## **Entity Registration**

## **ENTITY REGISTRATION**

National Practitioner Data Bank Healthcare Integrity and Protection Data Bank

Complete this form to register your entity with the NPDB, HIPDB, or both Data Banks, and click Continue. If you are actively registered and need to update your current entity registration, log into the IQRS as the entity's administrator and select Update Registration Profile from the Administrator Options menu. If you have been locked out of the IQRS because your password has expired or if you have been deactivated, do not complete this form. You must call the Customer Service Center and request a new password. If you need to renew your entity registration, log into the IQRS as the entity's administrator and follow the instructions provided after you log in.

After completing this form, you will be instructed to print the Entity Registration, provide an original signature, and mail the form to the Data Banks. Once the signed form has been processed, the Data Banks will send you a confirmation notice, which provides your Data Bank Identification Number (DBID) and other important information. Only entities authorized by law may register with the Data Banks.

OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 1 hour to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

ENTITY IDENTIFICATION INFORMATI	ON Help ?
Name of Entity: Department or Office to Which Mail Should be Addressed: Street Address:	
Address Line 2:	
City: State: ZIP Code:	CHOOSE ONE FROM LIST
Country (if U.S., leave blank): E-mail Address to Which Correspondence Should be Sent:	
·	(To ensure your entity is able to receive Data Bank e-mail, add npdb-hipdb@sra.com to your Safe Sender list. For assistance, call the Customer Service Center at 1-800-767-6732.)
Department Fax Number:	
Taxpayer Identification Number (TIN):	
National Crime Information Center Originating Agency Identifier (ORI)	

(For law enforcement only):			
Ownership of the Entity:	CHOOSE ONE FROM LIST	₩	
If Federal, Specify Department:	CHOOSE ONE FROM LIST		



submitting your entity registration.

Complete this section if you already have a Data Bank Identification Number (DBID). Leave this section blank if you are registering for the first time. If you have a DBID and your password has expired or if you have been deactivated, do not complete this form. Call the Customer Service Center to request a new password.

Existing DBID:		
Reason for this Registration:	CHOOSE ONE FROM LIST	▼
	_	
Additional Comments:		
	▼	
ELIGIBILITY/STATUTORY AUTHO	ORITY Help ?	

For each of the three statutes below, entities must select the most appropriate function/service category based on their primary function or service. Review each of these statutes and regulations prior to

- 1. Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended;
- 2. Public Law 100-93, Section 5[b] of the Medicare and Medicaid Patient and Program Protection Act of 1987, [Section 1921 of the Social Security Act]; and
- 3. Section 221[a], Public Law 104-191, the *Health Insurance Portability and Accountability Act of 1996*, more commonly referred to as Section 1128E of the *Social Security Act*.

Each entity is responsible for determining its legal obligation or eligibility under the applicable laws and regulations, and must register accordingly. For a complete description of the requirements and penalties of each authority, follow the links at the top of each authority selection list. You may wish to seek advice from legal counsel before specifying your statutory authority(ies). If no function/service applies to you in the block, select "None of These."

If you are registering under Section 1921 of the Social Security Act, please be aware that this legislation has not been implemented. Therefore, reports and queries are not accepted under this authority at this time. You will be notified when final regulations to implement Section 1921 have been established. Until that time, your certification election for this statute will be stored but will remain inactive.

## Title IV Statutory Authority Selections

National Practitioner Data Bank - Title IV Statutory Function/Service Categories  More information about Title IV querying eligibility and reporting requirements	ategories Statutory Requirements	
Function/Service (select one)	Querying	Reporting
© Board of Medical/Dental Examiners*	Optional	Mandatory
Other State Practitioner Licensing Board	Optional	No Requirement

○ Hospital**	Mandatory	Mandatory
○ Professional Society**	Optional	Mandatory
○ Other Health Care Entity**	Optional	Mandatory
C Medical Malpractice Payer	Prohibited	Mandatory
○ None of These	Prohibited	Prohibited

<sup>\*</sup> Includes Composite Boards for physicians or dentists and other health care practitioners.

## Section 1921 Statutory Authority Selections

National Practitioner Data Bank - Section 1921 Statutory Function/Service Categories More information about Section 1921 querying eligibility and reporting requirements	Statutory Requirements	
Function/Service (select one)	Querying	Reporting
State Health Care Practitioner Licensing Board	Optional	Mandatory
C State Health Care Entity Licensing Board	Optional	Mandatory
© Quality Improvement Organization under Contract with the Centers for Medicare & Medicaid Services (CMS)	Optional	Mandatory
C Private Accreditation Organization	Prohibited	Mandatory
○ Hospital*	Optional	No Requirement
© Other Health Care Entity, including Professional Society*	Optional	No Requirement
© Agency Administering a Federal Health Care Program, including Private Entities Under Contract	Optional	No Requirement
<ul> <li>State Agency Administering or Supervising the Administration of a State Health Care Program</li> </ul>	Optional	No Requirement
C State Medicaid Fraud Control Unit	Optional	No Requirement
O Attorney General/Other Law Enforcement Agency	Optional	No Requirement
○ None of These	Prohibited	Prohibited

<sup>\*</sup> Must provide health care services directly or indirectly and must follow a formal peer review process for the furthering of quality health care.

## Section 1128E Statutory Authority Selections

Healthcare Integrity and Protection Data Bank - Section 1128e Statutory Function/Service Categories More information about Section 1128e querying eligibility and reporting requirements	Statutory Requirements	
Function/Service (select one)	Querying	Reporting
○ Federal Government Agency	Optional	Mandatory
State Government Agency	Optional	Mandatory

<sup>\*\*</sup> Must provide health care services directly or indirectly and must follow a formal peer review process for the furthering of quality health care.

୍ Health Plan	Optional	Mandatory
○ None of These	Prohibited	Prohibited

#### PRIMARY FUNCTION OF ENTITY



Select the category that best describes the primary function that your organization performs. Make only one selection from this list. If the code says "specify," describe the function. Entities that provide health care services and are self-insured for malpractice liability should register as health care service providers, not as malpractice payers.

Primary Function of Entity:	CHOOSE ONE FROM LIST	•
If Other, Specify:		

## QUERY OPTIONS FOR ENTITIES AUTHORIZED BY LAW TO QUERY BOTH THE NPDB AND THE HIPDB Help?

Select the Data Bank(s) you elect to query. Fees are assessed for each Data Bank you choose to query (except for Federal agencies, which, by law, are exempt from HIPDB query fees). Complete this section only if you are eligible to query both the NPDB and the HIPDB, based on the selections made in the ELIGIBILITY/STATUTORY AUTHORITY section. Hospitals MUST query the NPDB under Title IV.

- O Query the NPDB and the HIPDB for each guery submitted.
- O Query only the NPDB for each query submitted.
- O Query only the HIPDB for each query submitted.
- O Do not query either the NPDB or the HIPDB.
- □ I have elected not to query the NPDB but I wish to query the NPDB after the publication of final regulations implementing Section 1921 of the Social Security Act.

## POINT OF CONTACT FOR REPORTS



A report point of contact is applicable only if the entity is eligible under law to submit reports. You may designate an individual or office to be the point of contact to be included on all reports submitted by your organization to the NPDB and/or the HIPDB. If your entity does not designate a point of contact, the submitter of each individual report will be listed as the point of contact for that report.

Name or Office:		
Title or Department:		
Telephone:	Ext.	

#### **ENTITY ADMINISTRATOR**



The entity administrator is the person who is responsible for overseeing the use of the IQRS at your entity, establishing individual user accounts, and updating entity profile information. Enter the entity administrator's Name, Title, and Telephone information below.

Name: Title: Telephone:	Ext.
CERTIFICATION Help ?	
AUTHORITY section and is eligible to per the entity may be subject to sanctions und required in the statutes and regulations of HIPDB other than the purposes for which this registration information to the NPDB-complete. If I become aware that any informatify the NPDB-HIPDB of this fact immedialsification of any information contained information to the NPDB-HIPDB to complete.	alifies under law as specified in the ELIGIBILITY/STATUTORY form the querying and/or reporting functions. I understand that der Federal statute for failure to report final adverse actions as r for the use of information obtained from the NPDB or the it was provided. I further certify that I am authorized to submit HIPDB and that the information provided is true, correct, and ormation in this form is not true, correct, or complete, I agree to diately. I understand that any omission, misrepresentation, or in this form or contained in any communication supplying ete or clarify this form may be punishable by criminal, civil, or s, penalties, and/or imprisonment under Federal law.
Name of Certifying Official:	
Title of Certifying Official:	
Telephone:	Ext.
Certification Date (MMDDYYYY):	11102006
Continue	

## Agent Registration

#### AGENT REGISTRATION

National Practitioner Data Bank Healthcare Integrity and Protection Data Bank

Complete this form to register as an authorized agent to query and/or report to the NPDB, the HIPDB, or both, on behalf of eligible, registered entities. In most cases, an authorized agent is an independent contractor used for centralized credentialing (e.g., a county medical society or State hospital association). Complete this form only if you are an authorized agent. If you are actively registered and need to update your current agent registration, log into the IQRS as the administrator and select **Update Registration Profile** from the Administrator Options menu. If you have been locked out of the IQRS because your password has expired or you have been deactivated, do not complete this form. You must call the Customer Service Center and request a new password. If you need to renew your agent registration, log into the IQRS as the administrator and follow the instructions provided after you log in. Entities that are authorized by law to query, report, or both on their own behalf must register using the <a href="Entity Registration">Entity Registration</a> form.

After completing this form, you must click **Continue** and print the Agent Registration, provide an original signature, and mail the form to the Data Banks. Once the signed form has been processed, the Data Banks will send you a confirmation notice, which provides your Data Bank Identification Number (DBID) and other important information.

All agents must review and sign this registration form to ensure knowledge of and compliance with the confidentiality requirements of Public Law 99-660, the *Health Care Quality Improvement Act of 1986*, as amended; Public Law 100-93, Section 5[b] of the *Medicare and Medicaid Patient and Program Protection Act of 1987*, as amended by Public Law 101-508, *Omnibus Budget Reconciliation Act of 1990*; and/or Public Law 104-191, the *Health Insurance Portability and Accountability Act of 1996*, as amended; that applies to information submitted to the NPDB-HIPDB. Review each of these statutes and regulations prior to submitting your agent registration.

OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 15 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

#### **AUTHORIZED AGENT IDENTIFICATION INFORMATION**

Agent Organization Name:	
Department or Office to Which Mail Should be Addressed:	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST ▼
ZIP Code:	-
Country (if U.S., leave blank):	

(To ensure your entity is able to receive Data Bank e-mail, add npdb-hipdb@sra.com to your Safe Sender list. For assistance, call the Customer Service Center at 1-800-767-6732.)
?
is responsible for overseeing the use of the IQRS at your ts, and updating entity profile information. Enter the entity e information below.
Ext.

#### **AUTHORIZED AGENT REQUIREMENTS**

As an agent authorized to report and query the NPDB-HIPDB on behalf of an eligible entity, I certify that the organization has read and understands the provisions of Public Law 99-660, as amended; the NPDB regulation (45 CFR Part 60); Public Law 100-93, as amended by Public Law 101-508; and/or the HIPDB regulation (45 CFR Part 61), Public Law 104-191, as amended; and that I will meet and comply with the following requirements:

- . I am authorized to conduct business in my State.
- . My facilities are secure to ensure the confidentiality of NPDB-HIPDB information.
- I understand and can comply with the technical requirements for electronically reporting to and querying the NPDB-HIPDB, as provided by the NPDB-HIPDB and/or guidance distributed by the NPDB-HIPDB.
- . I will use my own password and DBID to report and query on behalf of my NPDB-HIPDB client.
- I understand that I must query the NPDB and/or the HIPDB separately for each entity on whose behalf I am authorized to query. My agreement(s) with the entity(ies) I represent explicitly prohibits me from using information obtained from the NPDB-HIPDB other than the purpose for which the disclosure was made.
- I will not use a single query response for a particular practitioner, provider, or supplier on behalf of more than one entity.
- To my knowledge, the information I am submitting is accurate and truthful.
- I will keep registration information concerning my organization in the NPDB-HIPDB up-to-date; and I will delete NPDB-HIPDB query and report information from my organization's database that I provided or obtained on behalf of any entity for whom I am no longer acting as agent.

 My activities as an agent are subject to the provisions of Public Law 104-191, as amended; Public Law 100-93, as amended by Public Law 101-508; and Public Law 104-191, as amended and regulations codified at 45 CFR Parts 60 and 61.

#### CERTIFICATION

Notice: 18 U.S.C. §1001 authorizes criminal penalties against whomever in any matter within the jurisdiction of the executive, legislative, or judicial branch of the Government, knowingly and willfully falsifies, conceals, or covers-up by any trick, scheme, or writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry. Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to 5 years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C.§3571, Section 3571 (d) also authorizes fines of up to the greater of twice the gross gain derived by the offender or twice the gross loss sustained by another as a result of the offense. By signing this document, I certify that I satisfy the requirements as specified above. I understand that if I do not comply with the stated requirements, my status as an authorized agent with the NPDB-HIPDB may be suspended or revoked by the Government. I further understand that any omission, misrepresentation, or falsification of any information contained in this form or in any communication supplying information to the NPDB-HIPDB to complete or clarify this form may be punishable by criminal, civil, or other administrative actions including fines, penalties, and/or imprisonment under Federal law.

Name of Certifying Official:	
Fitle of Certifying Official:	
Гelephone:	Ext.
Certification Date (MMDDYYYY):	06092006
Continue	
Continue	

Return to NPDB-HIPDB Home Page

## **Entity Registration Update**

# UPDATE ENTITY PROFILE National Practitioner Data Bank Healthcare Integrity and Protection Data Bank

Entity: STATE BOARD OF MEDICAL EXAMINERS (FAIRFAX, VA)

To update entity registration information, complete the fields that require a change, then click **Submit to Data Bank(s)**. Some changes will require that a signed copy be mailed to the NPDB-HIPDB; please follow any instructions provided after submitting in order to process your registration update.



OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

**ELIGIBILITY/STATUTORY AUTHORITY** 

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 5 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

#### ENTITY IDENTIFICATION INFORMATION Help STATE BOARD OF MEDICAL EXAMINERS Name of Entity: Department or Office to Which Mail Should be Addressed: 4350 FAIR LAKES COURT Street Address: Address Line 2: **SUITE 4001** City: **FAIRFAX** State: VA Virginia ▾ ZIP Code: 22033 4435 Country (if U.S., leave blank): E-mail Address to Which mail2me@gmail.com Correspondence Should be Sent: (To ensure your entity is able to receive Data Bank e-mail, add npdb-hipdb@sra.com to your Safe Sender list. For assistance, call the Customer Service Center at 1-800-767-6732.) Department Fax Number: Taxpayer Identification Number (TIN): 77777777 National Crime Information Center Originating Agency Identifier (ORI) (For law enforcement only): Ownership of the Entity: State Government Agency If Federal, Specify Department: CHOOSE ONE FROM LIST

For each of the three statutes below, entities must select the most appropriate function/service category

Help

based on their primary function or service. <u>Review each of these statutes and regulations</u> prior to submitting your entity registration.

- 1. Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended;
- 2. Public Law 100-93, Section 5[b] of the Medicare and Medicaid Patient and Program Protection Act of 1987. [Section 1921 of the Social Security Act]; and
- 3. Section 221[a], Public Law 104-191, the *Health Insurance Portability and Accountability Act of 1996*, more commonly referred to as Section 1128E of the *Social Security Act*.

Each entity is responsible for determining its legal obligation or eligibility under the applicable laws and regulations, and must register accordingly. For a complete description of the requirements and penalties of each authority, follow the links at the top of each authority selection list. You may wish to seek advice from legal counsel before specifying your statutory authority(ies). If no function/service applies to you in the block, select "None of These."

If you are registering under Section 1921 of the Social Security Act, please be aware that this legislation has not been implemented. Therefore, reports and queries are not accepted under this authority at this time. You will be notified when final regulations to implement Section 1921 have been established. Until that time, your certification election for this statute will be stored but will remain inactive.

#### Title IV Statutory Authority Selections

National Practitioner Data Bank - Title IV Statutory Function/Service Categories  More information about Title IV querying eligibility and reporting requirements	Statutory Requirements	
Function/Service (select one)	Querying Reporting	
○ Board of Medical/Dental Examiners*	Optional	Mandatory
Other State Practitioner Licensing Board	Optional	No Requirement
	Mandatory	Mandatory
○ Professional Society**	Optional	Mandatory
Other Health Care Entity**	Optional	Mandatory
Medical Malpractice Payer	Prohibited	Mandatory
○ None of These	Prohibited	Prohibited

<sup>\*</sup> Includes Composite Boards for physicians or dentists and other health care practitioners.

## Section 1921 Statutory Authority Selections

National Practitioner Data Bank - Section 1921 Statutory Function/Service Categories More information about Section 1921 querying eligibility and reporting requirements	Statutani Baguiramanta	
Function/Service (select one)	Querying	Reporting
State Health Care Practitioner Licensing Board	Optional	Mandatory
State Health Care Entity Licensing Board	Optional	Mandatory
C Quality Improvement Organization under Contract with the Centers for Medicare & Medicaid Services (CMS)	Optional	Mandatory

<sup>\*\*</sup> Must provide health care services directly or indirectly and must follow a formal peer review process for the furthering of quality health care.

C Private Accreditation Organization	Prohibited	Mandatory
⊕ Hospital*	Optional	No Requirement
C Other Health Care Entity, including Professional Society*	Optional	No Requirement
© Agency Administering a Federal Health Care Program, including Private Entities Under Contract	Optional	No Requirement
C State Agency Administering or Supervising the Administration of a State Health Care Program	Optional	No Requirement
C State Medicaid Fraud Control Unit	Optional	No Requirement
C Attorney General/Other Law Enforcement Agency	Optional	No Requirement
○ None of These	Prohibited	Prohibited

<sup>\*</sup> Must provide health care services directly or indirectly and must follow a formal peer review process for the furthering of quality health care.

## Section 1128E Statutory Authority Selections

Healthcare Integrity and Protection Data Bank - Section 1128e Statutory Function/Service Categories More information about Section 1128e querying eligibility and reporting requirements	Statutory Requirements	
Function/Service (select one)	Querying	Reporting
○ Federal Government Agency	Optional	Mandatory
State Government Agency	Optional	Mandatory
୍ Health Plan	Optional	Mandatory
O None of These	Prohibited	Prohibited

## PRIMARY FUNCTION OF ENTITY



Select the category that best describes the primary function that your organization performs. Make only one selection from this list. If the code says "specify," describe the function. Entities that provide health care services and are self-insured for malpractice liability should register as health care service providers, not as malpractice payers.

Primary Function of Entity:	44 Hospital	•
If Other, Specify:		

## QUERY OPTIONS FOR ENTITIES AUTHORIZED BY LAW TO QUERY BOTH THE NPDB AND THE HIPDB Help?

Select the Data Bank(s) you elect to query. Fees are assessed for each Data Bank you choose to query (except for Federal agencies, which, by law, are exempt from HIPDB query fees). Complete this section only if you are eligible to query both the NPDB and the HIPDB, based on the selections made in the ELIGIBILITY/STATUTORY AUTHORITY section. Hospitals MUST query the NPDB under Title IV.

- Query the NPDB and the HIPDB for each query submitted.
- Query only the NPDB for each query submitted.

<ul><li>Query only the HIPDB for each query s</li><li>Do not query either the NPDB or the H</li></ul>		
$\hfill \square$ I have elected not to query the NPDB regulations implementing Section 1921 of		after the publication of final
POINT OF CONTACT FOR REPORTS	Help ?	
A report point of contact is applicable only designate an individual or office to be the organization to the NPDB and/or the HIPE submitter of each individual report will be	point of contact to be include DB. If your entity does not de	d on all reports submitted by your signate a point of contact, the
Name or Office:	WER	
Title or Department:	WERER	
Telephone:	2342342342	Ext.
ENTITY ADMINISTRATOR Help	?	
The entity administrator is the person who entity, establishing individual user accound administrator's Name, Title, and Telephon	ts, and updating entity profile	g the use of the IQRS at your information. Enter the entity
Name:	NOUNOU	
Title:	TESTER	
Telephone:	3012111212	Ext. 111
CERTIFICATION  I certify that the entity identified above qua AUTHORITY section and is eligible to per the entity may be subject to sanctions und required in the statutes and regulations or HIPDB other than the purposes for which this registration information to the NPDB-tcomplete. If I become aware that any infonotify the NPDB-HIPDB of this fact immedialsification of any information contained in information to the NPDB-HIPDB to complete other administrative actions including finest Name of Certifying Official:  Title of Certifying Official:  Telephone:	form the querying and/or reporter Federal statute for failure for the use of information ob it was provided. I further certal HPDB and that the information mation in this form is not truliately. I understand that any in this form or contained in an ete or clarify this form may be s, penalties, and/or imprisonman	orting functions. I understand that to report final adverse actions as tained from the NPDB or the tify that I am authorized to submit on provided is true, correct, and e, correct, or complete, I agree to omission, misrepresentation, or y communication supplying punishable by criminal, civil, or
Certification Date (MMDDYYYY): 11072006		
Submit to Data Bank(s)		

Return to Administrator Options End Session & Return to Login

## **Agent Registration Update**

Name:

Telephone:

Title:

## **National Practitioner Data Bank UPDATE AGENT PROFILE** Healthcare Integrity and Protection Data Bank Entity: AGENT SERVICES INC (HOMETOWN, VA) To update agent registration information, complete the fields that require a change, then Help click Submit to Data Bank(s). OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07 Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 5 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857. AGENT IDENTIFICATION INFORMATION AGENT SERVICES INC Agent Organization Name: Department or Office to Which Mail Should be Addressed: Street Address: 123 ANYWHERE STREET Address Line 2: HOMETOWN City: State: VA Virginia ZIP Code: 22191 Country (if U.S., leave blank): E-mail Address to Which mail@gmail.com Correspondence Should be Sent: (To ensure your entity is able to receive Data Bank e-mail, add npdb-hipdb@sra.com to your Safe Sender list. For assistance, call the Customer Service Center at 1-800-767-6732.) 2345325235 Department Fax Number: Taxpayer Identification Number (TIN): 253234532 **ENTITY ADMINISTRATOR** Help The entity administrator is the person who is responsible for overseeing the use of the IQRS at your entity, establishing individual user accounts, and updating entity profile information. Enter the entity administrator's Name, Title, and Telephone information below.

John Smith

Programmer

2352352345

Ext.

#### AUTHORIZED AGENT REQUIREMENTS

As an agent authorized to report and query the NPDB-HIPDB on behalf of an eligible entity, I certify that the organization has read and understands the provisions of Public Law 99-660, as amended; the NPDB regulation (45 CFR Part 60); Public Law 100-93, as amended by Public Law 101-508; and/or the HIPDB regulation (45 CFR Part 61), Public Law 104-191, as amended; and that I will meet and comply with the following requirements:

- . I am authorized to conduct business in my State.
- My facilities are secure to ensure the confidentiality of NPDB-HIPDB information.
- I understand and can comply with the technical requirements for electronically reporting to and querying the NPDB-HIPDB, as provided by the NPDB-HIPDB and/or guidance distributed by the NPDB-HIPDB.
- I will use my own password and DBID to report and query on behalf of my NPDB-HIPDB client.
- I understand that I must query the NPDB and/or the HIPDB separately for each entity on whose behalf I am authorized to query. My agreement(s) with the entity(ies) I represent explicitly prohibits me from using information obtained from the NPDB-HIPDB other than the purpose for which the disclosure was made.
- I will not use a single query response for a particular practitioner, provider, or supplier on behalf of more than one entity.
- To my knowledge, the information I am submitting is accurate and truthful.
- I will keep registration information concerning my organization in the NPDB-HIPDB up-to-date; and I will delete NPDB-HIPDB query and report information from my organization's database that I provided or obtained on behalf of any entity for whom I am no longer acting as agent.
- My activities as an agent are subject to the provisions of Public Law 104-191, as amended; Public Law 100-93, as amended by Public Law 101-508; and Public Law 104-191, as amended and regulations codified at 45 CFR Parts 60 and 61.

#### CERTIFICATION

Notice: 18 U.S.C. §1001 authorizes criminal penalties against whomever in any matter within the jurisdiction of the executive, legislative, or judicial branch of the Government, knowingly and willfully falsifies, conceals, or covers-up by any trick, scheme, or writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry. Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to 5 years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C.§3571, Section 3571 (d) also authorizes fines of up to the greater of twice the gross gain derived by the offender or twice the gross loss sustained by another as a result of the offense. By signing this document, I certify that I satisfy the requirements as specified above. I understand that if I do not comply with the stated requirements, my status as an authorized agent with the NPDB-HIPDB may be suspended or revoked by the Government. I further understand that any omission, misrepresentation, or falsification of any information contained in this form or in any communication supplying information to the NPDB-HIPDB to complete or clarify this form may be punishable by criminal, civil, or other administrative actions including fines, penalties, and/or imprisonment under Federal law.

Name of Certifying Official:	
Title of Certifying Official:	

	Return to Administrator Options End Session & Return to Lo	ain
Submit to Data Bank(s)		
Certification Date (MMDDYYYY):	11232006	
Telephone:	Ext.	

## **Entity Registration Renewal**

## RENEW ENTITY REGISTRATION Healthcare Integrity and Protection Data Bank Entity: STATE BOARD OF MEDICAL EXAMINERS (FAIRFAX, VA)

Complete this form to renew your registration, and click Submit to Data Bank(s). After completing this form, you must print the Entity Registration Renewal, provide an original signature, and mail the form to the Data Banks. Once the signed form has been processed. the Data Banks will send you correspondence confirming your registration renewal via the Data Bank Correspondence screen, accessible through the Administrator Options menu.

OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 1 hour to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

Help

#### **ENTITY IDENTIFICATION INFORMATION**

STATE BOARD OF MEDICAL EXAMINERS
4350 FAIR LAKES COURT
SUITE 4001
FAIRFAX
VA Virginia
22033 - 4435

Name of Entity: Department or Office to Which Mail Should be Addressed: Street Address: Address Line 2: City: State: ZIP Code: Country (if U.S., leave blank): E-mail Address to Which mail2me@gmail.com Correspondence Should be Sent:

> (To ensure your entity is able to receive Data Bank e-mail, add npdb-hipdb@sra.com to your Safe Sender list. For assistance, call the Customer Service Center at 1-800-767-6732.)

**National Practitioner Data Bank** 

Department Fax Number: 77777777 Taxpayer Identification Number (TIN): National Crime Information Center Originating Agency Identifier (ORI) (For law enforcement only): Ownership of the Entity: State Government Agency If Federal, Specify Department: CHOOSE ONE FROM LIST

**ELIGIBILITY/STATUTORY AUTHORITY** 

Help ?

For each of the three statutes below, entities must select the most appropriate function/service category based on their primary function or service. Review each of these statutes and regulations prior to submitting your entity registration.

- 1. Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended;
- Public Law 100-93, Section 5[b] of the Medicare and Medicaid Patient and Program Protection Act of 1987, [Section 1921 of the Social Security Act]; and
- 3. Section 221[a], Public Law 104-191, the *Health Insurance Portability and Accountability Act of 1996*, more commonly referred to as Section 1128E of the *Social Security Act*.

Each entity is responsible for determining its legal obligation or eligibility under the applicable laws and regulations, and must register accordingly. For a complete description of the requirements and penalties of each authority, follow the links at the top of each authority selection list. You may wish to seek advice from legal counsel before specifying your statutory authority(ies). If no function/service applies to you in the block, select "None of These."

If you are registering under Section 1921 of the Social Security Act, please be aware that this legislation has not been implemented. Therefore, reports and queries are not accepted under this authority at this time. You will be notified when final regulations to implement Section 1921 have been established. Until that time, your certification election for this statute will be stored but will remain inactive.

#### Title IV Statutory Authority Selections

National Practitioner Data Bank - Title IV Statutory Function/Service Categories  More information about Title IV querying eligibility and reporting requirements	Statutory Requirements	
Function/Service (select one)	Querying Reporting	
○ Board of Medical/Dental Examiners*	Optional	Mandatory
Other State Practitioner Licensing Board	Optional	No Requirement
Hospital**	Mandatory	Mandatory
○ Professional Society**	Optional	Mandatory
Other Health Care Entity**	Optional	Mandatory
C Medical Malpractice Payer	Prohibited	Mandatory
○ None of These	Prohibited	Prohibited

<sup>\*</sup> Includes Composite Boards for physicians or dentists and other health care practitioners.

#### Section 1921 Statutory Authority Selections

National Practitioner Data Bank - Section 1921 Statutory Function/Service Categories More information about Section 1921 querying eligibility and reporting requirements	Statutory Requirements	
Function/Service (select one)	Querying	Reporting
C State Health Care Practitioner Licensing Board	Optional	Mandatory
C State Health Care Entity Licensing Board	Optional	Mandatory
C Quality Improvement Organization under Contract with the Centers for Medicare & Medicaid	Optional	Mandatory

<sup>\*\*</sup> Must provide health care services directly or indirectly and must follow a formal peer review process for the furthering of quality health care.

Services (CMS)		
C Private Accreditation Organization	Prohibited	Mandatory
	Optional	No Requirement
<ul> <li>Other Health Care Entity, including Professional Society*</li> </ul>	Optional	No Requirement
<ul> <li>Agency Administering a Federal Health Care Program, including Private Entities Under Contract</li> </ul>	Optional	No Requirement
C State Agency Administering or Supervising the Administration of a State Health Care Program	Optional	No Requirement
C State Medicaid Fraud Control Unit	Optional	No Requirement
C Attorney General/Other Law Enforcement Agency	Optional	No Requirement
○ None of These	Prohibited	Prohibited

<sup>\*</sup> Must provide health care services directly or indirectly and must follow a formal peer review process for the furthering of quality health care.

### Section 1128E Statutory Authority Selections

Healthcare Integrity and Protection Data Bank - Section 1128e Statutory Function/Service Categories More information about Section 1128e querying eligibility and reporting requirements	Statutory Requirements		
Function/Service (select one)	Querying	Reporting	
○ Federal Government Agency	Optional	Mandatory	
State Government Agency	Optional	Mandatory	
○ Health Plan	Optional	Mandatory	
○ None of These	Prohibited	Prohibited	

#### PRIMARY FUNCTION OF ENTITY



Select the category that best describes the primary function that your organization performs. Make only one selection from this list. If the code says "specify," describe the function. Entities that provide health care services and are self-insured for malpractice liability should register as health care service providers, not as malpractice payers.

Primary Function of Entity:	44 Hospital	▼
If Other, Specify:		

## QUERY OPTIONS FOR ENTITIES AUTHORIZED BY LAW TO QUERY BOTH THE NPDB AND THE HIPDB Help?

Select the Data Bank(s) you elect to query. Fees are assessed for each Data Bank you choose to query (except for Federal agencies, which, by law, are exempt from HIPDB query fees). Complete this section only if you are eligible to query both the NPDB and the HIPDB, based on the selections made in the ELIGIBILITY/STATUTORY AUTHORITY section. Hospitals MUST query the NPDB under Title IV.

• Query the NPDB and the HIPDB for each query submitted.

<ul> <li>Query only the NPDB for each query s</li> <li>Query only the HIPDB for each query s</li> <li>Do not query either the NPDB or the H</li> </ul>	submitted.
$\hfill \square$ I have elected not to query the NPDB regulations implementing Section 1921 of	but I wish to query the NPDB after the publication of final the Social Security Act.
POINT OF CONTACT FOR REPORTS	Help ?
designate an individual or office to be the organization to the NPDB and/or the HIPE	rif the entity is eligible under law to submit reports. You may point of contact to be included on all reports submitted by your DB. If your entity does not designate a point of contact, the listed as the point of contact for that report.
Name or Office:	WER
Title or Department:	WERER
·	00.400.400.40
Telephone:	2342342342 Ext.
ENTITY ADMINISTRATOR Help	?
	is responsible for overseeing the use of the IQRS at your ts, and updating entity profile information. Enter the entity re information below.
Name:	NOUNOU
Title:	TESTER
Telephone:	3012111212 Ext. 111
relephone.	EXI. III
CERTIFICATION Help ?	
AUTHORITY section and is eligible to per the entity may be subject to sanctions und required in the statutes and regulations or HIPDB other than the purposes for which this registration information to the NPDB-complete. If I become aware that any informatify the NPDB-HIPDB of this fact immedialsification of any information contained information to the NPDB-HIPDB to complete.	alifies under law as specified in the ELIGIBILITY/STATUTORY form the querying and/or reporting functions. I understand that the Federal statute for failure to report final adverse actions as for the use of information obtained from the NPDB or the it was provided. I further certify that I am authorized to submit HIPDB and that the information provided is true, correct, and ormation in this form is not true, correct, or complete, I agree to diately. I understand that any omission, misrepresentation, or in this form or contained in any communication supplying sete or clarify this form may be punishable by criminal, civil, or is, penalties, and/or imprisonment under Federal law.
Name of Certifying Official:	
Title of Certifying Official:	
Telephone:	Ext.
Certification Date (MMDDYYYY):	11072006
Submit to Data Bank(s)	
	Return to Previous Page

## **Agent Registration Renewal**

Name: Title:

Telephone:

## **National Practitioner Data Bank** UPDATE AGENT PROFILE Healthcare Integrity and Protection Data Bank Entity: AGENT SERVICES INC (HOMETOWN, VA) To update agent registration information, complete the fields that require a change, then Help click Submit to Data Bank(s). OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07 Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 5 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857. AGENT IDENTIFICATION INFORMATION Agent Organization Name: AGENT SERVICES INC Department or Office to Which Mail Should be Addressed: Street Address: 123 ANYWHERE STREET Address Line 2: City: HOMETOWN State: VA Virginia ZIP Code: 22191 Country (if U.S., leave blank): E-mail Address to Which mail@gmail.com Correspondence Should be Sent: (To ensure your entity is able to receive Data Bank e-mail, add npdb-hipdb@sra.com to your Safe Sender list. For assistance, call the Customer Service Center at 1-800-767-6732.) Department Fax Number: 2345325235 Taxpayer Identification Number (TIN): 253234532 **ENTITY ADMINISTRATOR** Help The entity administrator is the person who is responsible for overseeing the use of the IQRS at your entity, establishing individual user accounts, and updating entity profile information. Enter the entity administrator's Name, Title, and Telephone information below.

John Smith

Programmer 2352352345

Ext.

21

#### **AUTHORIZED AGENT REQUIREMENTS**

As an agent authorized to report and query the NPDB-HIPDB on behalf of an eligible entity, I certify that the organization has read and understands the provisions of Public Law 99-660, as amended; the NPDB regulation (45 CFR Part 60); Public Law 100-93, as amended by Public Law 101-508; and/or the HIPDB regulation (45 CFR Part 61), Public Law 104-191, as amended; and that I will meet and comply with the following requirements:

- . I am authorized to conduct business in my State.
- · My facilities are secure to ensure the confidentiality of NPDB-HIPDB information.
- I understand and can comply with the technical requirements for electronically reporting to and querying the NPDB-HIPDB, as provided by the NPDB-HIPDB and/or guidance distributed by the NPDB-HIPDB.
- . I will use my own password and DBID to report and query on behalf of my NPDB-HIPDB client.
- I understand that I must query the NPDB and/or the HIPDB separately for each entity on whose behalf I am authorized to query. My agreement(s) with the entity(ies) I represent explicitly prohibits me from using information obtained from the NPDB-HIPDB other than the purpose for which the disclosure was made.
- I will not use a single query response for a particular practitioner, provider, or supplier on behalf of more than one entity.
- To my knowledge, the information I am submitting is accurate and truthful.
- I will keep registration information concerning my organization in the NPDB-HIPDB up-to-date; and I will delete NPDB-HIPDB query and report information from my organization's database that I provided or obtained on behalf of any entity for whom I am no longer acting as agent.
- My activities as an agent are subject to the provisions of Public Law 104-191, as amended; Public Law 100-93, as amended by Public Law 101-508; and Public Law 104-191, as amended and regulations codified at 45 CFR Parts 60 and 61.

#### CERTIFICATION

Notice: 18 U.S.C. §1001 authorizes criminal penalties against whomever in any matter within the jurisdiction of the executive, legislative, or judicial branch of the Government, knowingly and willfully falsifies, conceals, or covers-up by any trick, scheme, or writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry. Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to 5 years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C.§3571, Section 3571 (d) also authorizes fines of up to the greater of twice the gross gain derived by the offender or twice the gross loss sustained by another as a result of the offense. By signing this document, I certify that I satisfy the requirements as specified above. I understand that if I do not comply with the stated requirements, my status as an authorized agent with the NPDB-HIPDB may be suspended or revoked by the Government. I further understand that any omission, misrepresentation, or falsification of any information contained in this form or in any communication supplying information to the NPDB-HIPDB to complete or clarify this form may be punishable by criminal, civil, or other administrative actions including fines, penalties, and/or imprisonment under Federal law.

Name of Certifying Official:	
Title of Certifying Official:	

	Return to Administrator Options End Session & Return	to Login
Submit to Data Bank(s)		
Certification Date (MMDDYYYY):	11232006	
Telephone:	Ext.	

## **Initial AAR**

## FEDERAL LICENSURE

Individual Subject: Initial Report

Please provide as much of the following information as possible. Failure to provide sufficient information to permit identification of a single subject will result in the report being rejected, necessitating resubmission.

Do not print this page. A printable copy of your report submission will be provided after submission.

OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 45 minutes to complete the forms, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

Subject	Namo:				
Subject	Last Nam	е	First Name	Middle Name	Suffix (e.g., Jr, III)
Other N	ames Used	:			
	Last Nan	ne	First Name	Middle Name	Suffix (e.g., Jr, III)
1.					
2.					
3.					
4.					
5.					
Gender		Male OF	emale OUnkno	wn	
Birth Da (MMDD	ite YYYY):				
Work	, . ,				
Organiz Name:	ation _				
Organiz	ation	HOOSE ONE	EDOMLIST		
Type:	1				▼
	De	escription (i	f 'Other' was seled	ned above):	_

## **ADDRESSES**

Click Help ? for informat	ion on filling out non-U.S. and military addresses.
Work Address	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST ▼
ZIP Code:	-
Country (if U.S., leave blank):	
Home Address/Address of Record	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST ▼
ZIP Code:	-
Country (if U.S., leave blank):	
Is Subject Deceased? C No	C Unknown C YesDeceased Date (MMDDYYYY)
SOCIAL SECURITY NUMBER	RS (SSN) (FORMAT NNNNNNNN)
1.	2.
3.	4.
INDIVIDUAL TAXPAYER IDE	NTIFICATION NUMBERS (ITIN) (FORMAT 9NNNNNNNN)
1.	2.
3.	4.
FEDERAL EMPLOYER IDEN	TIFICATION NUMBERS (FEIN)
1.	2.
3.	4.

NATIONAL PROVIDER IDENTIFIERS (NPI)

1.		2.
3.		4.
DRI	JG ENFORCEMENT A	ADMINISTRATION (DEA) NUMBERS
1.		2.
3.		4.
UNI	QUE PHYSICIAN IDE	NTIFICATION NUMBERS (UPIN)
1.		2.
3.		4.
PR	OFESSIONAL SCHOO	OLS ATTENDED YEAR OF GRADUATION (Format YYYY)
1.		
2.		
3.		
4.		
5.		
		TE LICENSURE INFORMATION ry is required. If no State License Number, check the 'No License' box.)
1.	State License Number:	OR □ No License
	State of Licensure:	CHOOSE ONE FROM LIST
	Occupation/Field of Licensure:	010 Physician (MD)
		Description (complete only if 'Other' is selected above):
	Specialty:	CHOOSE ONE FROM LIST
	Additional State Licenses	/Occupations
2.	State License Number:	OR □ No License
	State of Licensure:	CHOOSE ONE FROM LIST
	Occupation/Field of	

	Description (complete only if 'Other' is selected above):
Specialty:	CHOOSE ONE FROM LIST
Additional State Licenses	/Occupations
State License Number:	OR □ No License
State of Licensure:	CHOOSE ONE FROM LIST
Occupation/Field of Licensure:	CHOOSE ONE FROM LIST ▼
	Description (complete only if 'Other' is selected above):
Specialty:	CHOOSE ONE FROM LIST
Additional State Licenses	/Occupations
State License Number:	OR □ No License
State of Licensure:	CHOOSE ONE FROM LIST
Occupation/Field of Licensure:	CHOOSE ONE FROM LIST   ▼
	Description (complete only if 'Other' is selected above):
Specialty:	CHOOSE ONE FROM LIST
Additional State Licenses	/Occupations
State License Number:	OR □ No License
State of Licensure:	CHOOSE ONE FROM LIST
Occupation/Field of Licensure:	CHOOSE ONE FROM LIST
	Description (complete only if 'Other' is selected above):
Specialty:	CHOOSE ONE FROM LIST
Additional State Licenses	/Occupations
State License Number:	OR □ No License

	State of Licensure: Occupation/Field of	CHOOSE ONE FROM LIST	_
	Licensure:	CHOOSE ONE FROM LIST	▼
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses/	Occupations	
7.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST ▼	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	▼
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses/	Occupations	
8.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST ▼	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	▼
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses/	Occupations	
9.	State License Number:	OR □ No License	
9.			
9.	Number:	OR □ No License	▼
9.	Number: State of Licensure: Occupation/Field of	OR □ No License	▼
9.	Number: State of Licensure: Occupation/Field of	OR □ No License  CHOOSE ONE FROM LIST  CHOOSE ONE FROM LIST	▼

Additional State Licenses/Occupations

10.	State License Number:	OR □ No License
	State of Licensure:	CHOOSE ONE FROM LIST
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST
		Description (complete only if 'Other' is selected above):
	Specialty:	CHOOSE ONE FROM LIST
HE/	ALTH CARE ENTITIES	WITH WHICH THE SUBJECT IS AFFILIATED OR ASSOCIATED
Inclu actio		sociated health care entity in this report does not imply complicity in the reported
Clic	k Help ? for infor	mation on filling out non-U.S. and military addresses.
Olici	K Help 1 Ioi Illioi	mation on ming out horro.s. and mintary addresses.
1.	Name of	
١.	Affiliated/Associate Health Care Entity	
	Street Address:	
	Address Line 2:	
	City:	
	State:	CHOOSE ONE FROM LIST
	ZIP Code:	-
	Country (if U.S., le blank):	ave
	Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST
		Other Description (complete only if 'Other' is selected above):
	More Affiliated/Associ	ated Health Care Entities
2.	Name of Affiliated/Associate	
	Health Care Entity	
	Street Address:	
	Address Line 2:	

City:

	State:	CHOOSE ONE FROM LIST ▼
	ZIP Code:	-
	Country (if U.S., leave blank):	
	Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST
	Allilate.	Other Description (complete only if 'Other' is selected
		above):
	More Affiliated/Associated I	Health Care Entities
3.	Name of Affiliated/Associated	
	Health Care Entity:	
	Street Address:	
	Address Line 2:	
	City:	
	State:	CHOOSE ONE FROM LIST
	ZIP Code:	-
	Country (if U.S., leave blank):	
	Nature of Subject's Relationship to	CHOOSE ONE FROM LIST
	Affiliate:	Other Description (complete only if 'Other' is selected
		above):
	More Affiliated/Associated I	Health Care Entities
1.	Name of	
	Affiliated/Associated Health Care Entity:	
	Street Address:	
	Address Line 2:	
	City:	
	State:	CHOOSE ONE FROM LIST
	ZIP Code:	

Country (if U.S., leave blank): Nature of Subject's	
Relationship to Affiliate:	CHOOSE ONE FROM LIST
Allillate.	Other Description (complete only if 'Other' is selected above):
ADVERSE ACTION INFORMA	ATION Help ?
Name of Agency or Program that Took the Adverse Action Specified in This Report: Date Action Was Taken (MMDDYYYY):	
Date Action Became Effective (MMDDYYYY):	
Length of Action:	C Permanent C Indefinite/Unspecified C Specific Period Years: Months: Days:
	Completion of Adverse Action Period? © Yes © No nalty, Assessment and/or Restitution or fine (Format NNNNN.NN): field blank.
Description of Act(s) or Omissi	ion(s) or Other Reasons for Action Taken personal identification information (e.g., names) of anyone other
	<u>~</u>
Is the Action on Appeal?	○Yes ○No ○Unknown
Date of Appeal (MMDDYYYY)	:

## BASIS FOR ACTION

Select one or more codes that best describe the reason the action was taken.

1.	CHOOSE ONE FROM THE LIST					▼
Other Description (complete only if 'Other' is selected above):						
2.	CHOOSE ONE FROM THE LIST					<b>V</b>
	Other Description (complete only if 'Oth	ner' is selec	ted above	e):		
3.	CHOOSE ONE FROM THE LIST					V
Other Description (complete only if 'Other' is selected above):						
4.	CHOOSE ONE FROM THE LIST					v
	Other Description (complete only if 'Oth	ner' is selec	ted above	e):		
5.	CHOOSE ONE FROM THE LIST					•
	Other Description (complete only if 'Oth	ner' is selec	ted above	e):		
ENTITY INTERNAL REPORT REFERENCE  This optional field allows your entity to include an internal file number or other reference information to help you identify this report in your files. This information is not used by the Data Banks, but it will be provided on copies of the report sent to queriers.  Entity Internal Report Reference (e.g., claim number):						
CERTIFICATION						
I certify that I am authorized to submit this transaction and that all information is true and correct to the best of my knowledge.						
Αι	Authorized Submitter's Name:					
Αι	thorized Submitter's Title:					
Αι	thorized Submitter's Phone:				Ext.	
Da	ite (MMDDYYYY):	02052007				
in du	☐ Check this box if you wish to add/update this subject in your subject database for use in future queries and/or reports. Duplicate entries in your subject database may result in duplicate queries. You will be notified of potential duplicate entries prior to completing this subject entry.					

Submit to Data Bank(s)

Return to Options

## **Correction AAR**

## STATE LICENSURE

#### Report Correction

To submit a **correction** to previously submitted report DCN 7920000044097138, complete all necessary modifications in the form below, and press **Submit to Data Bank(s)**.

The report entered here will replace the original report, so please ensure that all known data is entered in its entirety. Failure to provide sufficient information to permit identification of a single subject may result in the report being rejected, necessitating resubmission.

Do not print this page. A printable copy of your report submission will be provided after submission.

OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 15 minutes to complete the forms, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

SUBJEC	T INFORMATIO	N Help ?		
_	ame: Last Name 2074	First Name	Middle Name	Suffix (e.g., Jr, III)
Other Nan	nes Used: Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
1.	DEVB	VERSION		
2.	<u> </u>			
3.				
4.				
5.				
Gender: Birth Date (MMDDY) Work Organizati Name: Organizati	YYY): 10101910	Female • Unkno	own	-
Type:	Description	(if 'Other' was sele	cted above).	_

ADDRESSES					
Click Help ? for informat	ion on filling out non-U.S. and military addresses.				
Work Address					
Street Address:	FSG				
Address Line 2:					
City:	GFSD				
State:	CHOOSE ONE FROM LIST ▼				
ZIP Code:	-				
Country (if U.S., leave blank):	GDSF				
Home Address/Address of Record					
Street Address:					
Address Line 2:					
City:					
State:	CHOOSE ONE FROM LIST				
ZIP Code:	-				
Country (if U.S., leave blank):					
Is Subject Deceased? One Onknown OyesDeceased Date (MMDDYYYY)  SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN)  1. 666888777 2. 4.					
INDIVIDUAL TAXPAYER IDENTIFICATION NUMBERS (ITIN) (FORMAT 9NNNNNNNN)					
1.	2.				
3.	4.				
	TIFICATION NUMBERS (FEIN)				
1.	2.				
3.	4.				

NATIONAL PROVIDER IDENTIFIERS (NPI)							
1.		2.					
3.		4.					
DRI	UG ENFORCEMENT A	ADMINISTRATION (	DEA) NUMBE	RS			
1.		2.					
3.		4.					
UNI	QUE PHYSICIAN IDE	NTIFICATION NUM	BERS (UPIN)				
1.		2.					
3.		4.					
PR	PROFESSIONAL SCHOOLS ATTENDED YEAR OF GRADUATION (Format YYYY)						
1.	SCHOOL		1999				
2.							
3.							
4.							
5.							
	OCCUPATION AND STATE LICENSURE INFORMATION (At least one licensure entry is required. If no State License Number, check the 'No License' box.)						
1.	State License Number:	10101910	OR	□ No License			
	State of Licensure:	NV Nevada	•				
Occupation/Field of Licensure: 120 Nurse Midwife							
		Description (complete only if 'Other' is selected above):					
	Specialty:	CHOOSE ONE FROM	I LIST	$\overline{\mathbf{v}}$			
	Additional State Licenses	Occupations					
2.	State License Number:		OR	□ No License			
	State of Licensure:	CHOOSE ONE FROM	ILIST _				
	Occupation/Field of						

	Licensure:	CHOOSE ONE FROM LIST	▼
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses/	Occupations	
3.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses/	Occupations	
4.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses/	Occupations	
5.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST ▼	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	_
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses/	Occupations	

6.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses/	Occupations .	
	State License		
7.	Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	₩
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	Specialty:	CHOOSE ONE PROMICIST	
	Additional State Licenses/	Occupations	
8.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST ▼	
	Occupation/Field of	_	_
	Licensure:	CHOOSE ONE FROM LIST	▼
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses/	Occupations	
	State License		
9.	Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST ▼	
	Occupation/Field of	CHOOSE ONE FROM LIST	V
	Licensure:	Description (complete only if 'Other' is selected above):	
		Coordinate only if Other is selected above).	

	Specialty:	CHOOSE ONE FROM LIST ▼	
	Additional State Licenses/	Occupations	
10.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
HE/	ALTH CARE ENTITIES	WITH WHICH THE SUBJECT IS AFFILIATED OR ASSOCIA	TED
Inclu actio		sociated health care entity in this report does not imply complici	ty in the reported
Clic	K Help ? for infor	mation on filling out non-U.S. and military addresses.	
1.	Name of Affiliated/Associate Health Care Entity Street Address: Address Line 2: City: State: ZIP Code: Country (if U.S., leblank): Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST  CHOOSE ONE FROM LIST  Other Description (complete only if 'Other' is selected above):	
	More Affiliated/Associ	ated Health Care Entities	_
2.	Name of Affiliated/Associate Health Care Entity Street Address:		

	Address Line 2:	
	City:	
	State:	CHOOSE ONE FROM LIST ▼
	ZIP Code:	-
	Country (if U.S., leave blank):	
	Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST  ▼
	Ailliate.	Other Description (complete only if 'Other' is selected above):
	More Affiliated/Associated I	Health Care Entities
3.	Name of Affiliated/Associated Health Care Entity:	
	Street Address:	
	Address Line 2:	
	City:	
	State:	CHOOSE ONE FROM LIST
	ZIP Code:	
	Country (if U.S., leave blank):	
	Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST
	Ailliate.	Other Description (complete only if 'Other' is selected above):
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	More Affiliated/Associated I	Health Care Entities
4.	Name of Affiliated/Associated Health Care Entity:	
	Street Address:	
	Address Line 2:	
	City:	
	State:	CHOOSE ONE FROM LIST

ZIP Code:	
Country (if U.S., leave	
blank): Nature of Subject's	
Relationship to Affiliate:	CHOOSE ONE FROM LIST
	Other Description (complete only if 'Other' is selected
	above):
ADVERSE ACTION INFORMA	ATION Help ?
N	
Name of Agency or Program that Took the Adverse Action	DEPT A
Specified in This Report:	
Date Action Was Taken (MMDDYYYY):	12022002
Date Action Became Effective	12022002
(MMDDYYYY): Length of Action:	
Length of Action.	<ul><li>Permanent</li><li>Indefinite/Unspecified</li><li>Specific Period</li></ul>
	Years:
	Months:
	Days:
Is Reinstatement Automatic at	Completion of Adverse Action Period?   • Yes   • No
Total Amount of Monetary Per	nalty, Assessment and/or Restitution or fine (Format NNNNN.NN)
Note: If no amount, leave this \$1.02	field blank.
•	ion(s) or Other Reasons for Action Taken
	personal identification information (e.g., names) of anyone other
LGKJOIJOIAJFIWUHFIUHVUI IUVI	HSIUHVNISHNVI 🔼
Is the Action on Appeal?	⊂Yes ⊂No
Date of Appeal (MMDDYYYY)	:

## BASIS FOR ACTION

Select one or more codes that best describe the reason the action was taken.

4 A4 Defects on Health Education Language Calcul		_		
1.   44 Default on Health Education Loan or Schola     Other Description (complete only if !Oth	Other Description (complete only if 'Other' is selected above):			
Other Description (complete only if Other	er is selected above).			
2. CHOOSE ONE FROM THE LIST		•		
Other Description (complete only if 'Oth	ner' is selected above):			
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Cities Description (complete only if Oil	ier is selected above).			
4 . CHOOSE ONE FROM THE LIST		•		
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5 . CHOOSE ONE FROM THE LIST		Ţ		
Other Description (complete only if 'Oth	ner' is selected above):	Ī		
	<u> </u>			
help you identify this report in your files. T provided on copies of the report sent to qu	lude an internal file number or other reference information to his information is not used by the Data Banks, but it will be seriers.			
Entity Internal Report Reference (e.g., clainumber):	m			
CERTIFICATION				
I certify that I am authorized to submit this best of my knowledge.	transaction and that all information is true and correct to the			
Authorized Submitter's Name:				
Authorized Submitter's Title:				
Authorized Submitter's Phone:	Ext.			
Date (MMDDYYYY):	01162007			
Submit to Data Bank(s) Validate Without	Submitting Store as a Draft			
Casamete Sala Salinjo,				
		_		

## **Correction Legacy AAR**

# Adverse Action Report Report Correction

To submit a **correction** to previously submitted report DCN 0119950060105000, complete all necessary modifications in the form below, and press **Submit to Data Bank(s)**.

The report entered here will replace the original report, so please ensure that all known data is entered in its entirety. Failure to provide sufficient information to permit identification of a single subject may result in the report being rejected, necessitating resubmission.

Do not print this page. A printable copy of your report submission will be provided after submission.

OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 15 minutes to complete the forms, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

Subject	Name:			
	Last Name	First Name	Middle Name	Suffix (e.g., Jr
	Smith	John	M	
Other N	lame Used:			
	Last Name	First Name	Middle Name	Suffix (e.g., Jr
Work Organiz Name:	zation Medical Ce	nter of Virginia		
ADDRE	SSES			
Click 🧧	Help ? for informa	ation on filling out	non-U.S. and militar	y addresses.
Work A	Address			
Stree	t Address:	123 Department	of Emergency Med	licine

City:	Woodbridge
State:	VA Virginia ▼
ZIP Code:	22191
Country (if U.S., leave blank):	
Home Address/Address of Record	f
Street Address:	123 Somewhere Street
Address Line 2:	
City:	Woodbridge
State:	VA Virginia ▼
ZIP Code:	22191
Country (if U.S., leave blank):	
DRUG ENFORCEMENT AD  1. BP7777777777  3.	MINISTRATION (DEA) NUMBERS  2. 4. 5. ATTENDED. SEARCH OF ORABITATION
PROFESSIONAL SCHOOL	S ATTENDED YEAR OF GRADUATION (Format YYYY)
1. VIRGINIA UNIV. SCHO	OL OF MEDI
2.	
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4.	
5.	
0.	
	LICENSURE INFORMATION is required. If no State License Number, check the 'No License' box.)
1. State License Number:	ABBCCDD666 OR □ No License
State of Licensure:	VA Virginia

	Occupation/Field of Licensure:	010 Physician (MD)	•
		Description (complete only if 'Other' is selected above):	
	Additional State Licenses	/Occupations	
2.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST ▼	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	▼
	Eloonodio.	Description (complete only if 'Other' is selected above):	_
	Additional State Licenses	/Occupations	
3.	State License Number:	OR ☐ No License	
	State of Licensure:	CHOOSE ONE FROM LIST ▼	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	▼
	Licensure.	Description (complete only if 'Other' is selected above):	
		,	
	Additional State Licenses.	/Occupations	
	State License		
4.	Number:	OR No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	<b>V</b>
		Description (complete only if 'Other' is selected above):	
	Additional State Licenses.	/Occupations	
5.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of	CHOOSE ONE FROM LIST	

		Description (complete only if Other is selected above):	
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6.	State License Number: State of Licensure: Occupation/Field of Licensure:	OR □ No License  CHOOSE ONE FROM LIST  CHOOSE ONE FROM LIST  Description (complete only if 'Other' is selected above):	▼
	Additional State Licenses	Occupations	
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9.	State License Number: State of Licensure: Occupation/Field of Licensure:	OR □ No License  CHOOSE ONE FROM LIST  CHOOSE ONE FROM LIST	•

	Additional State Licenses/	Occupations				
10.	State License Number: State of Licensure: Occupation/Field of Licensure:	CHOOSE ONE F		•		
AD\	/ERSE ACTION INFO	RMATION				
Тур	e of Action Taken (sel	ect one):				
$\circ$	Licensure © Clinic	cal Privileges	<ul> <li>Society Membership</li> </ul>			
Acti	ion Classification:	630.10 Un	nprofessional Conduct	▼		
Dat	e of the Action:	1216199	94			
Len	gth of Action:	○ Perma Specif	anent C Indefinite	Days: 0		
Effe	ective Date:	1216199	94			
DUF	orter's Description of ARING THIS SIX-MONTH PERUIRED TO UNDERGO PERUIRED	RIOD, DR. SMITH				
This help prov	TITY INTERNAL REPO s optional field allows yo o you identify this report vided on copies of the ity Internal Report Reforber):	our entity to inc t in your files. T report sent to qu	blude an internal file number or This information is not used by t ueriers.	other reference information to the Data Banks, but it will be		
CE	RTIFICATION					
l ce bes	rtify that I am authorize t of my knowledge.	ed to submit this	s transaction and that all inform	ation is true and correct to the		
Aut	horized Submitter's Na	me:	Susan Smith			
Aut	Authorized Submitter's Title: Supervisor					
Aut	horized Submitter's Ph	one:	777777777	xt.		

Date (MMDDYYYY):	11232006			
Submit to Data Bank(s)	Validate Without Submitting	Store as a Draft		
			Return to Options	

### **Revision to Action AAR**

### STATE LICENSURE

#### Revision to Action

To submit a **revision to action** on previously submitted report DCN 7920000044100622, enter all report data for the action, and press **Submit to Data Bank(s)**.

Enter all known data in its entirety. Failure to provide sufficient information to permit identification of a single subject may result in the report being rejected, necessitating resubmission.

Do not print this page. A printable copy of your report submission will be provided after submission.

OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 15 minutes to complete the forms, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

SUBJE	CT INF	ORMATION	Help ?		
Subject I	Name:				
,	Last N	ame	First Name	Middle Name	Suffix (e.g., Jr, III)
	SMITH	-	JOHN		
Other Na	ımes Us	sed:			
	Last N	lame	First Name	Middle Name	Suffix (e.g., Jr, III)
1.					
2.					
3.					
4.					
5.					
Gender:		○ Male ○ F	emale © Unknow	n	
Birth Dat (MMDD)		10101955			
Work	1111).				
Organiza	ation				
Name:	ation				
Organiza Type:	auon	CHOOSE ONE	FROM LIST		▼
		Description (i	f 'Other' was selecte	ed above):	

ADDRESSES	
Click Help ? for information	ation on filling out non-U.S. and military addresses.
Work Address	
Street Address:	123 MAIN STREET
Address Line 2:	
City:	WOODBRIDGE
State:	VA Virginia 🔻
ZIP Code:	22191 -
Country (if U.S., leave blank):	
Home Address/Address of Record	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	
Country (if U.S., leave blank):	
Is Subject Deceased? C No	o
SOCIAL SECURITY NUMBE	ERS (SSN) (FORMAT NNNNNNNNN)
1. 223366998	2.
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INDIVIDUAL TAXPAYER ID	ENTIFICATION NUMBERS (ITIN) (FORMAT 9NNNNNNNN)
1.	2.
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1.	2.
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1.		2.
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1. [	AK556677	2.
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UNI	QUE PHYSICIAN IDEI	NTIFICATION NUMBERS (UPIN)
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PR	OFESSIONAL SCHOO	DLS ATTENDED YEAR OF GRADUATION (Format YYYY)
1.	UNIVERSITY	1999
2.		
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4.		
5.		
		TE LICENSURE INFORMATION  y is required. If no State License Number, check the 'No License' box.)
1.	State License Number:	445566777 OR □ No License
	State of Licensure:	DC District of Columbia
	Occupation/Field of Licensure:	010 Physician (MD)
		Description (complete only if 'Other' is selected above):
	Specialty:	05 Anesthesiology   ▼
	Additional State Licenses/	<u>Occupations</u>
2.	State License Number:	OR □ No License
	State of Licensure:	CHOOSE ONE FROM LIST  ▼

Occupation/Field of

	Licensure:	CHOOSE ONE FROM LIST	▼
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses/	Occupations	
3.	State License Number:	OR □ No License	
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	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	▼
		Description (complete only if 'Other' is selected above):	
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4.	State License Number:	OR □ No License	
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	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	
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	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	V
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
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3.	State License Number:	OR □ No License	
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	Coocieltu	CHOOSE ONE EDOM LIST	
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	Specialty:	CHOOSE ONE FROM LIST		▼	
	Additional State Licenses	/Occupations			
10.	State License Number:		OR	□ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	•		
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST			•
		Description (complete on	y if 'Oth	er' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST		▼	
	. ,	,		_	
HEA	ALTH CARE ENTITIES	S WITH WHICH THE SUB	IECT IS	AFFILIATED OR ASS	OCIATED
Incli actio		ssociated health care entity	in this	report does not imply co	emplicity in the reported
Clic	k Help ? for info	rmation on filling out non-U	.S. and	military addresses.	
1.	Name of Affiliated/Associat Health Care Entity				
	Street Address:	,.			
	Address Line 2:				
	City:				
	State:	CHOOSE ONE FROM LI	ST	▼	
	ZIP Code:		7		
	Country (if U.S., le	eave			
	blank):				
	Nature of Subject' Relationship to Affiliate:	CHOOSE ONE FROM LIS	ST		•
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	More Affiliated/Associ	iated Health Care Entities			
^	Managa at				
2.	Name of Affiliated/Associat				
	Health Care Entity Street Address:	y:			
	Sileet Address.	1			

	Address Line 2:		
	City:		
	State:	CHOOSE ONE FROM LIST	
	ZIP Code:	-	
	Country (if U.S., leave blank):		
	Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST	•
		Other Description (complete only if 'Other' is selected above):	
	More Affiliated/Associated I	Health Care Entities	
3.	Name of Affiliated/Associated Health Care Entity:		
	Street Address:		
	Address Line 2:		
	City:		
	State:	CHOOSE ONE FROM LIST ▼	
	ZIP Code:		
	Country (if U.S., leave blank):		
	Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST	▼
		Other Description (complete only if 'Other' is selected above):	
	More Affiliated/Associated I	Health Care Entities	
l.	Name of Affiliated/Associated Health Care Entity:		
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ZIP Code: Country (if U.S., leave blank): Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST  Other Description (complete only if 'Other' is selected above):
ADVERSE ACTION INFORMATION AND ACTION INFORMATION AND ACTION INFORMATION AND ACTION AND ACTION ACTION AND ACTION ACTION AND ACTION ACTI	ATION Help ?
Length of Action:	<ul> <li>Permanent</li> <li>Indefinite/Unspecified</li> <li>Specific Period</li> <li>Years:</li> <li>Months:</li> </ul>
	Days:
Total Amount of Monetary Per Note: If no amount, leave this \$  Is the Adverse Action Specified	Completion of Adverse Action Period? C Yes C No nalty, Assessment and/or Restitution or fine (Format NNNNN.NN): field blank.  d in This Report Based on the Subject's Professional Competence Affected, or Could Have Adversely Affected, the Health or Welfare
Description of Act(s) or Omissi Note: Do not reference any p than the subject of this report.	ion(s) or Other Reasons for Action Taken personal identification information (e.g., names) of anyone other
	<b>▲</b>
Is the Action on Appeal?	○Yes ○No ○Unknown
Date of Appeal (MMDDYYYY)	:

ENTITY INTERNAL REPORT REFERENCE

This optional field allows your entity to include an internal file number or other reference information to help you identify this report in your files. This information is not used by the Data Banks, but it will be provided on copies of the report sent to queriers.				
Entity Internal Report Reference (e.g., clanumber):	aim			
CERTIFICATION				
I certify that I am authorized to submit this best of my knowledge.	s transaction and that all information is true and correct to the			
Authorized Submitter's Name:				
Authorized Submitter's Title:				
Authorized Submitter's Phone:	Ext.			
Date (MMDDYYYY):	02052007			
Submit to Data Bank(s) Validate Without	t Submitting Store as a Draft			
	Return to Options			

## **Explicit Query**

Work Address

To submit a query, enter all known subject data.

OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

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SUBJEC	TINF	ORMATION	Help ?			
Subject N	ame:					
	Last Na	ame	First Name	Middle Name	Suffix (e.g., Jr	, III)
Other Nan	nes Us	ed:				
	Last N	ame	First Name	Middle Name	Suffix (e.g., Jr	r, III)
1.						
2.						
3.						
4.						
5.						
	,				,	
Gender:		O Male O F	Female © Unknow	0		
Birth Date	,	- Widle of		'		
(MMDDY)	YYY):					
PIN:						
Work Organizat	ion					
Name:						
Organization Type:		CHOOSE ONE	FROM LIST		•	
		Description (if 'Other' was selected above):				
ADDRESS	SES					
Click Hel	p ?	for informat	tion on filling out nor	-U.S. and military	addresses.	

58

Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST ▼
ZIP Code:	-
Country (if U.S., leave blank):	
Home Address/Address of Record	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST ▼
ZIP Code:	-
Country (if U.S., leave blank):	
1 3	2.         4.
INDIVIDUAL TAXPAYER IDE	ENTIFICATION NUMBERS (ITIN) (FORMAT 9NNNNNNNN)
1.	2.
3.	4.
FEDERAL EMPLOYER IDEN	NTIFICATION NUMBERS (FEIN)
1.	2.
3.	4.
NATIONAL PROVIDER IDEN	NTIFIERS (NPI)
1.	2.
3.	4.
DRUG ENFORCEMENT ADM	MINISTRATION (DEA) NUMBERS
1.	2.

3. [		4.
UNI	QUE PHYSICIAN IDE	NTIFICATION NUMBERS (UPIN)
1.   3.		2.         4.
PR	OFESSIONAL SCHOO	DLS ATTENDED YEAR OF GRADUATION (Format YYYY)
1.		(romat rrrr)
2.		
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5.		
		TE LICENSURE INFORMATION  ry is required. If no State License Number, check the 'No License' box.)
1.	State License Number:	OR □ No License
	State of Licensure:	CHOOSE ONE FROM LIST ▼
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST
		Description (complete only if 'Other' is selected above):
	Specialty:	CHOOSE ONE FROM LIST
	Additional State Licenses/	<u>Occupations</u>
2.	State License Number:	OR □ No License
	State of Licensure:	CHOOSE ONE FROM LIST
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST
		Description (complete only if 'Other' is selected above):
	Specialty:	CHOOSE ONE FROM LIST
	Additional State Licenses/	Occupations

3.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses	/Occupations	
4.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST ▼	
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	Licensure:	CHOOSE ONE FROM LIST	▼
		Description (complete only if 'Other' is selected above):	
	Charialtu	CHOOSE ONE FROM LIST ▼	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses	<u>/Occupations</u>	
5.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses	/Occupations	
^	State License	02 - 11 11	
6.	Number:	OR No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	▼
		Description (complete only if 'Other' is selected above):	

	Specialty:	CHOOSE ONE FROM LIST ▼	
	Additional State Licenses/	Occupations	
7.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses/	Occupations	
8.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses/	Occupations	
9.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses/	Occupations	
10.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of		

Licensure:	CHOOSE ONE FROM LIST		▼
	Description (complete only it	f 'Other' is selected above):	
Specialty:	CHOOSE ONE FROM LIST	<b>V</b>	
	ou wish to store this subject in you reports. Duplicate entries in your s		
Continue			
		Return t	o Options

### **Subject Database (individual)**

OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 5 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

SUBJECT IN	FORMATION	Help ?			
Subject Name:					
Last N	Name	First Name	Middle Name	Suffix (e.g., Jr, III)	
Other Names U					
	Name	First Name	Middle Name	Suffix (e.g., Jr, III)	
1.					
2.					
3.					
4.					
5.					
Gender:	OMale O	Female © Unknov	vn		
Birth Date					
(MMDDYYYY): Work					
Organization				-	
Name:					
Organization Type: CHOOSE ON Description		FROM LIST		▼	
		if 'Other' was select	ed above):		
Department:	CHOOSE ONE	FROM LIST	▼		
ADDRESSES					
Click Help 1	🔰 for informa	tion on filling out no	n-U.S. and militar	y addresses.	

Work Address	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST ▼
ZIP Code:	-
Country (if U.S., leave blank):	
Home Address/Address of Record	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	-
Country (if U.S., leave blank):	
In Outsing December 10 CON	CHalmanna CV December Date (MMDD)(000)
SOCIAL SECURITY NUMBE	C Unknown C YesDeceased Date (MMDDYYYY)  ERS (SSN) (FORMAT NNNNNNNNN)  2.
SOCIAL SECURITY NUMBE	ERS (SSN) (FORMAT NNNNNNNN)  2.
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SOCIAL SECURITY NUMBER  1.	ERS (SSN) (FORMAT NNNNNNNN)  2 4 ENTIFICATION NUMBERS (ITIN) (FORMAT 9NNNNNNNN)  2
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DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1.   3.		2
3. J		4.
UNI	QUE PHYSICIAN IDE	NTIFICATION NUMBERS (UPIN)
1. 3.		2.         4.
PR	OFESSIONAL SCHOO	DLS ATTENDED YEAR OF GRADUATION (Format YYYY)
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		TE LICENSURE INFORMATION ry is required. If no State License Number, check the 'No License' box.)
1.	State License Number:	OR □ No License
	State of Licensure:	CHOOSE ONE FROM LIST ▼
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST  ▼
		Description (complete only if 'Other' is selected above):
	Specialty:	CHOOSE ONE FROM LIST
	Additional State Licenses	Occupations
2.	State License Number:	OR □ No License
	State of Licensure:	CHOOSE ONE FROM LIST ▼
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST
		Description (complete only if 'Other' is selected above):
	Specialty:	CHOOSE ONE FROM LIST ▼

### Additional State Licenses/Occupations

3.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST ▼	
	Additional State Licenses	Occupations (Occupations	
4.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	_
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses	Occupations	
5	State License		
5.	State License Number:	OR □ No License	
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	State License Number: State of Licensure: Occupation/Field of Licensure: Specialty: Additional State Licenses State License Number:	OR No License  CHOOSE ONE FROM LIST  CHOOSE ONE FROM LIST  Description (complete only if 'Other' is selected above):  CHOOSE ONE FROM LIST  CHOOSE ONE FROM LIST  OCcupations  OR No License	▼ ▼

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State Occup Licens Speci Additio State Occup Licens State Numb State Occup Licens Speci	ber: e of Licensure: upation/Field of nsure: cialty: onal State Licenses e License	CHOOSE ONE FROM LIST  CHOOSE ONE FROM LIST  Description (complete only if 'Other' is selected above):  CHOOSE ONE FROM LIST  S/Occupations	3
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State	e License	OR □ No License	
Occup	e of Licensure:	CHOOSE ONE FROM LIST ▼	
	upation/Field of	_	
	•	CHOOSE ONE FROM LIST	-
		Description (complete only if 'Other' is selected above):	
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Additio	cialty:	CHOOSE ONE FROM LIST	
0. State	cialty: onal State Licenses		

State of Licensure:	CHOOSE ONE FROM LIST
Occupation/Field of Licensure:	CHOOSE ONE FROM LIST ▼
	Description (complete only if 'Other' is selected above):
Specialty:	CHOOSE ONE FROM LIST
Validate Without Storing	Store

Return to Previous Page

## **Subject Database (organization)**

1.

OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 5 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

SUBJECT INFORMATIO	N Help ?	
Organization Name:		
Other Organization N	lames Used:	
1.		
2.		
3.		
4.		
5.		
-		
Click Help ? for information	ation on filling out non-U.S. and military addresses.	
Street Address:		
Address Line 2:		
City:		
State:	CHOOSE ONE FROM LIST ▼	
ZIP Code:	-	
Country (if U.S., leave blank):		
Organization Type:	CHOOSE ONE FROM LIST	•
	Description (if 'Other' was selected above):	
D	E FROM LIOT	
Department: CHOOSE ON	E FROM LIST	
FEDERAL EMPLOYER IDE	NTIFICATION NUMBERS (FEIN)	

2.

3.		4.				
so	CIAL SECURITY NU	MBERS (SSN) (	FORMAT NNNNN	INNNN)		
1.		2.				
3.		4.				
INE	OIVIDUAL TAXPAYE	R IDENTIFICAT	ION NUMBERS (I	TIN) (FORMAT 9N	NNNNNN)	
1.		2.				
3.		4.				
PR	INCIPAL OFFICERS	AND OWNERS		Suffix (e.g., Jr.,		
	Last Name Fi	rst Name	Middle Name	III)	Title	
1.						
2.						
3.						
4.						
5.						
OR	GANIZATION STATE	E LICENSURE I	NFORMATION			
(lf r	no State License, che	ck the 'No Licens	se' box.)			
1.	State License Number:		OR	□ No License		
	State of Licensure:	CHOOSE ONE F	ROM LIST _			
2.	State License Number:		OR	□ No License		
	State of Licensure:	CHOOSE ONE F	ROM LIST 🔻			
3.	State License Number:		OR	□ No License		
	State of Licensure:	CHOOSE ONE F	ROM LIST -			

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1.	2.	
3.	4.	
CLINICAL LABORATORY IM	PROVEMENT ACT (CLIA) NUMBERS	
1. 3. Second	2.       4.	
5. FEDERAL FOOD AND DRUG	6. ADMINISTRATION (FDA) NUMBERS	
1	2.         4.         6.	
NATIONAL PROVIDER IDEN	TIFIERS (NPI)	
1	2.         4.	
MEDICARE PROVIDER/SUPPLIER NUMBERS		
1	2.         4.	
Validate Without Storing St	ore	

Return to Previous Page

# Self Query (individual)

#### INDIVIDUAL SELF-QUERY INSTRUCTIONS

Complete the Individual Self-Query form on-line, review the information entered on the form for completeness and accuracy, click **Continue**, and print the formatted copy of your self-query. Sign the formatted copy **in ink** and in the presence of a Notary Public, and mail the notarized copy to the address printed at the top of the page.

**DO NOT PRINT OR NOTARIZE THIS FORM.** A printable copy will be made available to you upon transmission of this form.

#### FEE AND PAYMENT INFORMATION

All individual self-queries are automatically sent to both the NPDB and the HIPDB. An \$8.00 fee per self-query is assessed by the NPDB; an \$8.00 fee per self-query is also assessed by the HIPDB. Fees must be paid by credit card (VISA, MasterCard, Discover or American Express). Cash and checks are not accepted.

#### CONFIDENTIALITY OF INFORMATION

Persons and entities that receive confidential information from the NPDB-HIPDB, either directly or indirectly from another party, must use it solely with respect to the purpose for which it was provided. Any person who violates the confidentiality provisions of the Data Bank(s) shall be subject to a civil penalty for each violation.

In compliance with the Privacy Act, the results of an individual self-query are sent only to the practitioner's home or work address as certified on the self-query form. Individual health care practitioners who obtain information about themselves from the NPDB-HIPDB are permitted to share that information with anyone they choose.

OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 25 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

SUBJECT	INFORMATION	Help ?		
Subject Na	me:			
Ĺ	ast Name	First Name	Middle Name	Suffix (e.g., Jr, III)

Other Names U	lsed: Name	First Name	Middle Name	Suffix (o.g. le	. 111)
1.	Name	First Name	Middle Name	Suffix (e.g., Jr	, III)
2.					
3.					
4.					
5.					
Gender: Birth Date (MMDDYYYY): Work Organization Name: Organization Type:	CHOOSE ONE Description (	E FROM LIST if 'Other' was select	ed above):		•
		vork) to which you w dress, be sure to ind			st line of the address.
Street Addres			,		
Address Line	2:				
City:					
State:		CHOOSE ONE FROM	I LIST <u></u> ▼		
ZIP Code:		-			
Country (if U. blank):	S., leave				
Telephone:			Ext.		
SOCIAL SECU	RITY NUMBE	RS (SSN) (FORMA	T NNNNNNNN)	Help ?	
1.		2.			
3.		4.			
INDIVIDUAL TA	AXPAYER IDE	ENTIFICATION NUM	MBERS (ITIN) (FC	RMAT 9NNNNI	NNNN)
1		2			

3.		4.
FEC	ERAL EMPLOYER ID	ENTIFICATION NUMBERS (FEIN)
1.   3.		2.         4.
NA	TIONAL PROVIDER ID	ENTIFIERS (NPI)
1.   3.		2.         4.
DRU	JG ENFORCEMENT A	DMINISTRATION (DEA) NUMBERS
1. [ 3. [		2
UNI	QUE PHYSICIAN IDE	NTIFICATION NUMBERS (UPIN)
1. 3.		2.         4.
PR	OFESSIONAL SCHOO	LS ATTENDED YEAR OF GRADUATION (Format YYYY)
1.		
2. 3.		
3. 4.		
5.		
		E LICENSURE INFORMATION Help ?  y is required. If no State License Number, check the 'No License' box.)
1.	State License Number:	OR □ No License
	State of Licensure:	CHOOSE ONE FROM LIST
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST
		Description (complete only if 'Other' is selected above):

	Specialty:	CHOOSE ONE FROM LIST		▼	
	Additional State Licenses/	Occupations .			
2.	State License Number:	0	R	□ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	<b> </b>		
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST			•
		Description (complete only if '	Othe	er' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST		Y	
	Additional State Licenses/	Occupations			
3.	State License Number:	0	R	□ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	-		
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST			•
		Description (complete only if '	Othe	er' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST		$\overline{\mathbf{v}}$	
	Additional State Licenses/	Occupations .			
4.	State License Number:	0	R	□ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	•		
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST			▼
	Elochodio.	Description (complete only if '	Othe	er' is selected above):	_
	Specialty:	CHOOSE ONE FROM LIST			
	Additional State Licenses/	Occupations			
5.	State License	0	D	□ No License	
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	State of Licensure:	CHOOSE ONE FROM LIST	▼		
	Occupation/Field of				

	Licensure:	CHOOSE ONE FROM LIST	$\overline{}$
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses/	Occupations	
3.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST ▼	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses/	Occupations	
7.	State License	OR ☐ No License	
	State of Licensure:	CHOOSE ONE FROM LIST ▼	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	⊌
	Electionic.	Description (complete only if 'Other' is selected above):	_
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses/	Occupations	
	0		
3.	State License Number:	OR ☐ No License	
	State of Licensure:	CHOOSE ONE FROM LIST ▼	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses/	Occupations .	

9.	Number:	OR □ No License
	State of Licensure:	CHOOSE ONE FROM LIST
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST   ▼
		Description (complete only if 'Other' is selected above):
	Specialty:	CHOOSE ONE FROM LIST
	A LEG LOCAL CO.	Occupations
	Additional State Licenses/	<u>Occupations</u>
	Additional State Licenses/	Occupations
10.	State License	OR □ No License
10.	State License	
10.	State License Number: State of Licensure: Occupation/Field of	OR No License
10.	State License Number: State of Licensure:	OR □ No License
10.	State License Number: State of Licensure: Occupation/Field of	OR No License
10.	State License Number: State of Licensure: Occupation/Field of	OR No License  CHOOSE ONE FROM LIST  CHOOSE ONE FROM LIST

#### REPORT PASSWORD PREFERENCE

Once your self-query request is processed, the Data Banks will send a response to the address specified. The self-query response will consist of either a notification that no information exists in the Data Bank(s), or a copy of all information concerning you that has been submitted by eligible reporting entities.

You must select below whether to include in this self-query response a Report Password that will allow you to access the Report Response Service. The service allows you to add, modify, or remove a Subject Statement, initiate or withdraw a dispute or request for Secretarial Review, or modify your address as maintained by the Data Banks. If you are the subject of a report, you will be assigned a unique, confidential password to access the Report Response Service. If you plan to share your self-query results with another person or organization, such as a State licensing board (i.e., a third party), you may wish to omit password information from the self-query results.

- I wish to have my Report Password displayed on my self-query results. This option is recommended for individuals who do not plan to share their self-query results with a third party.
- I wish to have my Report Password omitted from my self-query results. This option is recommended for individuals who plan to share their self-query results with a third party.

# **PAYMENT INFORMATION**

The fee per self-query is \$16.00, payable by credit card only. Individual self-queries are automatically sent to the NPDB and the HIPDB (\$8.00 is assessed by the NPDB and \$8.00 by the HIPDB). Please

enter a valid credit card number (VISA, MasterCard, Discover or American Express) and expiration date. Your credit card will not be charged until the NPDB-HIPDB receives and processes your notarized self-query. Your signature on this form indicates consent to pay this fee.

Credit Card Number:	
Expiration Date:	Month ▼/ Year ▼
	formation is the same as the Subject Name and Home or se, enter the billing information for this credit card below. This self-query.
Cardholder's Name:	
Cardholder's Billing Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST ▼
ZIP Code:	-
Country (if U.S., leave blank):	
	n. If you choose this option, be sure to write your credit of your self-query, or your self-query will be rejected.
To learn about how we keep your persona	l data secure, click <u>here</u>
Continue	
	Return to Options

# **Self Query Organization**

#### ORGANIZATION SELF-QUERY INSTRUCTIONS

Complete the Organization Self-Query form on-line, review the information entered on the form for completeness and accuracy, click **Continue**, and print the formatted copy of your self-query. Sign the formatted copy **in ink** and in the presence of a Notary Public, and mail the notarized copy to the address printed at the top of the page.

**DO NOT PRINT OR NOTARIZE THIS FORM.** A printable copy will be made available to you upon transmission of this form.

#### FEE AND PAYMENT INFORMATION

All organization self-queries are sent only to the HIPDB. An \$8.00 fee per self-query is assessed by the HIPDB. Fees must be paid by credit card (VISA, MasterCard, Discover or American Express). Cash and checks are not accepted.

#### CONFIDENTIALITY OF INFORMATION

Persons and entities that receive confidential information from the NPDB-HIPDB, either directly or indirectly from another party, must use it solely with respect to the purpose for which it was provided. Any person who violates the confidentiality provisions of the Data Bank(s) shall be subject to a civil penalty for each violation.

In compliance with the Privacy Act, the results of an organization self-query are sent only to the organization's address as certified on the self-query form. Health care organizations that obtain information about themselves from the NPDB-HIPDB are permitted to share that information with anyone they choose.

OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 25 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

SUBJECT INFORMATION	Help ?
Organization Name:	
Other Organization Name	s Used:
1.	

2.		
3.		
4.		
5.		
Click Help ? for inform	nation on filling out non-U.S. and military addresses.	
Street Address:		
Address Line 2:		
City:		
State:	CHOOSE ONE FROM LIST	
ZIP Code:	-	
Country (if U.S., leave blank):		
Organization Type:	CHOOSE ONE FROM LIST	<b>V</b>
	Description (if 'Other' was selected above):	
FEDERAL EMPLOYER IDI	ENTIFICATION NUMBERS (FEIN)	
1.	2.	
3.	4.	
	BERS (SSN) (FORMAT NNNNNNNNN)	
1.	2.	
3.	4.	
INDIVIDUAL TAXPAYER II	DENTIFICATION NUMBERS (ITIN) (FORMAT 9NNNNNNNN)	
1.	2.	
3.	4.	
ORGANIZATION STATE L	ICENSURE INFORMATION	
(If no State License, check	the 'No License' box.)	
1. State License	OR □ No License	

	State of Licensure:	CHOOSE ONE FROM LIST
2.	State License Number: State of Licensure:	OR No License
3.	State License Number: State of Licensure:	OR No License
DR	UG ENFORCEMENT	ADMINISTRATION (DEA) NUMBERS
1. 3.		2.       4.
CLI	NICAL LABORATOR	RY IMPROVEMENT ACT (CLIA) NUMBERS
1. 3. 5.		2.         4.         6.
FE	DERAL FOOD AND [	DRUG ADMINISTRATION (FDA) NUMBERS
1. 3. 5.		2.         4.         6.
NA.	TIONAL PROVIDER	IDENTIFIERS (NPI)
1. 3.		2.         4.
ME	DICARE PROVIDER	SUPPLIER NUMBERS
1.   3.		2.         4.

# CERTIFICATION

I certify that I am authorized to request this information and that I am a representative of the organization described in Section A of this form. I further certify that the information on this form is true

and complete.	
Authorized Submitter's Name:	
Authorized Submitter's Title:	
Authorized Submitter's Phone:	Ext.

#### REPORT PASSWORD PREFERENCE

Once your self-query request is processed, the Data Banks will send a response to the address specified. The self-query response will consist of either a notification that no information exists in the Data Bank(s), or a copy of all information concerning you that has been submitted by eligible reporting entities.

You must select below whether to include in this self-query response a Report Password that will allow you to access the Report Response Service. The service allows you to add, modify, or remove a Subject Statement, initiate or withdraw a dispute or request for Secretarial Review, or modify your address as maintained by the Data Banks. If you are the subject of a report, you will be assigned a unique, confidential password to access the Report Response Service. If you plan to share your self-query results with another person or organization, such as a State licensing board (i.e., a third party), you may wish to omit password information from the self-query results.

- I wish to have my Report Password displayed on my self-query results. This option is recommended for organizations that do not plan to share their self-query results with a third party.
- I wish to have my Report Password omitted from my self-query results. This option is recommended for organizations that plan to share their self-query results with a third party.

#### PAYMENT INFORMATION

The fee per organization self-query is \$8.00, payable by credit card only. Organization self-queries are sent only to the HIPDB. Please enter a valid credit card number (VISA, MasterCard, Discover or American Express) and expiration date. Your credit card will not be charged until the NPDB-HIPDB receives and processes your notarized self-query. Your signature on this form indicates consent to pay this fee.

Month ▼ / Year ▼	
formation is the same as the Subject Name ar se, enter the billing information for this credit c self-query.	
CHOOSE ONE FROM LIST	
1	formation is the same as the Subject Name ar e, enter the billing information for this credit c self-query.

ZIP Code:	-		
Country (if U.S., leave blank):			
☐ Continue without credit card information card information on the formatted copy			
To learn about how we keep your personal	l data secure, click <u>here</u>		
Continue			
	Return to	o Options	

# **Subject Dispute**

#### SUBJECT STATEMENT AND DISPUTE

**National Practitioner Data Bank** Healthcare Integrity and Protection Data Bank

To add, modify, or remove a statement to the report referenced below, and/or to place the report in, or withdraw the report from, disputed status, complete the appropriate section(s) below, and click Submit To Data Bank(s). You will receive an on-line confirmation message regarding this transaction. The reporting entity and any queriers who received a previous version of the report will receive a copy noting the modifications.

MEDICAL MALPRACTICE PAYMENT REPORT Report Type:

Report Number: 7920000044100521 Subject's Name: SMITH, JOHN

Report Maintained In: [X] The National Practitioner Data Bank

[ ] The Healthcare Integrity and Protection Data Bank

SUBJECT STATEMENT Help ?



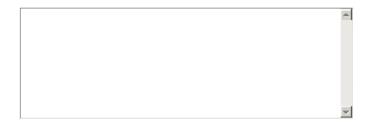
As the subject of the referenced report, you have the right to include a statement expressing your view of the action described in the report. The statement becomes part of the report and is disclosed to authorized queriers. To add a statement, type the statement in the designated area below exactly as you wish it to appear in the report. To substitute an existing statement with a new one, modify the statement in the designated area below exactly as you wish it to appear in the report. (If you have a statement on file, it will appear below.) Your statement must be in English and may not exceed 2,000 characters, including spaces and punctuation. If you add a statement to the report, it will be formatted in a block style; paragraph breaks cannot be included.

Note: Patient information is confidential. Do NOT include identifying information (names, addresses, etc.) about patients or other persons in your statement. All Subject Statements are reviewed by the Data Banks to determine whether they include individual names, addresses, or telephone numbers. If this information is discovered, it will be removed and you will be sent an amended version.

OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 45 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRŚA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

Subject Statement



# DISPUTE Help ?

You may dispute either the factual accuracy of the action described in the referenced report or whether the report was submitted in accordance with Data Bank reporting requirements (e.g., was a reportable event). You may NOT dispute the appropriateness of any action, finding or judgment, or information regarding the facts or circumstances that led to the reported action. You also must contact the reporting entity or its agent, identified in Section A of the report, to attempt to resolve disputed issues. (Do not contact the reporting entity for information about Data Bank reporting requirements or operational procedures.)

Information in Data Bank reports can be changed only by the entity that submitted the report or by the Secretary of the U.S. Department of Health and Human Services following review. The report will remain in the Data Bank(s) unchanged until the reporting entity or the Secretary changes it.

OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 5 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

#### The referenced report is currently NOT in disputed status.

☐ Check here if you wish to place the referenced report in disputed status.

# CERTIFICATION Help ?

I certify that I am the individual subject identified in Section B of the referenced report, or that I am the designated employee representing the organization subject referenced in Section B, and I request that the action(s) above be taken.

Authorized Submitter's Name:	
Authorized Submitter's Title:	
Authorized Submitter's Phone:	Ext.
Date (MMDDYYYY):	02052007

Continue

Return to Report Response Options

# **Secretarial Review**

# REQUEST FOR SECRETARIAL REVIEW

National Practitioner Data Bank Healthcare Integrity and Protection Data Bank

At your request, the report identified below has been placed in disputed status. All queriers who previously received the report are notified that the information they received from the National Practitioner Data Bank (NPDB) and/or the Healthcare Integrity and Protection Data Bank (HIPDB) is in dispute. The reporting entity, identified in Section A, also has been notified.

OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 8 hours to complete the activities associated with this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

Report Type: STATE LICENSURE ACTION

Report Number: 7910000040831642

Subject's Name: DOE, JOHN

Report Maintained In: [X] The National Practitioner Data Bank

[X] The Healthcare Integrity and Protection Data Bank

#### REQUESTING SECRETARIAL REVIEW



Before requesting a review by the Secretary of the U.S. Department of Health and Human Services (HHS), you must first attempt to resolve the disagreement with the reporting entity. If your disagreement cannot be resolved through discussions with the reporting entity (e.g., the reporting entity declines to change the report), you may then request that the Secretary review the report for accuracy.

Please be advised that the Secretary will review your case only to determine the following:

- . Whether a report should have been filed in accordance with reporting regulations, and if so,
- If the information contained in the report is a factually accurate reflection of the action taken and the reasons the action was taken are specified in relevant documents.

The Secretary will not review the merits of a medical malpractice claim in the case of a payment or the appropriateness of, or basis for, an adverse action or judgment or conviction. The Secretary can only determine if the action was reportable and if the report accurately describes the action and the reasons the action was taken. The Secretary cannot review the extent to which entities followed due process guidelines. Due process issues must be resolved between the subject and the reporter.

As part of the Secretarial Review process, you should submit to the Data Banks documentation that supports your position that the reporting entity's information is inaccurate. Documentation must relate directly to the facts in dispute and substantially contribute to a determination of the factual accuracy of the report. Documentation may not exceed 10 pages, including attachments and exhibits. Click **Help** for examples of acceptable documentation.

You must also submit proof that you attempted to resolve the disagreement with the reporting entity, but were unsuccessful (e.g., a copy of your correspondence to the reporting entity and the entity's response, if any).

To proceed with your request for Secretarial Review, follow the instructions below and click **Continue**. Otherwise, click **Return to Report Response Options** at the bottom of this page.

Do not print this page. A printable copy of your request will be provided after submission.

Below is the Subject Statement that you submitted in reference to the specified report. To change this statement, click **Return to Report Response Options** at the bottom of the page, then click **Statement and Dispute**. Once you are satisfied with your Subject Statement, return to this screen to continue processing your request for Secretarial Review.

Patient was informed of potential side effect.

# COMMENTS TO SECRETARY



Comments directed to the Secretary must be entered below. Enter a clear and brief statement describing which facts are in dispute, what you believe to be the correct facts, and, if appropriate, why you believe the report should not have been filed. Your comments must be in English and may not exceed 2,000 characters, including spaces and punctuation. These comments are to the Secretary and do not replace the Subject Statement that you may have previously submitted. These comments will not be disclosed as part of your report.

	_
	~

I have attempted to resolve my dispute with the reporting entity and, after 30 days, have received no response.

# OR

I have attempted to resolve my dispute with the reporting entity; however, the entity has declined to correct or void the report.

# CERTIFICATION



I certify that I am the individual subject identified in Section B of the referenced report, or that I am the designated employee representing the organization subject referenced in Section B, and I request that the action(s) above be taken.

Authorized Submitter's Name:		
Authorized Submitter's Title:		
Authorized Submitter's Phone:		Ext.
Date (MMDDYYYY):	11202006	

Continue

Return to Report Response Options

# **Authorized Agent Designation**

#### DESIGNATE AUTHORIZED AGENT

National Practitioner Data Bank Healthcare Integrity and Protection Data Bank

Complete this form to select an authorized agent who can query and/or report on your behalf. Specify (1) the last four digits of the agent's Data Bank Identification Number, (2) the Agent Organization Name, City, State, ZIP Code, and Country (if applicable), (3) whether to allow the agent to query or report, (4) whether query and/or report responses will be routed to the agent or the entity, and (5) whether the agent's or the entity's EFT account will be charged when EFT is the method of payment used for a query submission. Once the data provided here is validated, you will be instructed to print the Agent Designation Request for your records. This document will serve as the sole record of your request.



OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 15 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

# AGENT INFORMATION

Data Bank Identification Number (last 4 digits): Agent Organization Name: City: State: ZIP Code: Country (if U.S., leave blank):	CHOOSE ONE FROM LIST
Allow Agent to: ☐ Query ☐ Report	
Route Query/Report Responses to C Agent C Entity  NOTE: Both the agent and the enthe Internet and the responses are	ntity must have access to the Internet if the agent queries/reports via
the entity is ultimately responsible	nt to charge to my EFT account. es an authorized agent to query and/or report on behalf of the entity, for payment (even if EFT charges are directed to that de by credit card at the time of querying, regardless of EFT routing

# CERTIFICATION

I certify that I am authorized to designate the authorized agent identified above to report to and/or query the NPDB-HIPDB on my behalf.

		Return to Administrator Options
Continue		
Certification Date (MMDDYYYY):	03232006	
Telephone:		Ext.
Title of Certifying Official:		
Name of Certifying Official:		

# **Authorized Agent Designation (update)**

# **DESIGNATE AUTHORIZED AGENT**

**National Practitioner Data Bank Healthcare Integrity and Protection Data Bank** 

Complete this form to modify an authorized agent who can query and/or report on your behalf. Specify (1) whether query and/or report responses will be routed to the agent or the entity, and (2) whether the agent's or the entity's EFT account will be charged when EFT is the method of payment used for a query submission. Once the data provided here is validated, you will be instructed to print the Agent Designation Request for your records. This document will serve as the sole record of your request.



OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 5 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

AGENT INFORMATION	
Agent Organization Name: Address: City, State, Zip	AGENT SERVICES INC 123 ANYWHERE STREET HOMETOWN, VA 22191
Allow Agent to: □ Query □ Report	
Route Query/Report Responses to:  Agent Entity  NOTE: Both the agent and the entity must have a the line and the responses are sent to the entity.	ccess to the Internet if the agent queries/reports via y.
☐ I give permission for this agent to charge to my NOTE: When an entity designates an authorized the entity is ultimately responsible for payment (everagent). Payment may also be made by credit card assignment.	agent to query and/or report on behalf of the entity, en if EFT charges are directed to that
CERTIFICATION	
certify that I am authorized to designate the au and/or query the NPDB-HIPDB on my behalf.	ithorized agent identified above to report to
Name of Certifying Official:	

Title of Certifying Official:		
Telephone:		Ext.
Certification Date (MMDDYYYY):	11232006	
Continue		
		Determine Administrator Continue

# **Electronic Fund Transfer Authorization**

# **EFT AUTHORIZATION**

**National Practitioner Data Bank** Healthcare Integrity and Protection Data Bank

Complete this form to authorize payment of user fees directly from your bank account. Limit Help ? your responses to the number of characters, including spaces and punctuation, specified in parentheses for each field.



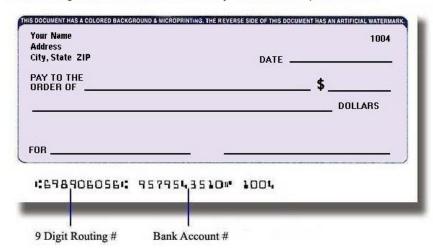
OMB # 0915-0239 expiration date 08/31/07 OMB # 0915-0126 expiration date 05/31/07

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 15 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

# ACCOUNT INFORMATION

Bank Routing Number (9 digits):	
Bank Account Number (max 17 digits):	
Bank Account Type:	Checking
	C Savings

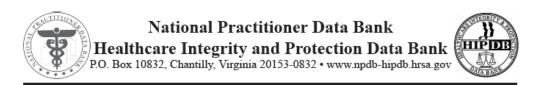
Bank routing information can be found on your check. See picture below.



CERTIFICATION

Name of Certifying Official:		
Title of Certifying Official:		
Telephone:		Ext.
Certification Date (MMDDYYYY):	11232006	
Submit to Data Bank(s)		
		Return to Administrator Options

# **Account Discrepancy Form**



#### ACCOUNT DISCREPANCY

If you cannot reconcile your credit card account statement or Electronic Funds Transfer (EFT) account statement, and determine that your account should be reviewed, please provide the information requested below. Type or print legibly in ink. Numbers in parentheses indicate the maximum number of characters including spaces and punctuation allowed per field.

OMB # 0915-0239 expiration date 08/31/07

OMB # 0915-0126 expiration date 05/31/07

Public Burden Statement: An agency may not conduct or sponsor and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 15 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

Printed Name of Entity Representative (40):  Signature of Entity Representative:  Signature Date:  Credit Card Number (if applicable):  Credit Card Expiration Date (MM/YY):  Dollar Amount of the Suspected Error(s): \$  Please provide an explanation of your discrepancy and include the Data Bank Control Number (DCN), if applicable	Telephone: Area Code (3)	Number (7)	Extension (5)
Signature Date:  Credit Card Number (if applicable):     Credit Card Expiration Date (MM/YY):     Dollar Amount of the Suspected Error(s): \$	Printed Name of Entity Representative	(40):	
Credit Card Number (if applicable): Credit Card Expiration Date (MM/YY): Dollar Amount of the Suspected Error(s): \$	Signature of Entity Representative:		
Credit Card Expiration Date (MM/YY):   _	Signature Date:		
Dollar Amount of the Suspected Error(s): \$	Credit Card Number (if applicable):		
	Credit Card Expiration Date (MM/YY	):	
Please provide an explanation of your discrepancy and include the Data Bank Control Number (DCN), if applicable	Dollar Amount of the Suspected Error	s): \$	
	Please provide an explanation of your	discrepancy and include the Dat	ta Bank Control Number (DCN), if applicable

believe you were charged in error.

For additional information, visit the NPDB-HIPDB Web site at www.npdb-hipdb.hrsa.gov. If you need assistance, contact the

NPDB-HIPDB Customer Service Center by e-mail at npdb-hipdb@sra.com or by phone at 1-800-767-6732 (TDD 703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB-HIPDB Customer Service Center is closed on all Federal holidays.

May 2006 1 of 1 2039001-00958.03.00

# **Initial Accreditation**

# **ACCREDITATION**

Organization Subject: Initial Report

Please provide as much of the following information as possible. Failure to provide sufficient information to permit identification of a single subject will result in the report being rejected, necessitating resubmission.

Do not print this page. A printable copy of your report submission will be provided after submission.

OMB # 0915-xxxx expiration date xx/xx/xx

.... ....

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project is 0915-xxxx (NPDB). Public reporting burden for this collection of information is estimated to average 45 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

SUBJECT INFORMATIO	Help ?	
Organization Name:		
Other Organization N	Names Used:	
1.		
2.		
3.		
4.		
5.		
Click Pelp 7 for inform  Street Address:	ation on filling out non-U.S. and military addresses.	
Address Line 2:		
City:		
State:	CHOOSE ONE FROM LIST	
ZIP Code:	-	
Country (if U.S., leave blank):		
Organization Type:	CHOOSE ONE FROM LIST	•
•	Description (if 'Other' was selected above):	

FE	DERAL EMPLOYER	IDENTIFICATIO	N NUMBERS (FE	EIN)		
1.		2.				
3.		4.				
	CIAL SECURITY NU		FORMAT NNNNN	NNNN)		
1.		2.				
3.		4.				
PR	INCIPAL OFFICERS	AND OWNERS				
		irst Name	Middle Name	Suffix (e.g., Jr.,	Title	
1.						
2. 3.						
4.						
5.						
		ouo.ubu	NEODIA TION			
	GANIZATION STAT					
1 II)	no State License, che	ck the 'No Licens	se' box.)			
1.	State License Number:		OR	□ No License		
	State of Licensure:	CHOOSE ONE F	ROM LIST _	I		
2.	State License Number:		OR	□ No License		
	State of Licensure:	CHOOSE ONE F	ROM LIST _	I		
3.	State License Number:		OR	□ No License		
	State of Licensure:	CHOOSE ONE F	ROM LIST <u>▼</u>	I		
DR	UG ENFORCEMENT	T ADMINISTRAT	ION (DEA) NUM	BERS		
1.		2.				
3.		4.				

CLINIC	AL LABORATORY IMP	PROVEMENT ACT (CLIA) NUMBERS
1.		2.
3.		4.
5.		6.
,	AL FOOD AND DRUG	ADMINISTRATION (FDA) NUMBERS
1.		2.
3.		4.
5.		6.
NATIO	NAL PROVIDER IDENT	TIFIERS (NPI)
1.		2.
3.		4.
MEDIC	ARE PROVIDER/SUPP	PLIER NUMBERS
1.		2.
3.		4.
ΗΕΔΙΤ	H CARE ENTITIES WIT	TH WHICH THE SUBJECT IS AFFILIATED OR ASSOCIATED
		ated health care entity in this report does not imply complicity in the reported
Click 🧧	Help ? for informati	on on filling out non-U.S. and military addresses.
1.	Name of Affiliated/Associated Health Care Entity:	
	Street Address:	
	Address Line 2:	
	City:	
	State:	CHOOSE ONE FROM LIST
	ZIP Code:	-
	Country (if U.S., leave blank):	
	Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST

Other Description (complete only if 'Other' is selected

		above):
	More Affiliated/Associated I	Health Care Entities
2.	Name of Affiliated/Associated Health Care Entity:	
	Street Address:	
	Address Line 2:	
	City:	
	State:	CHOOSE ONE FROM LIST
	ZIP Code:	-
	Country (if U.S., leave blank):	
	Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST
		Other Description (complete only if 'Other' is selected
		above):
	More Affiliated/Associated I	Health Care Entities
3.	Name of Affiliated/Associated Health Care Entity: Street Address:	
	Address Line 2:	
	City:	
	State:	CHOOSE ONE FROM LIST ▼
	ZIP Code:	
	Country (if U.S., leave blank):	
	Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST
		Other Description (complete only if 'Other' is selected above):

More Affiliated/Associated Health Care Entities...

4.	Name of Affiliated/Associated Health Care Entity:	
	Street Address:	
	Address Line 2:	
	City:	
	State:	CHOOSE ONE FROM LIST
	ZIP Code:	-
	Country (if U.S., leave blank): Nature of Subject's Relationship to Affiliate:	
		CHOOSE ONE FROM LIST
		Other Description (complete only if 'Other' is selected above):
that To Specifi Date A (MMDI Date A (MMDI	of Agency or Program book the Adverse Action ied in This Report: action Was Taken DYYYY): action Became Effective DYYYY): n of Action:	C Permanent C Indefinite/Unspecified C Specific Period Years: Months:
Is Reir	nstatement Automatic at	Days:  Completion of Adverse Action Period?  C Yes  No
Total A		nalty, Assessment and/or Restitution or fine (Format NNNNN.NN):

Description of Act(s) or Omission(s) or Other Reasons for Action Taken **Note**: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Is the Action on Appeal? © Yes © N	lo C Unknown
Date of Appeal (MMDDYYYY):	
BASIS FOR ACTION	
Select one or more codes that best describ	e the reason the action was taken.
1. CHOOSE ONE FROM THE LIST	▼
Other Description (complete only if 'Other	er' is selected above):
2 . CHOOSE ONE FROM THE LIST	▼
Other Description (complete only if 'Other	
3 . CHOOSE ONE FROM THE LIST	=
Other Description (complete only if 'Other	er' is selected above):
	ude an internal file number or other reference information to its information is not used by the Data Banks, but it will be eriers.
CERTIFICATION	
I certify that I am authorized to submit this best of my knowledge.	transaction and that all information is true and correct to the
Authorized Submitter's Name:	
Authorized Submitter's Title:	
Authorized Submitter's Phone:	Ext.
Date (MMDDYYYY):	12062005
	e this subject in your subject database for use entries in your subject database may result in

duplicate queries. You will be notified of potential duplicate entries prior to completing this subject entry.



# **Accreditation Correction**

# ACCREDITATION

# Report Correction

To submit a **correction** to previously submitted report DCN 7910000044240374, complete all necessary modifications in the form below, and press **Submit to Data Bank(s)**.

The report entered here will replace the original report, so please ensure that all known data is entered in its entirety. Failure to provide sufficient information to permit identification of a single subject may result in the report being rejected, necessitating resubmission.

Do not print this page. A printable copy of your report submission will be provided after submission.

OMB # 0915-xxxx expiration date xx/xx/xx

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project is 0915-xxxx (NPDB). Public reporting burden for this collection of information is estimated to average 15 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

SUBJECT INFORMATIO	N Help ?
Organization Name:	
Other Organization N	lames Used:
1.	
2.	
3.	
4.	
5.	
Click Help ? for informa	ation on filling out non-U.S. and military addresses.
Street Address:	333 ANYWHERE STREET
Address Line 2:	
City:	WOODBRIDGE
State:	VA Virginia <u>▼</u>
ZIP Code:	22191 -
Country (if U.S., leave blank):	
Organization Type:	361 Chiropractic Group/Practice   ▼

		Descript	tion (if 'Other' was	s selected above):	
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OR	GANIZATION STA	TE LICENSUR	E INFORMATION	N .	
(lf r	no State License, ch	eck the 'No Lic	ense' box.)		
1.	State License Number:	ASDF23452	235	R □ No License	
	State of Licensure:	DC District of	Columbia	•	
2.	State License Number:		O	R □ No License	
	State of Licensure	CHOOSE ON	E FROM LIST	•	
3.	State License Number:		0	R □ No License	
	State of Licensure:	CHOOSE ON	E FROM LIST	•	

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1.		2.
3.		4.
CLINI	CAL LABORATORY IMI	PROVEMENT ACT (CLIA) NUMBERS
1.		2.
3.		4.
5.		6.
FEDE	RAL FOOD AND DRUG	ADMINISTRATION (FDA) NUMBERS
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	CARE PROVIDER/SUPP	
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HEAL	TH CARE ENTITIES WI	TH WHICH THE SUBJECT IS AFFILIATED OR ASSOCIATED
Inclusi action		ated health care entity in this report does not imply complicity in the reporte
Click	Help ? for informati	on on filling out non-U.S. and military addresses.
1.	Name of Affiliated/Associated Health Care Entity:	
	Street Address:	
	Address Line 2:	
	City:	
	State:	CHOOSE ONE FROM LIST
	ZIP Code:	-
	Country (if U.S., leave blank):	
	Nature of Subject's	

	Relationship to Affiliate:	CHOOSE ONE FROM LIST				
	Ailliate.	Other Description (complete only if 'Other' is selected above):				
	More Affiliated/Associated Health Care Entities					
2.	Name of Affiliated/Associated Health Care Entity:					
	Street Address:					
	Address Line 2:					
	City:					
	State:	CHOOSE ONE FROM LIST ▼				
	ZIP Code:					
	Country (if U.S., leave blank):					
	Nature of Subject's	QUOQUE ONE FROM LIGT				
	Relationship to Affiliate:	CHOOSE ONE FROM LIST				
		Other Description (complete only if 'Other' is selected above):				
	More Affiliated/Associated	Health Care Entities				
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	Street Address:					
	Address Line 2:					
	City:					
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	ZIP Code:					
	Country (if U.S., leave blank):					
	Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST				
		Other Description (complete only if 'Other' is selected above):				

Name of Affiliated/Associated Health Care Entity:	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
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Description of Act(s) or Omission(s) or Other Reasons for Action Taken

Note: Do not reference any personal ide than the subject of this report.	ntification information (e.g., names) of anyone other
TEST	<b>▲</b>
Is the Action on Appeal? • Yes	No ○ Unknown
Date of Appeal (MMDDYYYY):	
BASIS FOR ACTION	
Select one or more codes that best describ	be the reason the action was taken.
1 . 91 Noncompliance With Private Accreditation	Standards
Other Description (complete only if 'Ot	her' is selected above):
2. CHOOSE ONE FROM THE LIST	▼
Other Description (complete only if 'Ot	her' is selected above):
3. CHOOSE ONE FROM THE LIST	▼
Other Description (complete only if 'Ot	her' is selected above):
ENTITY INTERNAL REPORT REFEREN This optional field allows your entity to inchelp you identify this report in your files. T provided on copies of the report sent to quentity Internal Report Reference (e.g., clanumber):	lude an internal file number or other reference information to his information is not used by the Data Banks, but it will be ueriers.
CERTIFICATION	
I certify that I am authorized to submit this best of my knowledge.	transaction and that all information is true and correct to the
Authorized Submitter's Name:	
Authorized Submitter's Title:	
Authorized Submitter's Phone:	Ext.
Date (MMDDYYYY):	01162007

Submit to Data Bank(s)

Validate Without Submitting

Store as a Draft

Return to Options

### **Accreditation Revision**

#### ACCREDITATION

#### Revision to Action

To submit a **revision to action** on previously submitted report DCN 7910000044240374, enter all report data for the action, and press **Submit to Data Bank(s)**.

Enter all known data in its entirety. Failure to provide sufficient information to permit identification of a single subject may result in the report being rejected, necessitating resubmission.

Do not print this page. A printable copy of your report submission will be provided after submission.

OMB # 0915-xxxx expiration date xx/xx/xx

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SUBJECT INFORMATIO	N Help ?
Organization ORGNAME	
Other Organization N	lames Used:
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2.	
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4.	
5.	
Click elp ? for information of the street Address:	ation on filling out non-U.S. and military addresses.  333 ANYWHERE STREET
Address Line 2:	
City:	WOODBRIDGE
State:	VA Virginia
ZIP Code:	22191 -
Country (if U.S., leave blank):	
Organization Type:	361 Chiropractic Group/Practice
	Description (if 'Other' was selected above):

EDERAL EMPLO	YER IDENTIFICAT	ΓΙΟΝ NUMBERS (F	EIN)	
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	4.			
OCIAL SECURIT	Y NUMBERS (SSI	N) (FORMAT NNNN	NNNN)	
	2.			
	4.			
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			III)	
state License State License Number:	ASDF2345		□ No License	
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State License "Number:		OR	□ No License	
State of Licens	ure: CHOOSE ON	E FROM LIST	-	
State License Number:		OR	□ No License	
State of Licens	ure: CHOOSE ON	E FROM LIST		
RUG ENFORCEN	MENT ADMINISTR	ATION (DEA) NUM	BERS	
	2.			

3.		4.
3. <u> </u>		4.
CLINIC	AL LABORATORY IM	PROVEMENT ACT (CLIA) NUMBERS
1.		2.
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5.		6.
FEDER	AL FOOD AND DRUG	ADMINISTRATION (FDA) NUMBERS
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1		2.
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5.		6.
NATIO	NAL PROVIDER IDEN	TIFIERS (NPI)
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MEDIC	ARE PROVIDER/SUPP	PLIER NUMBERS
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	U OADE ENTITIES WIT	TUNNINGUI TUE GUR IEGT IG A EEU IATER OR AGGGGIATER
		TH WHICH THE SUBJECT IS AFFILIATED OR ASSOCIATED
Inclusion.	on of an affiliated/associ	ated health care entity in this report does not imply complicity in the reported
Click 🧧	Help ? for informati	on on filling out non-U.S. and military addresses.
Olloit (	Tot Internation	on on mining out non-ole, and minitary addresses.
1.	Name of	
	Affiliated/Associated	
	Health Care Entity: Street Address:	
	Address Line 2:	
	City:	
	State:	CHOOSE ONE FROM LIST ▼
	ZIP Code:	UNICOSE ONE THOM EIGHT
	Country (if U.S., leave	
	blank):	
	Nature of Subject's Relationship to	CHOOSE ONE FROM LIST

	Affiliate:		
		Other Description (complete only if 'Other above):	er' is selected
	More Affiliated/Associated	Health Care Entities	
2.	Name of Affiliated/Associated Health Care Entity:		
	Street Address:		
	Address Line 2:		
	City:		
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	Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST	v
		Other Description (complete only if 'Other	er' is selected
		above):	7
	More Affiliated/Associated	Health Care Entities	
3.	Name of Affiliated/Associated Health Care Entity:		
	Street Address:		
	Address Line 2:		
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4.	Name of Affiliated/Associated Health Care Entity: Street Address:	
	Address Line 2:	
	City:	
	State:	CHOOSE ONE FROM LIST
	ZIP Code:	
	Country (if U.S., leave blank):	
	Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST
	Ailliate.	Other Description (complete only if 'Other' is selected above):
Name of that To Specific Date A (MMDI Date A (MMDI	of Agency or Program ok the Adverse Action ed in This Report: ction Was Taken DYYYY): ction Became Effective DYYYY): of Action:	Permanent C Indefinite/Unspecified Specific Period Years: Months: Days:
Total A		Completion of Adverse Action Period? © Yes © No nalty, Assessment and/or Restitution or fine (Format NNNNN.NN): field blank.
Note:	otion of Act(s) or Omissi Do not reference any p e subject of this report.	ion(s) or Other Reasons for Action Taken personal identification information (e.g., names) of anyone other

Is the Action on Appeal?	○ No ○ Unknown
Date of Appeal (MMDDYYYY):	
ENTITY INTERNAL REPORT REFERE This optional field allows your entity to in help you identify this report in your files. provided on copies of the report sent to Entity Internal Report Reference (e.g., c number):	nclude an internal file number or other reference information to This information is not used by the Data Banks, but it will be queriers.
CERTIFICATION	
I certify that I am authorized to submit the best of my knowledge.	nis transaction and that all information is true and correct to the
Authorized Submitter's Name:	
Authorized Submitter's Title:	
Authorized Submitter's Phone:	Ext.
Date (MMDDYYYY):	01162007
Submit to Data Bank(s) Validate Witho	Store as a Draft
	Return to Options

## **QIO Initial**

#### MEDICARE QUALITY IMPROVEMENT ORGANIZATION

Individual Subject: Initial Report

Please provide as much of the following information as possible. Failure to provide sufficient information to permit identification of a single subject will result in the report being rejected, necessitating resubmission.

Do not print this page. A printable copy of your report submission will be provided after submission.

OMB # 0915-xxxx expiration date xx/xx/xx

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SUBJE	CT INF	ORMATION	Help ?		
Subject I	Name:				
	Last N	ame	First Name	Middle Name	Suffix (e.g., Jr, III)
Other Na	ames Us	sed:			
	Last N	lame	First Name	Middle Name	Suffix (e.g., Jr, III)
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2.					
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Gender:		○Male ○F	emale © Unknowi	n	
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Organiza	ation				
Name:	ation				
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		Description (it	f 'Other' was selecte	d above):	,

**ADDRESSES** 

Click Help ? for informat	ion on filling out non-U.S. and military addresses.
Work Address	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST ▼
ZIP Code:	-
Country (if U.S., leave blank):	
Home Address/Address of Record	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST ▼
ZIP Code:	-
Country (if U.S., leave blank):	
Is Subject Deceased? O No	C Unknown C YesDeceased Date (MMDDYYYY)
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3.	4.
FEDERAL EMPLOYER IDEN	TIFICATION NUMBERS (FEIN)
1.	2.
3.	4.
NATIONAL PROVIDER IDEN	TIFIERS (NPI)
1.	2.
3.	4.
DRUG ENFORCEMENT ADM	INISTRATION (DEA) NUMBERS
1.	2.

3. [		4.
UNI	QUE PHYSICIAN IDE	NTIFICATION NUMBERS (UPIN)
1.   3.		2.         4.
PR	OFESSIONAL SCHOO	DLS ATTENDED YEAR OF GRADUATION (Format YYYY)
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3.		
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5.		
		TE LICENSURE INFORMATION ry is required. If no State License Number, check the 'No License' box.)
1.	State License Number:	OR □ No License
	State of Licensure:	CHOOSE ONE FROM LIST
	Occupation/Field of Licensure:	654 Professional Counselor, Alcohol
		Description (complete only if 'Other' is selected above):
	Specialty:	CHOOSE ONE FROM LIST ▼
	Additional State Licenses/	Occupations .
	0	
2.	State License Number:	OR □ No License
	State of Licensure:	CHOOSE ONE FROM LIST
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST
		Description (complete only if 'Other' is selected above):
	Specialty:	CHOOSE ONE FROM LIST
	Additional State Licenses/	Occupations

3.	State License Number:	OR No License	
	State of Licensure:	CHOOSE ONE FROM LIST ▼	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses	/Occupations	
4.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST ▼	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	<b>V</b>
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST   ▼	
	Additional State Licenses	/Occupations	
5.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST ▼	
	O		
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	▼
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6.	Specialty:  Additional State Licenses  State License Number: State of Licensure:	Description (complete only if 'Other' is selected above):  CHOOSE ONE FROM LIST  OR □ No License  CHOOSE ONE FROM LIST	•
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	Specialty:	CHOOSE ONE FROM LIST ▼	
	Additional State Licenses/	Occupations	
7.	State License Number: State of Licensure:	OR □ No License	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST  Description (complete only if 'Other' is selected above):	1
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	Additional State Licenses/	Occupations	
8.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST ▼	
	Additional State Licenses/	Occupations	
9.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST ▼	-
		Description (complete only if 'Other' is selected above):	-
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses/	Occupations	
10.	Number:	OR No License	
	State of Licensure:	CHOOSE ONE FROM LIST ▼	
	Occupation/Field of		

Licensure:	CHOOSE ONE FROM LIST	▼
	Description (complete only if 'Other' is selected above):	
Specialty:	CHOOSE ONE FROM LIST  ▼	

### HEALTH CARE ENTITIES WITH WHICH THE SUBJECT IS AFFILIATED OR ASSOCIATED

Inclusion of an affiliated/associated health care entity in this report does not imply complicity in the reported action.

action. Click Help for information on filling out non-U.S. and military addresses. 1. Name of Affiliated/Associated Health Care Entity: Street Address: Address Line 2: City: CHOOSE ONE FROM LIST • State: ZIP Code: Country (if U.S., leave blank): Nature of Subject's Relationship to CHOOSE ONE FROM LIST • Affiliate: Other Description (complete only if 'Other' is selected above): More Affiliated/Associated Health Care Entities... 2. Name of Affiliated/Associated Health Care Entity: Street Address: Address Line 2: City: State: CHOOSE ONE FROM LIST • ZIP Code: Country (if U.S., leave blank): Nature of Subject's

	Relationship to Affiliate:	CHOOSE ONE FROM LIST	•
	Annate.	Other Description (complete only if 'Other' is selected above):	
	More Affiliated/Associated I	Health Care Entities	
3.	Name of Affiliated/Associated Health Care Entity:		
	Street Address:		
	Address Line 2:		
	City:		
	State:	CHOOSE ONE FROM LIST  ▼	
	ZIP Code:	-	
	Country (if U.S., leave blank):		
	Nature of Subject's	CHOOSE ONE EDOM LIST	_
	Relationship to Affiliate:	CHOOSE ONE FROM LIST	
		Other Description (complete only if 'Other' is selected above):	
	More Affiliated/Associated	Health Care Entities	
4.	Name of Affiliated/Associated Health Care Entity:		
	Street Address:		
	Address Line 2:		
	City:		
	State:	CHOOSE ONE FROM LIST	
	ZIP Code:		
	Country (if U.S., leave blank):		
	Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST	•
		Other Description (complete only if 'Other' is selected above):	

FINDING INFORMATION Help ?	
M- □ 1831 - Re M-	ecommendation to Sanction from Participating in edicare, Medicaid ecommendation to Exclude from Participating in edicare, Medicaid ther Finding - Not Classified, Specify
Date of Finding (MMDDYYYY):	
Description of Finding:  Note: Do not reference any personal identific of this report.	cation information (e.g., names) of anyone other than the subjection
BASIS FOR FINDING	
CHOOSE ONE FROM THE LIST     Other Description (complete only if 'Other'	is selected above):
2 . CHOOSE ONE FROM THE LIST Other Description (complete only if 'Other'	is selected above):
	e an internal file number or other reference information to information is not used by the Data Banks, but it will be ers.

# CERTIFICATION

I certify that I am authorized to submit this best of my knowledge.	transaction and that all information is true and correct to the
Authorized Submitter's Name:	
Authorized Submitter's Title:	
Authorized Submitter's Phone:	Ext.
Date (MMDDYYYY):	12062005
in future queries and/or reports. Duplicate	ate this subject in your subject database for use entries in your subject database may result in otential duplicate entries prior to completing this
Submit to Data Bank(s) Validate Without	Submitting Store as a Draft
	Return to Options

## **QIO Correction**

### MEDICARE QUALITY IMPROVEMENT ORGANIZATION

## Report Correction

To submit a **correction** to previously submitted report DCN 7910000044240372, complete all necessary modifications in the form below, and press **Submit to Data Bank(s)**.

The report entered here will replace the original report, so please ensure that all known data is entered in its entirety. Failure to provide sufficient information to permit identification of a single subject may result in the report being rejected, necessitating resubmission.

Do not print this page. A printable copy of your report submission will be provided after submission.

OMB # 0915-xxxx expiration date xx/xx/xx

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project is 0915-xxxx (NPDB). Public reporting burden for this collection of information is estimated to average 15 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

SUBJE	CT INF	ORMATION	Help ?		
Subject N	lame:				
,	Last N	ame	First Name	Middle Name	Suffix (e.g., Jr, III)
	SMITI	4	JOHN		
Other Na	mes Us	sed:			
	Last N	lame	First Name	Middle Name	Suffix (e.g., Jr, III)
1.					
2.					
3.					
4.					
5.					
Gender:		Male ○ F	emale © Unknow	n	
Birth Date (MMDDYYYY):		10101966			
Work					
Organization Name:		MEDICAL C	ENTER MD		
Organiza	tion	361 Chiropracti	ic Group/Practice		▼
Type:		Description (i	f 'Other' was selecte	ed above):	

ADDRESSES	
Click Help ? for information	ation on filling out non-U.S. and military addresses.
Work Address	
Street Address:	444 ANYWHERE STREET
Address Line 2:	
City:	WOODBRIDGE
State:	VA Virginia ▼
ZIP Code:	22191 -
Country (if U.S., leave blank):	
Home Address/Address of Record	
Street Address:	666 ANYWHERE STREET
Address Line 2:	
City:	WOODBRIDGE
State:	VA Virginia
ZIP Code:	22191 -
Country (if U.S., leave blank):	
Is Subject Deceased? • No	O C Unknown C YesDeceased Date (MMDDYYYY)
SOCIAL SECURITY NUMBE	ERS (SSN) (FORMAT NNNNNNNNN)
1. 433252342	2.
3.	4.
FEDERAL EMPLOYER IDEI	NTIFICATION NUMBERS (FEIN)
1.	2.
3.	4.
NATIONAL PROVIDER IDE	NTIFIERS (NPI)
1.	2.
2	4

DR	JG ENFORCEMENT A	ADMINISTRATION (D	EA) NUMBI	ERS	
1. [		2.			
3. [		4.			
UNI	QUE PHYSICIAN IDE	NTIFICATION NUMB	ERS (UPIN)		
1.		2.			
3.		4.			
PR	OFESSIONAL SCHO	OLS ATTENDED	YEAR OF (Format Y	GRADUATION YYY)	
1.	MASON		2006		
2.					
3.					
4.					
5.					
(At	cupation and state east one licensure ent state License	ry is required. If no St	ate License		e 'No License' box.)
1.	Number:	235325235325	OR	☐ No License	
	State of Licensure:	DC District of Columbia	•	1	
	Occupation/Field of Licensure:	010 Physician (MD)			
		Description (comple	te only if 'Otl	her' is selected ab	ove):
	Specialty:	03 Aerospace Medicine		•	
	Additional State Licenses	Occupations			
2.	State License Number:		OR	□ No License	
	State of Licensure:	CHOOSE ONE FROM I	JIST 🔻		
	Occupation/Field of Licensure:	CHOOSE ONE FROM I	IST		<b>V</b>
		Description (comple	te only if 'Otl	her' is selected ab	ove):
					1
	Specialty:	CHOOSE ONE FROM I	IST	$\Box$	

## Additional State Licenses/Occupations

3.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST ▼	
	Additional State Licenses	Occupations	
4.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST ▼	
	Occupation/Field of	CUCOCE ONE EDOM LIST	_
	Licensure:	CHOOSE ONE FROM LIST	▼
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses	Occupations	
5.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses	Occupations // Occupations	
6.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST ▼	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•

	Description (complete only if 'Other' is selected above):
Specialty:	CHOOSE ONE FROM LIST
Additional State Licens	ses/Occupations
7. State License Number:	OR □ No License
State of Licensure:	CHOOSE ONE FROM LIST
Occupation/Field o Licensure:	CHOOSE ONE FROM LIST
	Description (complete only if 'Other' is selected above):
Specialty:	CHOOSE ONE FROM LIST
Additional State Licens	ses/Occupations
State License Number:	OR □ No License
State of Licensure:	CHOOSE ONE FROM LIST
Occupation/Field o Licensure:	CHOOSE ONE FROM LIST
	Description (complete only if 'Other' is selected above):
Specialty:	CHOOSE ONE FROM LIST
Additional State Licens	ses/Occupations
State License Number:	OR □ No License
State of Licensure:	CHOOSE ONE FROM LIST
Occupation/Field o Licensure:	CHOOSE ONE FROM LIST
	Description (complete only if 'Other' is selected above):
Specialty:	CHOOSE ONE FROM LIST
Additional State Licens	ses/Occupations
0. State License	OR □ No License

State of Licensure:	CHOOSE ONE FROM LIST	
Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	▼
	Description (complete only if 'Other' is selected above):	
Specialty:	CHOOSE ONE FROM LIST	

## HEALTH CARE ENTITIES WITH WHICH THE SUBJECT IS AFFILIATED OR ASSOCIATED

Inclusion of an affiliated/associated health care entity in this report does not imply complicity in the reported action.

Click Help ? for information on filling out non-U.S. and military addresses.

1.	Name of Affiliated/Associated Health Care Entity:		
	Street Address:		
	Address Line 2:		
	City:		
	State:	CHOOSE ONE FROM LIST	
	ZIP Code:	-	
	Country (if U.S., leave blank):		
	Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST	•
		Other Description (complete only if 'Other' is selected above):	
	More Affiliated/Associated	Health Care Entities	
2.	Name of Affiliated/Associated Health Care Entity:		
	Street Address:		
	Address Line 2:		
	City:		
	State:	CHOOSE ONE FROM LIST	
	ZIP Code:	-	
	Country (if U.S., leave		

	blank):		
	Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST	•
	Allillate.	Other Description (complete only if 'Other' is selected above):	
	More Affiliated/Associated I	Health Care Entities	
3.	Name of Affiliated/Associated Health Care Entity:		
	Street Address:		
	Address Line 2:		
	City:		
	State:	CHOOSE ONE FROM LIST	
	ZIP Code:	-	
	Country (if U.S., leave blank):		
	Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST	•
	Ailliate.	Other Description (complete only if 'Other' is selected above):	
	More Affiliated/Associated I	Health Care Entities	
4.	Name of Affiliated/Associated Health Care Entity:		
	Street Address:		
	Address Line 2:		
	City:		
	State:	CHOOSE ONE FROM LIST  ▼	
	ZIP Code:		
	Country (if U.S., leave		
	blank): Nature of Subject's		
	Relationship to Affiliate:	CHOOSE ONE FROM LIST	•

	above):
FINDING INFORMATION	Help ?
Name of Agency or Program that Authorized the Quality Improvement Review : Type of Negative Finding:	AGENCY2  ☑ 1830 - Recommendation to Sanction from Participating in Medicare, Medicaid  ☐ 1831 - Recommendation to Exclude from Participating in Medicare, Medicaid
	☐ 1889 - Other Finding - Not Classified, Specify
Date of Finding (MMDDYYYY)	: 10102006
Description of Finding:  Note: Do not reference any poof this report.  TEST	ersonal identification information (e.g., names) of anyone other than the subject
BASIS FOR FINDING	
	Presenting Imminent Danger to the Health, Safety or Well-Being of Patient or e only if 'Other' is selected above):
2 . CHOOSE ONE FROM THE LIS Other Description (complete	e only if 'Other' is selected above):
	entity to include an internal file number or other reference information to your files. This information is not used by the Data Banks, but it will be ort sent to queriers.

# CERTIFICATION

I certify that I am authorized to submit this best of my knowledge.	s transaction and that all information is true	and correct to the
Authorized Submitter's Name:		
Authorized Submitter's Title:		
Authorized Submitter's Phone:	Ext.	
Date (MMDDYYYY):	01162007	
Submit to Data Bank(s) Validate Without	Store as a Draft	
	Return	to Options

### **QIO Revision to Action**

# MEDICARE QUALITY IMPROVEMENT ORGANIZATION Revision to Action

To submit a **revision to action** on previously submitted report DCN 7910000044240372, enter all report data for the action, and press **Submit to Data Bank(s)**.

Enter all known data in its entirety. Failure to provide sufficient information to permit identification of a single subject may result in the report being rejected, necessitating resubmission.

Do not print this page. A printable copy of your report submission will be provided after submission.

OMB # 0915-xxxx expiration date xx/xx/xx

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project is 0915-xxxx (NPDB). Public reporting burden for this collection of information is estimated to average 15 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

SUBJEC	CT INF	ORMATION	Help ?		
Subject N	lame:				
,	Last Na	ame	First Name	Middle Name	Suffix (e.g., Jr, III)
	SMITH	1	JOHN		
Other Na	mes Us	ed:			
	Last N	ame	First Name	Middle Name	Suffix (e.g., Jr, III)
1.					
2.					
3.					
4.					
5.					
Gender:		Male ○ F	emale © Unknowr	n	
Birth Date		10101966			
(MMDDY	YYY):	10101966			
Work Organization					
Name:		MEDICAL CE	NTER MD		
Organiza	tion	361 Chiropractic	Group/Practice	▼	
Type:		Description (it	'Other' was selecte	d above):	_
		Decempation (II		a aboro,.	

# **ADDRESSES** Click Help ? for information on filling out non-U.S. and military addresses. Work Address Street Address: 444 ANYWHERE STREET Address Line 2: WOODBRIDGE City: VA Virginia ▾ State: 22191 ZIP Code: Country (if U.S., leave blank): Home Address/Address of Record Street Address: 666 ANYWHERE STREET Address Line 2: WOODBRIDGE City: State: VA Virginia ▾ ZIP Code: 22191 Country (if U.S., leave blank): Is Subject Deceased? No Unknown Yes--Deceased Date (MMDDYYYY) Is Subject Deceased? No Unknown Yes--Deceased Date (MMDDYYYY) Is Subject Deceased? SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN) 1. 433252342 2. 4. FEDERAL EMPLOYER IDENTIFICATION NUMBERS (FEIN) 1. 2. 3. 4.

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

4.

NATIONAL PROVIDER IDENTIFIERS (NPI)

1. 3.

1. [		2.	
3. [		4.	
UNI	QUE PHYSICIAN IDEI	NTIFICATION NUMBERS (UPIN)	
1.		2.	
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PR	OFESSIONAL SCHOO	DLS ATTENDED YEAR OF GRADUATION (Format YYYY)	
1.	MASON	2006	
2.			
3.			
4.			
5.			
(At I		TE LICENSURE INFORMATION y is required. If no State License Number, check the 'No License' box.)	)
1.	Number:	235325235325 OR □ No License	
	State of Licensure:	DC District of Columbia	
	Occupation/Field of Licensure:	010 Physician (MD)	
		Description (complete only if 'Other' is selected above):	
	Specialty:	03 Aerospace Medicine	
	Additional State Licenses/	<u>Occupations</u>	
2.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	

Additional State Licenses/Occupations

3.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST   ▼	
	Additional State Licenses	Occupations	
4.	State License Number:	OR □ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST	•
		Description (complete only if 'Other' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST	
	Additional State Licenses	/Occupations	
5.	State License	Occupations  OR □ No License	
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5.	State License Number: State of Licensure: Occupation/Field of	OR □ No License	<b>V</b>
5.	State License Number: State of Licensure:	OR □ No License  CHOOSE ONE FROM LIST  CHOOSE ONE FROM LIST	V
5.	State License Number: State of Licensure: Occupation/Field of	OR □ No License  CHOOSE ONE FROM LIST ▼	V
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5.	State License Number: State of Licensure: Occupation/Field of Licensure:  Specialty: Additional State Licenses. State License Number:	OR No License  CHOOSE ONE FROM LIST  Description (complete only if 'Other' is selected above):  CHOOSE ONE FROM LIST  CHOOSE ONE FROM LIST  OR No License	•
	State License Number: State of Licensure: Occupation/Field of Licensure:  Specialty: Additional State Licenses Number: State of Licensure:	OR No License  CHOOSE ONE FROM LIST  CHOOSE ONE FROM LIST  Description (complete only if 'Other' is selected above):  CHOOSE ONE FROM LIST	V
	State License Number: State of Licensure: Occupation/Field of Licensure:  Specialty: Additional State Licenses. State License Number:	OR No License  CHOOSE ONE FROM LIST  Description (complete only if 'Other' is selected above):  CHOOSE ONE FROM LIST  CHOOSE ONE FROM LIST  OR No License	V
	State License Number: State of Licensure: Occupation/Field of Licensure:  Specialty: Additional State Licenses Number: State of Licensure: Occupation/Field of	OR No License  CHOOSE ONE FROM LIST  Description (complete only if 'Other' is selected above):  CHOOSE ONE FROM LIST  CHOOSE ONE FROM LIST  OR No License  CHOOSE ONE FROM LIST	

	Specialty:	CHOOSE ONE FROM LIST		<u> </u>	
	Additional State Licenses	<u>/Occupations</u>			
7.	State License Number:		OR	□ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	•		
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST			~
	Liberiodie.	Description (complete only	if 'Oth	er' is selected above):	
	Specialty:	CHOOSE ONE FROM LIST		$\overline{\mathbf{v}}$	
	Additional State Licenses	Occupations			
3.	State License Number:		OR	□ No License	
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	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST			_
		Description (complete only	if 'Oth	er' is selected above)	_
	Specialty:	CHOOSE ONE FROM LIST		$\overline{}$	
	Additional State Licenses	/Occupations			
).	State License Number:		OR	□ No License	
	State of Licensure:	CHOOSE ONE FROM LIST	•		
	Occupation/Field of Licensure:	CHOOSE ONE FROM LIST			<b>~</b>
	Liceriodie.	Description (complete only	if 'Oth	er' is selected above):	
		. , , ,			
	Specialty:	CHOOSE ONE FROM LIST		▼	
	Specialty:  Additional State Licenses	•		<u> </u>	
0.	Additional State Licenses	•	OR	□ No License	
0.	Additional State Licenses	•	OR	□ No License	

Licensure:	CHOOSE ONE FROM LIST	▼
	Description (complete only if 'Other' is selected above):	
Specialty:	CHOOSE ONE FROM LIST	

# HEALTH CARE ENTITIES WITH WHICH THE SUBJECT IS AFFILIATED OR ASSOCIATED

Inclusion of an affiliated/associated health care entity in this report does not imply complicity in the reported action.

Click (	Help ? for informati	on on filling out non-U.S. and military addresses.
1.	Name of Affiliated/Associated Health Care Entity:	
	Street Address:	
	Address Line 2:	
	City:	
	State:	CHOOSE ONE FROM LIST
	ZIP Code:	-
	Country (if U.S., leave blank):	
	Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST
		Other Description (complete only if 'Other' is selected above):
	More Affiliated/Associated I	Health Care Entities
2.	Name of Affiliated/Associated Health Care Entity:	
	Street Address:	
	Address Line 2:	
	City:	
	State:	CHOOSE ONE FROM LIST
	ZIP Code:	-
	Country (if U.S., leave blank):	
	Nature of Subject's	

	Relationship to Affiliate:	CHOOSE ONE FROM LIST	•
	Annate.	Other Description (complete only if 'Other' is selected above):	
	More Affiliated/Associated	Health Care Entities	
3.	Name of Affiliated/Associated Health Care Entity:		
	Street Address:		
	Address Line 2:		
	City:		
	State:	CHOOSE ONE FROM LIST	
	ZIP Code:	-	
	Country (if U.S., leave blank):		
	Nature of Subject's Relationship to	CHOOSE ONE FROM LIST	•
	Affiliate:	CHOOSE ONE FROM LIST	
		Other Description (complete only if 'Other' is selected above):	
		above).	
	More Affiliated/Associated	Health Care Entities	
4.	Name of Affiliated/Associated Health Care Entity:		
	Street Address:		
	Address Line 2:		
	City:		
	State:	CHOOSE ONE FROM LIST	
	ZIP Code:	-	
	Country (if U.S., leave blank):		
	Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST	•
	, timuto.	Other Description (complete only if 'Other' is selected above):	

FINDING INFORMATION	Help ?
Name of Agency or Program that Authorized the Quality Improvement Review : Type of Negative Finding:	<ul> <li>□ 1840 - Withdrawal of Recommendation to Sanction from Participating in Medicare, Medicaid</li> <li>□ 1841 - Withdrawal of Recommendation to Exclude from Participating in Medicare, Medicaid</li> </ul>
Date of Finding (MMDDYYYY):	
Description of Finding:  Note: Do not reference any per of this report.	rsonal identification information (e.g., names) of anyone other than the subject
	ntity to include an internal file number or other reference information to our files. This information is not used by the Data Banks, but it will be sent to queriers.
CERTIFICATION	
I certify that I am authorized to s best of my knowledge.	submit this transaction and that all information is true and correct to the
Authorized Submitter's Name:	
Authorized Submitter's Title:	
Authorized Submitter's Phone:	Ext.
Date (MMDDYYYY):	01162007
Submit to Data Bank(s)	date Without Submitting Store as a Draft

Return to Options