STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

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

LICENSEE MANDATORY REPORTING FORM

Pursuant to Business and Professions Code (Code) sections 2878.1 and 4521.2, a licensed vocational nurse (LVN) or psychiatric technician (PT) is required to report another LVN or PT who is in violation of, or has violated, any of the statutes or regulations administered by the Board of Vocational Nursing and Psychiatric Technicians (Board). The report shall be made in writing within 30 calendar days of becoming aware of the violation. The reporting licensee shall fully cooperate with the Board in furnishing information or assistance as may be required. No person shall incur any civil penalty as a result of submitting any required report *(Code sections 2878.1 (e) and 4521.2 (e) and Civil Code Section 43.8)*.

LICENSEE REPORTING INFORMATION				
Full Name	First	Last		
License Number				
Resident Address	Street Address	City	State	Zip Code
Business Name or Employer				
Business or Employer Address	Street Address	City	State	Zip Code
Telephone Numbers	Home: ( )	Work: ( )	Cell: ( )	

LICENSEE COMMITTING VIOLATION(S)				
Name of Licensee Committing Violation(s)				
License Number				
Business Name or Employer				
Business or Employer Address	Street Address	City	State	Zip Code
Telephone Numbers	Home: ( )	Work: ( )	Cell: ( )	

Please mark all applicable boxes that best describe the violation(s) committed:

- □ Incompetence or gross negligence
- □ Use of excessive force or mistreatment of a patient
- □ Illegal use of controlled substances or alcohol
- □ Falsification of medical records
- □ Arrested or convicted of a criminal offense
- □ Failure to maintain confidentiality of patient medical information
- □ The commission of any act involving dishonesty, when the action is related to the duties of the licensee
- □ The knowing failure to provide infection control guidelines
- □ Illegal possession, prescribing, or self-administration of controlled substances
- □ Other (please describe): _____

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

PLEASE COMPLETE THE REVERSE SIDE

DESCRIPTION OF INCIDENT

(Please use additional sheets, if necessary.)

WITNESS INFORMATION

If there were any witnesses to the violation, please provide the following information for each witness:

Witness #1 Name:	Witness #2 Name:	Witness #3 Name:
Title:	Title:	Title:
Phone #:	Phone #:	Phone #:
Business:	Business:	Business:
Address:	Address:	Address:

VIOLATION REPORTED TO OTHER INDIVIDUALS OR ENTITIES

If the violation(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:

ATTACHMENTS

Please attach all available supporting documentation.

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** _____