IMPORTANT NOTICE: This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under 225 of the Illinois Compiled Statutes 100/26. Disclosure of this information is REQUIRED. Failure to provide any required information shall result in a Class A Misdemeanor.	RETURN TO: ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION ENFORCEMENT ADMINISTRATION UNIT Mandatory Report File Custodian 320 West Washington Street Springfield, Illinois 62786 Mark envelope “Personal and Confidential”

STATE AGENCY, BOARD OR COMMISSION

PODIATRY MANDATORY REPORT

PODIATRIC MEDICAL LICENSING BOARD

GENERAL INSTRUCTIONS

All agencies, boards, commissions, departments, or other instrumentalities of the government of the State of Illinois shall report to the Podiatric Medical Licensing Board any instance arising in connection with the operations of such agency, including the administration of any law by such agency, in which a podiatric physician licensed under the Illinois Podiatric Medical Practice Act has either committed an act or acts that may be a violation of the Act or that may constitute unprofessional conduct related directly to patient care or that indicates that a podiatric physician licensed under the Act may have a mental or physical disability that may endanger patients under that physician's care.

Reports must be filed with the Podiatric Medical Licensing Board in writing within 60 days after a determination that a report is required.

This report contains two parts.

Part 1 seeks basic information concerning the person making the report, the licensed individual who is the subject of the report, and any patient who may have been injured or endangered as a result of the licensed individual’s conduct or disability.

Part 2 seeks specific information concerning the conduct or disability of the licensed individual and any administrative or judicial action which may have resulted.

Both parts must be filled out completely. Where requested, **identify and attach explanatory documentation** which will be helpful to the Podiatric Medical Licensing Board in determining whether further investigation is warranted, except that no medical records may be revealed without the written consent of the patient.

The law requires that this report be kept strictly confidential. All communications regarding this report should be addressed only to authorized persons.

The law further provides that any individual or organization acting in good faith, and not in a willful and wanton manner, in complying with this law by providing any report or other information to the Board, or assisting in the investigation or preparation of such information, or by participating in proceedings of the Board, shall not, as a result of such actions, be subject to criminal prosecution or civil damages.

STATE AGENCY, BOARD OR COMMISSION

PODIATRY MANDATORY REPORT

PART 1 – BASIC INFORMATION

Official Use Only	
Code	Mandatory Report Number
5	**MR --**

A. SOURCE OF INFORMATION – (Individual making report)

NAME (Last, First, MI): _____

PROFESSIONAL TITLE AND/OR JOB TITLE: _____

STATE AGENCY: _____

ADDRESS: _____
Street Address City State ZIP Code

TELEPHONE NO.: _____ EMAIL ADDRESS: _____
Include Area Code

B. SUBJECT OF REPORT – (Individual licensed under the Podiatric Medical Practice Act. Please complete a separate report for each individual.)

NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

TELEPHONE NO.: _____ EMAIL ADDRESS: _____
Include Area Code

PROFESSIONAL LICENSE NO.: _____

C. PATIENT INFORMATION – (If occurrence(s) or circumstances which necessitate this report are not related to patient care, please enter "Not Applicable." If more than one patient is involved, please check the appropriate box and provide information regarding additional patients on page 4 of this form.)

MULTIPLE PATIENTS? ☐

PATIENT NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

TELEPHONE NO.: _____ EMAIL ADDRESS: _____
Include Area Code

DOB: _____ DATE OF OCCURRENCE: _____

PART 2 – SPECIFIC INFORMATION

A. CONDUCT OR DISABILITY NECESSITATING REPORT – Please provide below a brief description of any act or acts, including the dates of any occurrences on the part of the subject of this report which may be a violation of the Podiatric Medical Practice Act or which may constitute unprofessional conduct related directly to patient care, or which indicates such person may be mentally or physically disabled so as to endanger patients under that person's care (**identify and attach any appropriate documents,** if applicable):

B. AGENCY ACTION

Did the act or acts necessitating this report result in the initiation of formal action by the state agency or the referral to any other government authority?

☐ **Yes** ☐ **No**

Date Of Action: _____

Please explain, and if applicable, attach any documents reflecting the disposition of such agency action or referral:

C. COURT ACTION – (Attach copies of any appropriate pleadings you may have including appearances and orders.)

Did the act(s) result in any court action, civil or criminal?

☐ **Yes** ☐ **No** If yes, please identify.

Case Name: _____

Court in which filed: _____

Docket Number: _____

Date Filed: _____

Status of Court Action:

PART 3 - SIGNATURE

NAME	TITLE	DATE	OFFICAL USE ONLY

MULTIPLE PATIENTS REPORT

Official Use Only

MR -

ATTACH DESCRIPTION OF FACTS THAT PERTAIN TO EACH CASE AND, IF APPLICABLE, ATTACH ADDITIONAL DOCUMENTATION

A.
PATIENT NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

DOB: _____ DATE OF OCCURRENCE: _____

B.
PATIENT NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

DOB: _____ DATE OF OCCURRENCE: _____

C.
PATIENT NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

DOB: _____ DATE OF OCCURRENCE: _____

D.
PATIENT NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

DOB: _____ DATE OF OCCURRENCE: _____

E.
PATIENT NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

DOB: _____ DATE OF OCCURRENCE: _____

F.
PATIENT NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

DOB: _____ DATE OF OCCURRENCE: _____

G.
PATIENT NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

DOB: _____ DATE OF OCCURRENCE: _____

H.
PATIENT NAME (Last, First, MI): _____

ADDRESS: _____
Street Address City State ZIP Code

DOB: _____ DATE OF OCCURRENCE: _____