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 65/65-65. 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”

CLINICAL PRIVILEGE ACTION

NURSING MANDATORY REPORT

BOARD OF NURSING

GENERAL INSTRUCTIONS

The chief administrator or executive officer of a health care institution licensed by the Department of Public Health, which provides the minimum due process set forth in Section 10.4 of the Hospital Licensing Act, shall report to the Board when an advanced practice nurse's organized professional staff clinical privileges are terminated or are restricted based on a final determination, in accordance with that institution's bylaws or rules and regulations, that (i) a person has either committed an act or acts that may directly threaten patient care and that are not of an administrative nature or (ii) that a person may have a mental or physical disability that may endanger patients under that person's care. The chief administrator or officer shall also report if an advanced practice nurse accepts voluntary termination or restriction of clinical privileges in lieu of formal action based upon conduct related directly to patient care and not of an administrative nature, or in lieu of formal action seeking to determine whether a person may have a mental or physical disability that may endanger patients under that person's care.

Reports must be filed with the Board of Nursing 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 conduct or liability.
>
> Part 2 seeks specific information concerning the conduct or disability 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 Board of Nursing 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.

CLINICAL PRIVILEGE ACTION
NURSING 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 Nurse 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: _____

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

DOB: _____ DATE OF OCCURRENCE: _____

D. TYPE OF ACTION – (Please mark all that are appropriate.)

☐ Restriction of Privileges ☐ Termination of Privileges

☐ Voluntary Surrender Was Voluntary Surrender in Lieu of Adverse Action? ☐ Yes ☐ No

PART 2 – SPECIFIC INFORMATION

A. CONDUCT OR DISABILITY NECESSITATING REPORT – Please provide below a brief description of any act or acts, including the dates of any occurrences, which resulted in a final determination that the subject of the report committed unprofessional conduct related directly to patient care or may be mentally or physically disabled in such a manner as to endanger patients under that person's care (**identify and attach any appropriate documents,** if applicable):

B. HEALTH CARE INSTITUTION ACTION

Date of final determination or acceptance of voluntary restriction or termination: _____

Action taken, including the length and scope of any restriction (**please attach any appropriate documents**):

Years: _____ Months: _____

C. COURT ACTION – (Attach copies of any appropriate pleadings you may have including appearances and orders.)

Did the act(s) result in any court action, civil or criminal?

☐ **Yes** ☐ **No** If yes, please identify.

Case Name: _____

Court in which filed: _____

Docket Number: _____

Date Filed: _____

Status of Court Action: _____

PART 3 - SIGNATURE

NAME	TITLE	DATE	OFFICAL USE ONLY

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: _____