COLLEGE OF KINESIOLOGISTS OF ONTARIO

Reporting Form

Reporter Information

Name of person filing report: _____

Profession and registration number (if applicable): _____

Company name (if applicable): _____

Mailing or business address: _____
Street number Street

_____
City Province Postal code

Telephone number: _____

Email address: _____

Type of Report

☐ Mandatory Report – Sexual Abuse

☐ Mandatory Report – Termination/suspension, dissolution of partnership, corporation, or association for reasons of professional misconduct, incompetence or incapacity

☐ Mandatory Report – Resignation while facing termination/suspension, dissolution of partnership, corporation, or association for reasons of professional misconduct, incompetence or incapacity

☐ Mandatory Report – facility operator – incompetence or incapacity

☐ Mandatory Report – self report: offence

☐ Mandatory Report – Self report: finding of negligence or malpractice

☐ Other

Member Information

Name: _____

Company name: _____

Practice address: _____

Registration number: _____

Other Information

Name of the patient/client (if applicable and not subject to consent of patient/client):

_____

Is the patient/client aware of the report? ☐ Yes ☐ No

Date of incident(s): _____

Location(s) of incident(s): _____

Submission date of this report: _____

**Disclaimer: CKO will only initiate the report process upon receiving this form.*

Names of other health care providers you have spoken to about the incident(s):

Specific concerns:

Any other additional information:

Please complete the form and send:

By email: complaints@coko.ca

By mail: Registrar c/o Professional Conduct Department
College of Kinesiologists of Ontario
160 Bloor Street East, Suite 1402
Toronto, ON
M4W 1B9

By Fax: (416) 961-7009