



Medical Board of California

Outpatient Surgery Patient Death Reporting Form

Enforcement Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2528
Fax: (916) 263-2435
complaint@mbc.ca.gov

State law (Section 2240(a) of the California Business and Professions Code) requires that whenever a patient death results from a medical procedure outside of a general acute care hospital, either by the physician or by a person acting under the physician's orders or supervision, the physician must complete this form and send it to Medical Board of California, 2005 Evergreen Street, Sacramento, CA 95815, Attn: Central Complaint Unit, **within 15 days after the occurrence.**

1. PATIENT INFORMATION

Last Name		First Name		Middle Name	
Street address			City		State Zip Code
Date of Birth	Medical Record Number		Physical Location of Medical Record		

2. PHYSICIAN WHO PERFORMED SURGERY INFORMATION

Last Name		First Name		Middle Name	
2a. Physician's Practice Specialty and ABMS Certification				2b. Physician's License Number	

3. SURGERY INFORMATION

Surgery Date	3b. Patient Identifier (Social Security Number, Patient ID Number, etc.)
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4. NAME AND ADDRESS OF OUTPATIENT SETTING WHERE SURGERY/OUTPATIENT PROCEDURE WAS PERFORMED

Name				
Street address		City		State Zip Code

5. ACCREDITING AGENCY

Select one AAAHC AAAASF JC ACHC

and/or CDPH/CMS

6. TYPE(S) OF OUTPATIENT PROCEDURES PERFORMED:

7. CIRCUMSTANCES OF PATIENT'S DEATH: (PLEASE ATTACH ADDITIONAL SHEETS IF NECESSARY)

8. NAME AND LOCATION OF HOSPITAL OR EMERGENCY CENTER WHERE PATIENT WAS TRANSFERRED: (A SEPARATE PATIENT TRANSFER FORM MUST ALSO BE COMPLETED)

9. REPORT DATE AND FORM COMPLETION

Date of Report: _____ Physician Completing this form: _____
(Please Print Legibly)