STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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

Board of Vocational Nursing and Psychiatric Technicians
2535 Capitol Oaks Drive Suite 205, Sacramento, CA 95833-2945
Phone 916-263-7800 Fax 916-263-7857 Web www.bvnpt.ca.gov

EMPLOYER REPORTING FORM

Full Name	First	Last		
Title				
Business Name				
Business Address	Street Address	City	State	Zip Code
Telephone Numbers	Home: ( )	Work: ( )	Cell: ( )	
Email Address				

Full Name	First	Last		
License Number				
Address	Street Address	City	State	Zip Code
Telephone Numbers	Home: ( )	Work: ( )	Cell: ( )	

Pursuant to Business and Professions code 2878.1 and 4521.2, any employer of a licensed vocational nurse or psychiatric technician shall report to the board the suspension or termination for cause, or resignation for cause, of any licensee in its employ for any of the following reasons (check all appropriate boxes):

- ☐ Use of controlled substances or alcohol to the extent that it impairs the licensee's ability to safely practice vocational nursing.
- ☐ Unlawful sale of a controlled substance or other prescription items.
- ☐ Patient or client abuse, neglect, physical harm, or sexual contact with a patient or client.
- ☐ Falsification of medical records.
- ☐ Gross negligence or incompetence.
- ☐ Theft from patients or clients, other employees, or the employer.

Reports of all other incidents are considered voluntary.

This required reporting shall not constitute a waiver of confidentiality of medical records.

Please complete Description of Incident below.

LOCATION AND DATE(S) OF INCIDENT(S)				
Location	Hospital Home Other _____			
Business Name (If applicable)				
Address Incident Occurred	Street Address	City	State	Zip Code
Date(s) of Incident				

DESCRIPTION OF INCIDENT *(Please use additional sheets, if necessary)*

WITNESS INFORMATION		
If there were any witnesses to the incident, please provide the following information:		
Witness #1 Name:	Witness #2 Name:	Witness #3 Name:
Title:	Title:	Title:
Phone #:	Phone #:	Phone #:
Business:	Business:	Business:
Address:	Address:	Address:

INCIDENT REPORTED TO OTHER INDIVIDUALS OR ENTITIES		
If the incident(s) was reported to another individual or entity, please provide the following information for each individual or entity:		
Name:	Name:	Name:
Phone #:	Phone #:	Phone #:
Date Reported:	Date Reported:	Date Reported:
Action Taken:	Action Taken:	Action Taken:

I certify under penalty of perjury under the laws of the State of California that to the best of my knowledge the foregoing information is true and correct and that any documents attached are true copies. I am aware that, if any statements made by me are knowingly false, I may be subject to punishment.

Signature _____ **Date** _____