

## 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:       |        |             | <b>Nature of Illness (please check):</b><br><input type="checkbox"/> Substance Disorder <input type="checkbox"/> Psychiatric Disorder<br><input type="checkbox"/> Medical Disorder <input type="checkbox"/> Unknown |        |      |
| Licensing Board: |        |             |   |        |      |
| License Number:  |        |             |   |        |      |

**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: <input type="checkbox"/> Yes <input type="checkbox"/> No |        |  |       |