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”

PROFESSIONAL ASSOCIATIONS

PODIATRY MANDATORY REPORT

PODIATRIC MEDICAL LICENSING BOARD

GENERAL INSTRUCTIONS

The president or chief executive officer of any association or society of podiatric physicians licensed under the Illinois Podiatric Medical Practice Act operating within this State shall report to the Podiatric Medical Licensing Board when the association or society renders a final determination relating to the professional competence or conduct of the podiatric physician

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.

PROFESSIONAL ASSOCIATIONS
PODIATRY MANDATORY REPORT

PART 1 – BASIC INFORMATION

Official Use Only	
Code	Mandatory Report Number
2	**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 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 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 – (Please mark all that are appropriate.)

☐ Termination of Privileges or Membership ☐ Probation ☐ Other Action

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, which resulted in a final determination that the subject of the report committed unprofessional conduct related directly to patient care or may be mentally or physically disabled in such a manner as to endanger patients under that person's care (**identify and attach any appropriate documents,** if applicable):

B. PROFESSIONAL ASSOCIATION ACTION	**C. COURT ACTION** – (Attach copies of any appropriate pleadings you may have including appearances and orders.)
Date of final determination:_____ Action taken, including the length and scope of any restriction (**please attach any appropriate documents**):	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	

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: _____