



College of Licensed Practical Nurses
of British Columbia

Formal Complaint Form

Your Contact Information

Name in Full:

Home Address:

Tel:

Fax:

Email:

Business Address:

Tel:

Fax:

Email:

Full Name(s) fo LPN(s) involved in this Complaint:
Please include the LPN's position and healthcare facility, if possible.

Date of Incident _____ Time of Incident _____

NOTE: If you are reporting more than one incident please provide dates, times and locations of each incident. Please attach additional documentation, signed witness statements or evidence to support your complaint if possible.

Location of Incident:
