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

EMPLOYER MANDATORY REPORTING FORM

Pursuant to Business and Professions Code (B&PC) sections 3758 and 3758.6, any employer of a respiratory care practitioner (RCP) shall report to the Board the suspension or termination for cause of any RCP in their employ and that RCP's supervisor's name, professional license type, and license number. Failure to make a report is punishable by an administrative fine of up to $10,000 per violation. The reporting required herein shall not act as a waiver of confidentiality of medical records. The information reported or disclosed shall be kept confidential except as provided in B&PC section 800(c) and shall not be subject to discovery in civil cases. In addition, pursuant to B&PC sections 2318, 3759, and Civil Code section 43.8, no person shall incur any civil penalty as a result of making any report required.

EMPLOYER REGISTERING COMPLAINT

FULL NAME:		TITLE:
BUSINESS NAME:		
BUSINESS ADDRESS:		
TELEPHONE NUMBER:		FAX:
EMAIL:		

VIOLATION BEING REPORTED AGAINST

FULL NAME:		LICENSE NO.:
EMPLOYER:		
EMPLOYER ADDRESS:		
SUPERVISOR'S NAME:		SUPERVISOR'S LIC. NO.:
SUPERVISOR'S PHONE:		SUPERVISOR'S EMAIL:
SUSPENSION DATE:		TERMINATION DATE:

VIOLATION TYPE

Please mark the box below that best describes the type of violation committed:

- ☐ Unlawful Sale of Controlled Substance or Prescription
- ☐ 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

If there are any witnesses to the incident, please provide the following 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:	

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DESCRIPTION OF INCIDENT

Please either attach a copy of the internal investigation OR provide a detailed statement regarding the incident. If you submit a copy of the internal investigation, please be sure the evidence supporting the investigation is certified.

☐ Internal Investigation Attached

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: _____