting.

Part F – Incident summary

List incidents separately in chronological order. If more space is required, please attach a separate sheet.

Required information:

- Date of incident
- Date identified or discovered
- Location/unit
- Incident/event
- Actual or potential harm
- Licensee response or explanation (if obtained)
- Employer action taken
- Other comments

I am attaching additional pages of the incident summary *(please submit with this form)*.

Part F – Incident summary (cont'd)

Was an Investigation or Formal Review completed? Yes No In progress

Who conducted the investigation or review? Employer (management) Human resources
 External investigator Other: _____

Are investigation findings final? Yes No Pending

Are additional employer actions anticipated? Yes No

If yes, please describe: _____

Have any other agencies been notified of the incident? Yes No In progress

If yes, please specify: _____

Part G – Witnesses (if applicable)

Name: _____ Contact Info: _____

Relationship to incident: _____

Name: _____ Contact Info: _____

Relationship to incident: _____

Name: _____ Contact Info: _____

Relationship to incident: _____

Part H – Supporting documentation

Disclosure of relevant documentation to the college is lawful pursuant to section 33(2)(q) of the *Freedom of Information and Protection of Privacy Act*, which expressly permits the disclosure of personal information for the purpose of investigating a regulated individual.

Clinical and practice records

Please provide copies of the following (*where available*):

- Medical chart(s)/clinical notes
- Nursing notes and care plans
- Medication administration records (MARs)
- Omnicell dispensing and transaction reports
- Laboratory and diagnostic test results
- Incident reports, adverse event reports, and/or internal clinical reviews
- Nursing signature, assignment, or staffing sheet(s)
- Relevant hospital, unit, or employer policies, procedures, protocols, or standards of practice
- Other (*please specify*): _____

Part I – Employer/human resources materials

Please provide copies of the following (where available):

- Notes or minutes of fact-finding meetings
- Witness statements
- Interview notes and/or transcripts
- Audio or video recordings (e.g., surveillance or workplace security footage)
- Internal reports, findings, or summaries prepared for HR, management, or leadership
- Relevant employer policies, codes of conduct, or disciplinary frameworks relied upon
- Other (please specify): _____

Part J – Consent and authorization

By signing and submitting this form I agree to the following:

- I confirm this report is submitted in good faith and reflects the organization's understanding of its statutory reporting obligations.
- I confirm the information provided is accurate to the best of my knowledge.
- I understand this mandatory report will be shared with the licensee.
- I understand that BCCNM will be contacting involved parties for information.
- I understand that relevant records may be reviewed or disclosed to the Licensee and other participants to investigation as necessary. Information may become public in the course of a hearing..
- I confirm I am submitting this pursuant to my duty to report.
- I consent to BCCNM using this information for regulatory purposes.

Reporter signature: _____ Date (mm/dd/yy): _____

Submit this form to BCCNM:

Email: complaints@bccnm.ca

Fax: 604-899-0794

Mail: 900 – 200 Granville St., Vancouver, BC V6C 1S4