**EMPLOYER REPORTING FORM**

Section 168(1)(a) and (b) of the *Regulated Health Professions Act* indicates that if an employer **suspends or terminates** the employment or engagement of a member for misconduct, incompetence or incapacity, the employer must promptly notify the College Council (via the Executive Director). **The member must also receive a copy of the correspondence.** The College considers a period of 72 hours as prompt notification.

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| --- |
| EMPLOYER NAME: |

|  |  |
| --- | --- |
| REGISTRANT NAME: | REGISTRATION #: |

|  |
| --- |
| Background on Issue/Concern: |
|  |

|  |  |  |
| --- | --- | --- |
| Is this a repeat occurrence for the registrant? | Yes | No |

|  |
| --- |
| If Yes, please provide details: |
|  |

|  |  |  |
| --- | --- | --- |
| Was a Critical Incident report filed? | Yes | No |

|  |
| --- |
| If Yes, please provide report # and the date the report was filed: |
|  |

|  |  |
| --- | --- |
| Signature (insert copy of signature): | Date Submitted: |

Click or tap here to enter text.

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|  |
| --- |
| Print Name and Title: |

**EMPLOYEE SUSPENSION - Complete Page 2 if Employee was Suspended** *(mark N/A in additional details box and complete the signature portion on bottom of page 2 if employee was terminated and proceed to page 3)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Suspension Issued: (check all that apply) | | | | |
| Misconduct | Incompetence | Incapacity | Administrative | Disciplinary | |

|  |
| --- |
| Length of Suspension: (start and end dates) |
| Additional Details: |

|  |
| --- |
| Requirements required prior to return to work (list details): |
| Conditions upon return to work (list details): |

|  |  |  |
| --- | --- | --- |
| Have they been communicated to the registrant? | Yes | No |

|  |  |  |
| --- | --- | --- |
| Is this a repeat occurrence for the registrant? | Yes | No |

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| --- |
| If Yes, please provide details: |
|  |

|  |  |
| --- | --- |
| Signature (insert copy of signature): | Date Submitted: |

Click or tap here to enter text.

|  |
| --- |
| Print Name and Title: |

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**EMPLOYEE TERMINATED - Complete Page 3 if Employee was Terminated**

|  |  |
| --- | --- |
| Termination | Termination Effective date: |

|  |  |  |
| --- | --- | --- |
| Terminated due to: (check all that apply) | | |
| Misconduct | Incompetence | Incapacity |

|  |
| --- |
| Additional Details: |

|  |  |  |
| --- | --- | --- |
| Was a Critical Incident report filed? | Yes | No |

|  |
| --- |
| If Yes, please provide report # and the date the report was filed: |
|  |

|  |  |
| --- | --- |
| Signature (insert copy of signature): | Date Submitted: |

Click or tap here to enter text.

|  |
| --- |
| Print Name and Title: |

**Submission Instructions:**

1. Send completed form (ensure signature portion completed on each page) to the College of Paramedics of Manitoba [info@collegeparamb.ca](mailto:info@collegeparamb.ca) and include in Subject Line: Employer Report.
2. The Member/Registrant **MUST** be copied on the submission.

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