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 65/65-65. 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

NURSING MANDATORY REPORT

BOARD OF NURSING

GENERAL INSTRUCTIONS

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

Reports must be filed with the Board of Nursing 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 Board of Nursing 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

NURSING 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 Nurse 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 Nurse 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

OFFICAL USE ONLY

NAME	TITLE	DATE

IL486-2290

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: ____________________