MINNESOTA
HEALTH PROFESSIONALS
SERVICES PROGRAM

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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. Your report may be mailed, e-mailed or faxed 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.

INFORMATION FOR PERSON BEING REPORTED

Name:		**DOB:**	
Address:	**City:**	**State:**	**Zip:**
Phone Number:	**E-mail Address:**		
Profession:	**Specialty:**		
Licensing Board:	**License Number:**		
Nature of Illness (please check all that apply): Substance Disorder ☐ Psychiatric Disorder ☐ Medical Disorder ☐ Unknown ☐			

EMPLOYER INFORMATION OF PERSON BEING REPORTED (if applicable)

Employer:		**Phone:**	
Address:	**City:**	**State:**	**Zip:**

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

CONTACT INFORMATION FOR PERSON SUBMITTING REPORT

Personal or Work contact information may be used.

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