

Professional Reporting Requirements

Business and Professions Code Sections

801.01, 802.1, 802.5, 803, 803.5, 803.6 and 805

800. Central Files of Licensees' Individual Historical Records

(a) The Medical Board of California, the Board of Psychology, the Dental Board of California, the Osteopathic Medical Board of California, the State Board of Chiropractic Examiners, the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians, the State Board of Optometry, the Veterinary Medical Board, the Board of Behavioral Sciences, the Physical Therapy Board of California, the California State Board of Pharmacy, the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board, the California Board of Occupational Therapy, the Acupuncture Board, and the Physician Assistant Board shall each separately create and maintain a central file of the names of all persons who hold a license, certificate, or similar authority from that board. Each central file shall be created and maintained to provide an individual historical record for each licensee with respect to the following information:

(1) Any conviction of a crime in this or any other state that constitutes unprofessional conduct pursuant to the reporting requirements of Section 803.

(2) Any judgment or settlement requiring the licensee or his or her insurer to pay any amount of damages in excess of three thousand dollars (\$3,000) for any claim that injury or death was proximately caused by the licensee's negligence, error or omission in practice, or by rendering unauthorized professional services, pursuant to the reporting requirements of Section 801 or 802.

(3) Any public complaints for which provision is made pursuant to subdivision (b).

(4) Disciplinary information reported pursuant to Section 805, including any additional exculpatory or explanatory statements submitted by the licensee pursuant to subdivision (f) of Section 805. If a court finds, in a final judgment, that the peer review resulting in the 805 report was conducted in bad faith and the licensee who is the subject of the report notifies the board of that finding, the board shall include that finding in the central file. For purposes of this paragraph, "peer review" has the same meaning as defined in Section 805.

(5) Information reported pursuant to Section 805.01, including any explanatory or exculpatory information submitted by the licensee pursuant to subdivision (b) of that section.

(b) Each board shall prescribe and promulgate forms on which members of the public and other licensees or certificate holders may file written complaints to the board alleging any act of misconduct in, or connected with, the performance of professional services by the licensee.

If a board, or division thereof, a committee, or a panel has failed to act upon a complaint or report within five years, or has found that the complaint or report is without merit, the central file shall be purged of information relating to the complaint or report.

Notwithstanding this subdivision, the Board of Psychology, the Board of Behavioral Sciences, and the Respiratory Care Board of California shall maintain complaints or reports as long as each board deems necessary.

(c) The contents of any central file that are not public records under any other provision of law shall be confidential except that the licensee involved, or his or her counsel or representative, shall have the right to inspect and have copies made of his or her complete file except for the provision that may disclose the identity of an information source. For the purposes of this section, a board may protect an information source by providing a copy of the material with only those deletions necessary to protect the identity of the source or by providing a comprehensive summary of the substance of the material. Whichever method is used, the board shall ensure that full disclosure is made to the subject of any personal information that could reasonably in any way reflect or convey anything detrimental, disparaging, or

threatening to a licensee's reputation, rights, benefits, privileges, or qualifications, or be used by a board to make a determination that would affect a licensee's rights, benefits, privileges, or qualifications. The information required to be disclosed pursuant to Section 803.1 shall not be considered among the contents of a central file for the purposes of this subdivision.

The licensee may, but is not required to, submit any additional exculpatory or explanatory statement or other information that the board shall include in the central file.

Each board may permit any law enforcement or regulatory agency when required for an investigation of unlawful activity or for licensing, certification, or regulatory purposes to inspect and have copies made of that licensee's file, unless the disclosure is otherwise prohibited by law.

These disclosures shall effect no change in the confidential status of these records.

801.01 Report of Settlement of Arbitration Award

The Legislature finds and declares that the filing of reports with the applicable state agencies required under this section is essential for the protection of the public. It is the intent of the Legislature that the reporting requirements set forth in this section be interpreted broadly in order to expand reporting obligations.

(a) A complete report shall be sent to the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or the Physician Assistant Board with respect to a licensee of the board as to the following:

(1) A settlement over thirty thousand dollars (\$30,000) or arbitration award of any amount or a civil judgment of any amount, whether or not vacated by a settlement after entry of the judgment, that was not reversed on appeal, of a claim or action for damages for death or personal injury caused by the licensee's alleged negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services.

(2) A settlement over thirty thousand dollars (\$30,000), if the settlement is based on the licensee's alleged negligence, error, or omission in practice, or on the licensee's rendering of unauthorized professional services, and a party to the settlement is a corporation, medical group, partnership, or other corporate entity in which the licensee has an ownership interest or that employs or contracts with the licensee.

(b) The report shall be sent by the following:

(1) The insurer providing professional liability insurance to the licensee.

(2) The licensee, or his or her counsel, if the licensee does not possess professional liability insurance.

(3) A state or local governmental agency that self-insures the licensee. For purposes of this section, "state governmental agency" includes, but is not limited to, the University of California.

(c) The entity, person, or licensee obligated to report pursuant to subdivision (b) shall send the complete report if the judgment, settlement agreement, or arbitration award is entered against or paid by the employer of the licensee and not entered against or paid by the licensee. "Employer," as used in this paragraph, means a professional corporation, a group practice, a health care facility or clinic licensed or exempt from licensure under the Health and Safety Code, a licensed health care service plan, a medical care foundation, an educational institution, a professional institution, a professional school or college, a general law corporation, a public entity, or a nonprofit organization that employs, retains, or contracts with a licensee referred to in this section. Nothing in this paragraph shall be construed to authorize the employment of, or contracting with, any licensee in violation of Section 2400.

(d) The report shall be sent to the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or the Physician Assistant Board as appropriate, within 30 days after the written settlement agreement has been reduced to writing and signed by all parties thereto, within 30 days after service of the arbitration award on the parties, or within 30 days after the date of entry of the civil judgment.

(e) The entity, person, or licensee required to report under subdivision (b) shall notify the claimant or his or her counsel, if he or she is represented by counsel, that the report has been sent to the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or the Physician Assistant Board. If the claimant or his or her counsel has not received this notice within 45 days after the settlement was reduced to writing and signed by all of the parties or the arbitration award was served on the parties or the date of entry of the civil judgment, the claimant or the claimant's counsel shall make the report to the appropriate board.

(f) Failure to substantially comply with this section is a public offense punishable by a fine of not less than five hundred dollars (\$500) and not more than five thousand dollars (\$5,000).

(g) (1) The Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board may develop a prescribed form for the report.

(2) The report shall be deemed complete only if it includes the following information:

(A) The name and last known business and residential addresses of every plaintiff or claimant involved in the matter, whether or not the person received an award under the settlement, arbitration, or judgment.

(B) The name and last known business and residential addresses of every licensee who was alleged to have acted improperly, whether or not that person was a named defendant in the action and whether or not that person was required to pay any damages pursuant to the settlement, arbitration award, or judgment.

(C) The name, address, and principal place of business of every insurer providing professional liability insurance to any person described in subparagraph (B), and the insured's policy number.

(D) The name of the court in which the action or any part of the action was filed, and the date of filing and case number of each action.

(E) A description or summary of the facts of each claim, charge, or allegation, including the date of occurrence and the licensee's role in the care or professional services provided to the patient with respect to those services at issue in the claim or action.

(F) The name and last known business address of each attorney who represented a party in the settlement, arbitration, or civil action, including the name of the client he or she represented.

(G) The amount of the judgment, the date of its entry, and a copy of the judgment; the amount of the arbitration award, the date of its service on the parties, and a copy of the award document; or the amount of the settlement and the date it was reduced to writing and signed by all parties. If an otherwise reportable settlement is entered into after a reportable judgment or arbitration award is issued, the report shall include both the settlement and a copy of the judgment or award.

(H) The specialty or subspecialty of the licensee who was the subject of the claim or action.

(I) Any other information the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or the Physician Assistant Board may, by regulation, require.

(3) Every professional liability insurer, self-insured governmental agency, or licensee or his or her counsel that makes a report under this section and has received a copy of any written or electronic patient medical or hospital records prepared by the treating physician and surgeon, podiatrist, or physician assistant, or the staff of the treating physician and surgeon, podiatrist, or hospital, describing the medical condition, history, care, or treatment of the person whose death or injury is the subject of the report, or a copy of any deposition in the matter that discusses the care, treatment, or medical condition of the person, shall include with the report, copies of the records and depositions, subject to reasonable costs to be paid by the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or the Physician Assistant Board. If confidentiality is required by court order and, as a result, the reporter is unable to provide the records and depositions, documentation to that effect shall accompany the original report. The applicable board may, upon prior notification of the parties to the action, petition the appropriate court for modification of any protective order to permit disclosure to the board. A professional liability insurer, self-insured governmental agency, or licensee or

his or her counsel shall maintain the records and depositions referred to in this paragraph for at least one year from the date of filing of the report required by this section.

(h) If the board, within 60 days of its receipt of a report filed under this section, notifies a person named in the report, that person shall maintain for the period of three years from the date of filing of the report any records he or she has as to the matter in question and shall make those records available upon request to the board to which the report was sent.

(i) Notwithstanding any other provision of law, no insurer shall enter into a settlement without the written consent of the insured, except that this prohibition shall not void any settlement entered into without that written consent. The requirement of written consent shall only be waived by both the insured and the insurer.

(j) (1) A state or local governmental agency that self-insures licensees shall, prior to sending a report pursuant to this section, do all of the following with respect to each licensee who will be identified in the report:

(A) Before deciding that a licensee will be identified, provide written notice to the licensee that the agency intends to submit a report in which the licensee may be identified, based on his or her role in the care or professional services provided to the patient that were at issue in the claim or action. This notice shall describe the reasons for notifying the licensee. The agency shall include with this notice a reasonable opportunity for the licensee to review a copy of records to be used by the agency in deciding whether to identify the licensee in the report.

(B) Provide the licensee with a reasonable opportunity to provide a written response to the agency and written materials in support of the licensee's position. If the licensee is identified in the report, the agency shall include this response and materials in the report submitted to a board under this section if requested by the licensee.

(C) At least 10 days prior to the expiration of the 30-day reporting requirement under subdivision (d), provide the licensee with the opportunity to present arguments to the body that will make the final decision or to that body's designee. The body shall review the care or professional services provided to the patient with respect to those services at issue in the claim or action and determine the licensee or licensees to be identified in the report and the amount of the settlement to be apportioned to the licensee.

(2) Nothing in this subdivision shall be construed to modify either the content of a report required under this section or the timeframe for filing that report.

(k) For purposes of this section, "licensee" means a licensee of the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or the Physician Assistant Board.

802.1. Report of Charge of Felony, or Conviction of Felony or Misdemeanor

(a) (1) A physician and surgeon, osteopathic physician and surgeon, a doctor of podiatric medicine, and a physician assistant shall report either of the following to the entity that issued his or her license:

(A) The bringing of an indictment or information charging a felony against the licensee.

(B) The conviction of the licensee, including any verdict of guilty, or plea of guilty or no contest, of any felony or misdemeanor.

(2) The report required by this subdivision shall be made in writing within 30 days of the date of the bringing of the indictment or information or of the conviction.

(b) Failure to make a report required by this section shall be a public offense punishable by a fine not to exceed five thousand dollars (\$5,000).

802.5. Coroner's Report

(a) When a coroner receives information that is based on findings that were reached by, or documented and approved by a board-certified or board-eligible pathologist indicating that a death may be the result of a physician and surgeon's, podiatrist's, or physician assistant's gross negligence or incompetence, a

report shall be filed with the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, or the Physician Assistant Board. The initial report shall include the name of the decedent, date and place of death, attending physicians or podiatrists, and all other relevant information available. The initial report shall be followed, within 90 days, by copies of the coroner's report, autopsy protocol, and all other relevant information.

(b) The report required by this section shall be confidential. No coroner, physician and surgeon, or medical examiner, nor any authorized agent, shall be liable for damages in any civil action as a result of his or her acting in compliance with this section. No board-certified or board-eligible pathologist, nor any authorized agent, shall be liable for damages in any civil action as a result of his or her providing information under subdivision (a).

803. Report of crime or Liability for Death

(a) Except as provided in subdivision (b), within 10 days after a judgment by a court of this state that a person who holds a license, certificate, or other similar authority from the Board of Behavioral Sciences or from an agency mentioned in subdivision (a) of Section 800 (except a person licensed pursuant to Chapter 3 (commencing with Section 1200)) has committed a crime, or is liable for any death or personal injury resulting in a judgment for an amount in excess of thirty thousand dollars (\$30,000) caused by his or her negligence, error or omission in practice, or his or her rendering unauthorized professional services, the clerk of the court that rendered the judgment shall report that fact to the agency that issued the license, certificate, or other similar authority.

(b) For purposes of a physician and surgeon, osteopathic physician and surgeon, doctor of podiatric medicine, or physician assistant, who is liable for any death or personal injury resulting in a judgment of any amount caused by his or her negligence, error or omission in practice, or his or her rendering unauthorized professional services, the clerk of the court that rendered the judgment shall report that fact to the agency that issued the license.

803.1. Public Disclosure Information

(a) Notwithstanding any other provision of law, the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall disclose to an inquiring member of the public information regarding any enforcement actions taken against a licensee, including a former licensee, by the board or by another state or jurisdiction, including all of the following:

- (1) Temporary restraining orders issued.
- (2) Interim suspension orders issued.
- (3) Revocations, suspensions, probations, or limitations on practice ordered by the board, including those made part of a probationary order or stipulated agreement.
- (4) Public letters of reprimand issued.
- (5) Infractions, citations, or fines imposed.

(b) Notwithstanding any other provision of law, in addition to the information provided in subdivision (a), the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall disclose to an inquiring member of the public all of the following:

(1) Civil judgments in any amount, whether or not vacated by a settlement after entry of the judgment, that were not reversed on appeal and arbitration awards in any amount of a claim or action for damages for death or personal injury caused by the physician and surgeon's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services.

(2) (A) All settlements in the possession, custody, or control of the board shall be disclosed for a licensee in the low-risk category if there are three or more settlements for that licensee within the last 10 years, except for settlements by a licensee regardless of the amount paid where (i) the settlement is

made as a part of the settlement of a class claim, (ii) the licensee paid in settlement of the class claim the same amount as the other licensees in the same class or similarly situated licensees in the same class, and (iii) the settlement was paid in the context of a case where the complaint that alleged class liability on behalf of the licensee also alleged a products liability class action cause of action. All settlements in the possession, custody, or control of the board shall be disclosed for a licensee in the high-risk category if there are four or more settlements for that licensee within the last 10 years except for settlements by a licensee regardless of the amount paid where (i) the settlement is made as a part of the settlement of a class claim, (ii) the licensee paid in settlement of the class claim the same amount as the other licensees in the same class or similarly situated licensees in the same class, and (iii) the settlement was paid in the context of a case where the complaint that alleged class liability on behalf of the licensee also alleged a products liability class action cause of action. Classification of a licensee in either a "high-risk category" or a "low-risk category" depends upon the specialty or subspecialty practiced by the licensee and the designation assigned to that specialty or subspecialty by the Medical Board of California, as described in subdivision (f). For the purposes of this paragraph, "settlement" means a settlement of an action described in paragraph (1) entered into by the licensee on or after January 1, 2003, in an amount of thirty thousand dollars (\$30,000) or more.

(B) The board shall not disclose the actual dollar amount of a settlement but shall put the number and amount of the settlement in context by doing the following:

(i) Comparing the settlement amount to the experience of other licensees within the same specialty or subspecialty, indicating if it is below average, average, or above average for the most recent 10-year period.

(ii) Reporting the number of years the licensee has been in practice.

(iii) Reporting the total number of licensees in that specialty or subspecialty, the number of those who have entered into a settlement agreement, and the percentage that number represents of the total number of licensees in the specialty or subspecialty.

(3) Current American Board of Medical Specialties certification or board equivalent as certified by the Medical Board of California, the Osteopathic Medical Board of California, or the California Board of Podiatric Medicine.

(4) Approved postgraduate training.

(5) Status of the license of a licensee. By January 1, 2004, the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine shall adopt regulations defining the status of a licensee. The board shall employ this definition when disclosing the status of a licensee pursuant to Section 2027.

(6) Any summaries of hospital disciplinary actions that result in the termination or revocation of a licensee's staff privileges for medical disciplinary cause or reason, unless a court finds, in a final judgment, that the peer review resulting in the disciplinary action was conducted in bad faith and the licensee notifies the board of that finding. In addition, any exculpatory or explanatory statements submitted by the licensee electronically pursuant to subdivision (f) of that section shall be disclosed. For purposes of this paragraph, "peer review" has the same meaning as defined in Section 805.

(c) Notwithstanding any other provision of law, the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall disclose to an inquiring member of the public information received regarding felony convictions of a physician and surgeon or doctor of podiatric medicine.

(d) The Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board may formulate appropriate disclaimers or explanatory statements to be included with any information released, and may by regulation establish categories of information that need not be disclosed to an inquiring member of the public because that information is unreliable or not sufficiently related to the licensee's professional practice. The Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric

Medicine, and the Physician Assistant Board shall include the following statement when disclosing information concerning a settlement:

“Some studies have shown that there is no significant correlation between malpractice history and a doctor’s competence. At the same time, the State of California believes that consumers should have access to malpractice information. In these profiles, the State of California has given you information about both the malpractice settlement history for the doctor’s specialty and the doctor’s history of settlement payments only if in the last 10 years, the doctor, if in a low-risk specialty, has three or more settlements or the doctor, if in a high-risk specialty, has four or more settlements. The State of California has excluded some class action lawsuits because those cases are commonly related to systems issues such as product liability, rather than questions of individual professional competence and because they are brought on a class basis where the economic incentive for settlement is great. The State of California has placed payment amounts into three statistical categories: below average, average, and above average compared to others in the doctor’s specialty. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high-quality care by selecting a doctor based solely on malpractice history.

When considering malpractice data, please keep in mind:

Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make an individual doctor’s history more meaningful.

This report reflects data only for settlements made on or after January 1, 2003. Moreover, it includes information concerning those settlements for a 10-year period only. Therefore, you should know that a doctor may have made settlements in the 10 years immediately preceding January 1, 2003, that are not included in this report. After January 1, 2013, for doctors practicing less than 10 years, the data covers their total years of practice. You should take into account the effective date of settlement disclosure as well as how long the doctor has been in practice when considering malpractice averages.

The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to settle. Some doctors work primarily with high-risk patients. These doctors may have malpractice settlement histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.

Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the doctor. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

You may wish to discuss information in this report and the general issue of malpractice with your doctor.”

(e) The Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall, by regulation, develop standard terminology that accurately describes the different types of disciplinary filings and actions to take against a licensee as described in paragraphs (1) to (5), inclusive, of subdivision (a). In providing the public with information about a licensee via the Internet pursuant to Section 2027, the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall not use the terms “enforcement,” “discipline,” or similar language implying a sanction unless the physician and surgeon has been the subject of one of the actions described in paragraphs (1) to (5), inclusive, of subdivision (a).

(f) The Medical Board of California shall adopt regulations no later than July 1, 2003, designating each specialty and subspecialty practice area as either high risk or low risk. In promulgating these regulations, the board shall consult with commercial underwriters of medical malpractice insurance companies, health care systems that self-insure physicians and surgeons, and representatives of the California medical specialty societies. The board shall utilize the carriers’ statewide data to establish the two risk categories and the averages required by subparagraph (B) of paragraph (2) of subdivision (b). Prior to issuing

regulations, the board shall convene public meetings with the medical malpractice carriers, self-insurers, and specialty representatives.

(g) The Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, the Physician Assistant Board shall provide each licensee, including a former licensee under subdivision (a), with a copy of the text of any proposed public disclosure authorized by this section prior to release of the disclosure to the public. The licensee shall have 10 working days from the date the board provides the copy of the proposed public disclosure to propose corrections of factual inaccuracies. Nothing in this section shall prevent the board from disclosing information to the public prior to the expiration of the 10-day period.

(h) Pursuant to subparagraph (A) of paragraph (2) of subdivision (b), the specialty or subspecialty information required by this section shall group physicians by specialty board recognized pursuant to paragraph (5) of subdivision (h) of Section 651 unless a different grouping would be more valid and the board, in its statement of reasons for its regulations, explains why the validity of the grouping would be more valid.

803.5. Notice to Board of Filing Charging Licensee with Felony

(a) The district attorney, city attorney, or other prosecuting agency shall notify the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, the State Board of Chiropractic Examiners, the Physician Assistant Board, or other appropriate allied health board, and the clerk of the court in which the charges have been filed, of any filings against a licensee of that board charging a felony immediately upon obtaining information that the defendant is a licensee of the board. The notice shall identify the licensee and describe the crimes charged and the facts alleged. The prosecuting agency shall also notify the clerk of the court in which the action is pending that the defendant is a licensee, and the clerk shall record prominently in the file that the defendant holds a license from one of the boards described above.

(b) The clerk of the court in which a licensee of one of the boards is convicted of a crime shall, within 48 hours after the conviction, transmit a certified copy of the record of conviction to the applicable board.

803.6. Transmittal of Felony Preliminary Hearing Transcript

(a) The clerk of the court shall transmit any felony preliminary hearing transcript concerning a defendant licensee to the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, the Physician Assistant Board, or other appropriate allied health board, as applicable, where the total length of the transcript is under 800 pages and shall notify the appropriate board of any proceeding where the transcript exceeds that length.

(b) In any case where a probation report on a licensee is prepared for a court pursuant to Section 1203 of the Penal Code, a copy of that report shall be transmitted by the probation officer to the board.

805. Peer Review: Reports

(a) As used in this section, the following terms have the following definitions:

(1) (A) "Peer review" means both of the following:

(i) A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of licentiates to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following:

(I) Determine whether a licentiate may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, to determine the parameters of that practice.

(II) Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services.

(ii) Any other activities of a peer review body as specified in subparagraph (B).

(B) "Peer review body" includes:

(i) A medical or professional staff of any health care facility or clinic licensed under Division 2 (commencing with Section 1200) of the Health and Safety Code or of a facility certified to participate in the federal Medicare program as an ambulatory surgical center.

(ii) A health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that contracts with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code.

(iii) Any medical, psychological, marriage and family therapy, social work, professional clinical counselor, dental, or podiatric professional society having as members at least 25 percent of the eligible licentiates in the area in which it functions (which must include at least one county), which is not organized for profit and which has been determined to be exempt from taxes pursuant to Section 23701 of the Revenue and Taxation Code.

(iv) A committee organized by any entity consisting of or employing more than 25 licentiates of the same class that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity.

(2) "Licentiate" means a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, or physician assistant. "Licentiate" also includes a person authorized to practice medicine pursuant to Section 2113 or 2168.

(3) "Agency" means the relevant state licensing agency having regulatory jurisdiction over the licentiates listed in paragraph (2).

(4) "Staff privileges" means any arrangement under which a licentiate is allowed to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.

(5) "Denial or termination of staff privileges, membership, or employment" includes failure or refusal to renew a contract or to renew, extend, or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.

(6) "Medical disciplinary cause or reason" means that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

(7) "805 report" means the written report required under subdivision (b).

(b) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body:

(1) A licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason.

(2) A licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.

(3) Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.

(c) If a licentiate takes any action listed in paragraph (1), (2), or (3) after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason or after receiving notice that his or her application for membership or staff privileges is denied or will be denied for a medical disciplinary cause or reason, the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any

licensed health care facility or clinic where the licentiate is employed or has staff privileges or membership or where the licentiate applied for staff privileges or membership, or sought the renewal thereof, shall file an 805 report with the relevant agency within 15 days after the licentiate takes the action.

(1) Resigns or takes a leave of absence from membership, staff privileges, or employment.

(2) Withdraws or abandons his or her application for staff privileges or membership.

(3) Withdraws or abandons his or her request for renewal of staff privileges or membership.

(d) For purposes of filing an 805 report, the signature of at least one of the individuals indicated in subdivision (b) or (c) on the completed form shall constitute compliance with the requirement to file the report.

(e) An 805 report shall also be filed within 15 days following the imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days.

(f) A copy of the 805 report, and a notice advising the licentiate of his or her right to submit additional statements or other information, electronically or otherwise, pursuant to Section 800, shall be sent by the peer review body to the licentiate named in the report. The notice shall also advise the licentiate that information submitted electronically will be publicly disclosed to those who request the information.

The information to be reported in an 805 report shall include the name and license number of the licentiate involved, a description of the facts and circumstances of the medical disciplinary cause or reason, and any other relevant information deemed appropriate by the reporter.

A supplemental report shall also be made within 30 days following the date the licentiate is deemed to have satisfied any terms, conditions, or sanctions imposed as disciplinary action by the reporting peer review body. In performing its dissemination functions required by Section 805.5, the agency shall include a copy of a supplemental report, if any, whenever it furnishes a copy of the original 805 report.

If another peer review body is required to file an 805 report, a health care service plan is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason. If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

(g) The reporting required by this section shall not act as a waiver of confidentiality of medical records and committee reports. The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800 and Sections 803.1 and 2027, provided that a copy of the report containing the information required by this section may be disclosed as required by Section 805.5 with respect to reports received on or after January 1, 1976.

(h) The Medical Board of California, the Osteopathic Medical Board of California, and the Dental Board of California shall disclose reports as required by Section 805.5.

(i) An 805 report shall be maintained electronically by an agency for dissemination purposes for a period of three years after receipt.

(j) No person shall incur any civil or criminal liability as the result of making any report required by this section.

(k) A willful failure to file an 805 report by any person who is designated or otherwise required by law to file an 805 report is punishable by a fine not to exceed one hundred thousand dollars (\$100,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. A violation of this subdivision may constitute unprofessional conduct by the licentiate. A person who is alleged to have violated this subdivision may assert any defense available at law. As used in this subdivision, "willful" means a voluntary and intentional violation of a known legal duty.

(l) Except as otherwise provided in subdivision (k), any failure by the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report, shall be punishable by a fine that under no circumstances shall exceed fifty thousand dollars (\$50,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. The amount of the fine imposed, not exceeding fifty thousand dollars (\$50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report exercised due diligence despite the failure to file or whether they knew or should have known that an 805 report would not be filed; and whether there has been a prior failure to file an 805 report. The amount of the fine imposed may also differ based on whether a health care facility is a small or rural hospital as defined in Section 124840 of the Health and Safety Code.

(m) A health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that negotiates and enters into a contract with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code, when determining participation with the plan or insurer, shall evaluate, on a case-by-case basis, licentiates who are the subject of an 805 report, and not automatically exclude or deselect these licentiates.