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.rcb.ca.gov

# LICENSEE MANDATORY REPORTING FORM

Pursuant to Business and Professions Code (B&PC) section 3785.5, if a licensee has knowledge that another person may be in violation of, or has violated, any of the statues or regulations administered by the Board, the licensee shall report this information to the Board in writing and shall cooperate with the Board in furnishing information or assistance as may be required. B&PC sections 2318, 3759, and Civil Code section 43.8 states no person shall incur any civil penalty as a result of making any report required.

## LICENSEE REGISTERING COMPLAINT

| | | |
|---|---|---|
| FULL NAME: | | LICENSE NUMBER: |
| RESIDENT ADDRESS: | | |
| EMPLOYER: | | |
| TELEPHONE NUMBER: | HOME: | WORK: |
| EMAIL: | | |

## VIOLATION BEING REPORTED AGAINST

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

## VIOLATION TYPE

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

- ☐ 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

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: _____