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”

IMPAIRMENT/ADDICTION

PODIATRY MANDATORY REPORT

PODIATRIC MEDICAL LICENSING BOARD

GENERAL INSTRUCTIONS

Any administrator or officer of any hospital, nursing home or other health care agency or facility who has knowledge of any action or condition which reasonably indicates to him or her that a licensed podiatric physician practicing in such hospital, nursing home or other health care agency or facility is habitually intoxicated or addicted to the use of habit forming drugs, or is otherwise impaired, to the extent that such intoxication, addiction, or impairment adversely affects such podiatric physician's professional performance, or has knowledge that reasonably indicates to him or her that any podiatric physician unlawfully possesses, uses, distributes or converts habit-forming drugs belonging to the hospital, nursing home or other health care agency or facility for such podiatric physician's own use or benefit, shall promptly file a written report thereof to the Podiatric Medical Licensing Board.

Reports must be filed with the Podiatric Medical Licensing 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 impairment or addiction.

Part 2 seeks specific information concerning the nature of the impairment or addiction 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.

IMPAIRMENT/ADDICTION
PODIATRY 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 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.)

☐ Drug Abuse ☐ Alcohol Abuse

☐ Restriction ☐ Termination ☐ Counseling Program

PART 2 – SPECIFIC INFORMATION

A. COUNSELING/TREATMENT PROGRAM - (If the subject of the report is/was in a program of counseling or treatment, provide the information requested below. Any further information deemed necessary by the Podiatric Medical Licensing Board will be obtained directly from the licensed individual.)

NAME OF PROGRAM: _____

NAME OF PERSON RESPONSIBLE
FOR PROGRAM (Last, First, MI): _____

PROFESSIONAL TITLE AND/OR JOB TITLE: _____

ADDRESS: _____
Street Address City State ZIP Code

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

START DATE OF PROGRAM: _____ END DATE OF PROGRAM: _____

B. INTOXICATION AND/OR DRUG USE NECESSITATING REPORT – In the space below, provide a detailed description of the intoxication and/or drug use which gave cause to file the mandatory report, including the dates of any occurrences, cooperative agreements, and counseling or treatment programs initiated (**identify and attach any appropriate documents,** if applicable):

C. TERMS AND CONDITIONS – In the space below, provide a brief description of any terms or conditions of the subject's monitoring, if any, including any specific restrictions or limitations on practice (**attach any appropriate documentation** setting forth the terms or conditions).

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: _____