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 70/17.1. 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”

HEALTH CARE INSTITUTION

NURSING HOME ADMINISTRATORS MANDATORY REPORT

NURSING HOME ADMINISTRATORS LICENSING AND DISCIPLINARY BOARD

GENERAL INSTRUCTIONS

The owner or licensee of a long term care facility licensed under the Nursing Home Care Act who employs or contracts with a licensee under this the Nursing Home Administrators Licensing and Disciplinary Act (“the Act”) shall report to the Department any instance of which he or she has knowledge arising in connection with operations of the health care institution, including the administration of any law by the institution, in which a licensee under the Act has either committed an act or acts which may constitute a violation of the Act or unprofessional conduct related directly to patient care, or which may indicate that the licensee may have a mental or physical disability that may endanger patients under that licensee's care. Additionally, every nursing home shall report to the Department any instance when a licensee is terminated for cause which would constitute a violation of the Act.

For the purposes of this report, "owner" does not mean the owner of the real estate or physical plant who does not hold management or operational control of the licensed long term care facility.

Reports must be filed with the Nursing Home Administrators Licensing and Disciplinary 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 liability.

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

Both parts must be filled out completely. Where requested, **identify and attach explanatory documentation** which will be helpful to the Nursing Home Administrators Licensing and Disciplinary 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.

HEALTH CARE INSTITUTIONS
NURSING HOME ADMINISTRATORS MANDATORY REPORT

PART 1 – BASIC INFORMATION

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

A. SOURCE OF INFORMATION – (Individual making report)

NAME (Last, First, MI): _____

PROFESSIONAL TITLE AND/OR JOB TITLE: _____

NAME OF HEALTH CARE INSTITUTION: _____

ADDRESS: _____
Street Address City State ZIP Code

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

B. SUBJECT OF REPORT – (Individual licensed under the Nursing Home Administrators 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 circumstance(s) which necessitate this report is 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, "Multiple Patients Report," 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: _____

D. TYPE OF ACTION

☐ Unprofessional Conduct/Violation of Act ☐ Terminated for Cause ☐ Mental/Physical Disability

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 Nursing Home Administrators 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, or was terminated from employment for cause (**identify and attach any appropriate documents**, if applicable):

B. PROFESSIONAL ASSOCIATION ACTION

Date of final determination or acceptance of restriction(s), disciplinary action or termination: _____

Action taken, including the length and scope of any restriction (**please attach any appropriate documents**):

Years _____ Months _____

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: _____