BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

RESPIRATORY CARE BOARD OF CALIFORNIA

3750 Rosin Court, Suite 100, Sacramento, CA 95834

T: (916) 999-2190 | Toll-Free: (866) 375-0386 | F: (916) 263-7311

E: rcbinfo@dca.ca.gov | www.r

CONSUMER REPORTING FORM

Pursuant to Business and Professions Code (B&PC) sections 2318, 3759, and Civil Code section 43.8, complainants are immune from prosecution for registering complaints.

PERSON REGISTERING COMPLAINT

FULL NAME:		
RESIDENT ADDRESS:		
BUSINESS NAME:		
TELEPHONE NUMBER:	HOME:	WORK:
EMAIL:		

Would you like this information to remain confidential, for use by the Board only?
☐ YES ☐ NO

Would you like to remain anonymous? ☐ YES ☐ NO

VIOLATION BEING REPORTED AGAINST

FULL NAME:		LICENSE NUMBER:	
EMPLOYER:			
EMPLOYER ADDRESS:			
	CITY:	STATE:	ZIP:
TELEPHONE NUMBER:	HOME:	WORK:	
EMAIL:			

VIOLATION TYPE

☐ Unlawful Sale of Controlled Substance or Prescription Items
☐ Patient Neglect, Physical Harm to Patient(s), or Sexual Contact with a Patient(s)
☐ Use of Controlled Substance or Alcohol
☐ Falsification of Medical Records
☐ Other (please explain) _____
☐ Unlicensed Practice
☐ Theft from Patient(s), Other Employee(s), or Employer
☐ Arrested or Convicted of a Criminal Offense
☐ Gross Negligence or Incompetence

WITNESS INFORMATION

WITNESS NAME:	WITNESS NAME:	WITNESS NAME:
EMPLOYER:	EMPLOYER:	EMPLOYER:
TITLE:	TITLE:	TITLE:
PHONE:	PHONE:	PHONE:
EMAIL:	EMAIL:	EMAIL:

LOCATION AND DATE OF INCIDENT

LOCATION OF INCIDENT:	☐ Hospital ☐ Home ☐ Other _____
ADDRESS OF INCIDENT:	
DATE(S) OF INCIDENT:	

RELATIONSHIP TO THE SUBJECT

☐ PATIENT ☐ CO-WORKER ☐ RELATIVE ☐ EMPLOYER ☐ OTHER: _____

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DESCRIPTION OF INCIDENT

INCIDENT REPORTED TO OTHER ENTITIES

Was the incident reported to anyone else? If so, please provide the following information:

NAME:	NAME:	NAME:
PHONE:	PHONE:	PHONE:
DATE REPORTED:	DATE REPORTED:	DATE REPORTED:
ACTION TAKEN:	ACTION TAKEN:	ACTION TAKEN:

I certify that the foregoing statements made by me are true and any documents attached are true copies. I am aware that if any statements made by me are false, I am subject to punishment.

SIGNATURE: _____ DATE: _____

Collection and Use of Personal Information: The Department of Consumer Affairs, Respiratory Care Board collects the information requested on this form as authorized by B&PC sections 325 and 326. The Respiratory Care Board uses this information to follow up on your complaint.

Providing Personal Information Is Voluntary. You do not have to provide the personal information requested. If you do not wish to provide personal information, such as your name, home address, or telephone number, you may remain anonymous. In that case, however, we may not be able to contact you or help you resolve your complaint.

Access to Your Information. You may review the records maintained by the Respiratory Care Board that contain your personal information, as permitted by the Information Practices Act.

Possible Disclosure of Personal Information. We make every effort to protect the personal information you provide us. In order to follow up on your complaint, however, we may need to share the information you give us with the business you complained about or with other government agencies. This may include sharing any personal information you gave us.

The information you provide may also be disclosed in the following circumstances:

- In response to a Public Records Act request, as allowed by the Information Practices Act;
- To another government agency as required by state or federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant.

Contact Information. For questions about this notice or access to your records, you may contact the Respiratory Care Board at 3750 Rosin Court, Suite 100, Sacramento, CA 95834, (866) 375-0386, or email rcbinfo@dca.ca.gov. For questions about the Department of Consumer Affairs' privacy policy or the Information Practices Act, contact the Office of Privacy Protection, 1625 North Market Blvd., Sacramento, CA 95834, (866) 785-9663, or e-mail dca@dca.ca.gov

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AUTHORIZATION FOR RELEASE OF RECORDS

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

I, the undersigned, hereby authorize the following to disclose records in the course of my diagnosis and treatment to the Respiratory Care Board of California.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

The disclosure of records authorized herein is required for official use including investigation and possible proceedings regarding any violations of the laws of the State of California.

This authorization shall remain valid until the Respiratory Care Board of the State of California completes its investigation and proceedings arising out of the investigation.

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

SIGNATURE _____ DATE _____
(PATIENT)

SIGNATURE _____ DATE _____
(REPRESENTATIVE)

RELATIONSHIP TO PATIENT _____