**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:       |

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

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| Background on Issue/Concern: |
|       |

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

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| If Yes, please provide details: |
|       |

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

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| 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)*

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

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

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

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

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| --- | --- | --- |
| 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.

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| --- |
| 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 [ ]  |

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| --- |
| Additional Details:      |

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| --- | --- | --- |
| 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 and include in Subject Line: Employer Report.
2. The Member/Registrant **MUST** be copied on the submission.

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