MINNESOTA
HEALTH PROFESSIONALS
SERVICES PROGRAM

1360 Energy Park Drive, Suite 220
St Paul MN 55108
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fax: 651-797-1380
email: hlbhpsp@state.mn.us
web: mn.gov/boards/hpsp

CONFIDENTIAL THIRD PARTY REPORT FORM

To file a report with the Health Professionals Services Program (HPSP), complete this form to the best of your ability or send a letter that includes the information listed below. Your report may be mailed or faxed it to HPSP. HPSP will send you written acknowledgement of receipt of this report. Reports to HPSP are confidential and subject to immunity if made in good faith. This report may fulfill your professional reporting obligations.

CONTACT INFORMATION FOR PERSON BEING REPORTED

Name:		DOB:	Employer:		
Home Address:			Employer's Address:		
City:	State:	Zip:			
Home Phone:	Work Phone:		City:	State:	Zip:
Profession:			Phone:		
Specialty:			**Nature of Illness (please check):**		
Licensing Board:			☐ Substance Disorder	☐ Psychiatric Disorder	
License Number:			☐ Medical Disorder	☐ Unknown	

Describe in detail why this report is being made. Please include the precipitating event, dates, and additional documentation if necessary.

CONTACT INFORMATION FOR PERSON SUBMITTING REPORT

Name (print):	Signature:		Date:
Agency (if applicable) :		Phone:	Fax:
Address:		Relationship to person being reported:	
City: State: Zip:			
May we contact you for additional information: ☐ Yes ☐ No			