Entity Registration

ENTITY REGISTRATION

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

Help ?

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

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.

ENTITY IDENTIFICATION INFORMATION

Help ?

Name of Entity:

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):

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

EXISTING DBID Help ?

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 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;
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

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

* Includes Composite Boards for physicians or dentists and other health care practitioners.

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

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
○ State Health Care Entity Licensing Board	Optional	Mandatory
○ Quality Improvement Organization under Contract with the Centers for Medicare & Medicaid Services (CMS)	Optional	Mandatory
○ 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
○ State Agency Administering or Supervising the Administration of a State Health Care Program	Optional	No Requirement
○ State Medicaid Fraud Control Unit	Optional	No Requirement
○ Attorney General/Other Law Enforcement Agency	Optional	No Requirement
○ None of These	Prohibited	Prohibited

* 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 Help ?

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.

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

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 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.

Name:

Title:

Telephone: Ext.

CERTIFICATION Help ?

I certify that the entity identified above qualifies under law as specified in the ELIGIBILITY/STATUTORY AUTHORITY section and is eligible to perform the querying and/or reporting functions. I understand that the entity may be subject to sanctions under Federal statute for failure to report final adverse actions as required in the statutes and regulations or for the use of information obtained from the NPDB or the HIPDB other than the purposes for which it was provided. I further certify that I am authorized to submit this registration information to the NPDB-HIPDB and that the information provided is true, correct, and complete. If I become aware that any information in this form is not true, correct, or complete, I agree to notify the NPDB-HIPDB of this fact immediately. I understand that any omission, misrepresentation, or falsification of any information contained in this form or contained 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:

Telephone: Ext.

Certification Date (MMDDYYYY): 11102006

Continue

Return to NPDB-HIPDB Home Page

Agent Registration

AGENT REGISTRATION

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

Help ?

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 Entity Registration 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

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.

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):	

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):

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.

Name:

Title:

Telephone: 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:	
Telephone:	Ext.
Certification Date (MMDDYYYY):	06092006

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.

Help ?

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.

ENTITY IDENTIFICATION INFORMATION Help ?

Name of Entity:	STATE BOARD OF MEDICAL EXAMINERS
Department or Office to Which Mail Should be Addressed:	
Street Address:	4350 FAIR LAKES COURT
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 Correspondence Should be Sent:	mail2me@gmail.com

(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):	777777777
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;
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
◉ Hospital**	Mandatory	Mandatory
○ Professional Society**	Optional	Mandatory
○ Other Health Care Entity**	Optional	Mandatory
○ Medical Malpractice Payer	Prohibited	Mandatory
○ None of These	Prohibited	Prohibited

* Includes Composite Boards for physicians or dentists and other health care practitioners.

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

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
○ State Health Care Entity Licensing Board	Optional	Mandatory
○ Quality Improvement Organization under Contract with the Centers for Medicare & Medicaid Services (CMS)	Optional	Mandatory

○ 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
○ State Agency Administering or Supervising the Administration of a State Health Care Program	Optional	No Requirement
○ State Medicaid Fraud Control Unit	Optional	No Requirement
○ Attorney General/Other Law Enforcement Agency	Optional	No Requirement
○ None of These	Prohibited	Prohibited

* 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 Help ?

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.

○ Query only the HIPDB for each query submitted.
○ 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 Help ?

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:	WER
Title or Department:	WERER
Telephone:	2342342342 Ext.

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.

Name:	NOUNOU
Title:	TESTER
Telephone:	3012111212 Ext. 111

CERTIFICATION Help ?

I certify that the entity identified above qualifies under law as specified in the ELIGIBILITY/STATUTORY AUTHORITY section and is eligible to perform the querying and/or reporting functions. I understand that the entity may be subject to sanctions under Federal statute for failure to report final adverse actions as required in the statutes and regulations or for the use of information obtained from the NPDB or the HIPDB other than the purposes for which it was provided. I further certify that I am authorized to submit this registration information to the NPDB-HIPDB and that the information provided is true, correct, and complete. If I become aware that any information in this form is not true, correct, or complete, I agree to notify the NPDB-HIPDB of this fact immediately. I understand that any omission, misrepresentation, or falsification of any information contained in this form or contained 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:	
Telephone:	Ext.
Certification Date (MMDDYYYY):	11072006

Submit to Data Bank(s)


Return to Administrator Options
End Session & Return to Login

Agent Registration Update

UPDATE AGENT PROFILE

National Practitioner Data Bank
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 click **Submit to Data Bank(s)**. Help ?

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 Correspondence Should be Sent:	mail@gmail.com

(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.

Name:	John Smith
Title:	Programmer
Telephone:	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: _____

Telephone: Ext.

Certification Date (MMDDYYYY): 11232006

Submit to Data Bank(s)

Return to Administrator Options | End Session & Return to Login

Entity Registration Renewal

RENEW ENTITY REGISTRATION

National Practitioner Data Bank
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.

Help ?

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.

ENTITY IDENTIFICATION INFORMATION Help ?

Name of Entity:	STATE BOARD OF MEDICAL EXAMINERS
Department or Office to Which Mail Should be Addressed:	
Street Address:	4350 FAIR LAKES COURT
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 Correspondence Should be Sent:	mail2me@gmail.com

(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):	777777777
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;
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
◉ Hospital**	Mandatory	Mandatory
○ Professional Society**	Optional	Mandatory
○ Other Health Care Entity**	Optional	Mandatory
○ Medical Malpractice Payer	Prohibited	Mandatory
○ None of These	Prohibited	Prohibited

* Includes Composite Boards for physicians or dentists and other health care practitioners.

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

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
○ State Health Care Entity Licensing Board	Optional	Mandatory
○ Quality Improvement Organization under Contract with the Centers for Medicare & Medicaid	Optional	Mandatory

Services (CMS)		
○ 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
○ State Agency Administering or Supervising the Administration of a State Health Care Program	Optional	No Requirement
○ State Medicaid Fraud Control Unit	Optional	No Requirement
○ Attorney General/Other Law Enforcement Agency	Optional	No Requirement
○ None of These	Prohibited	Prohibited

* 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 Help ?

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.
○ Query only the HIPDB for each query submitted.
○ 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 Help ?

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:	WER
Title or Department:	WERER
Telephone:	2342342342 Ext.

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.

Name:	NOUNOU
Title:	TESTER
Telephone:	3012111212 Ext. 111

CERTIFICATION Help ?

I certify that the entity identified above qualifies under law as specified in the ELIGIBILITY/STATUTORY AUTHORITY section and is eligible to perform the querying and/or reporting functions. I understand that the entity may be subject to sanctions under Federal statute for failure to report final adverse actions as required in the statutes and regulations or for the use of information obtained from the NPDB or the HIPDB other than the purposes for which it was provided. I further certify that I am authorized to submit this registration information to the NPDB-HIPDB and that the information provided is true, correct, and complete. If I become aware that any information in this form is not true, correct, or complete, I agree to notify the NPDB-HIPDB of this fact immediately. I understand that any omission, misrepresentation, or falsification of any information contained in this form or contained 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:	
Telephone:	Ext.
Certification Date (MMDDYYYY):	11072006

Submit to Data Bank(s)

Return to Previous Page

Agent Registration Renewal

UPDATE AGENT PROFILE

National Practitioner Data Bank
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 click **Submit to Data Bank(s)**. Help ?

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 Correspondence Should be Sent:	mail@gmail.com

(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.

Name:	John Smith
Title:	Programmer
Telephone:	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: _____

Telephone: Ext.

Certification Date (MMDDYYYY): 11232006

Submit to Data Bank(s)

Return to Administrator Options | End Session & Return to Login

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

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 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 INFORMATION

Help ?

Subject Name:

Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)

Other Names Used:

	Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
1.				
2.				
3.				
4.				
5.				

Gender: ○ Male ○ Female ○ Unknown

Birth Date (MMDDYYYY):

Work Organization Name:

Organization Type: CHOOSE ONE FROM LIST

Description (if 'Other' was selected above):

ADDRESSES

Click Help ? for information 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? ○ No ○ Unknown ○ Yes--Deceased Date (MMDDYYYY)

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN)

1. 2.
3. 4.

INDIVIDUAL TAXPAYER IDENTIFICATION NUMBERS (ITIN) (FORMAT 9NNNNNNNN)

1. 2.
3. 4.

FEDERAL EMPLOYER IDENTIFICATION NUMBERS (FEIN)

1. 2.
3. 4.

NATIONAL PROVIDER IDENTIFIERS (NPI)

1. [ ] 2. [ ]
3. [ ] 4. [ ]

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. [ ] 2. [ ]
3. [ ] 4. [ ]

UNIQUE PHYSICIAN IDENTIFICATION NUMBERS (UPIN)

1. [ ] 2. [ ]
3. [ ] 4. [ ]

PROFESSIONAL SCHOOLS ATTENDED	**YEAR OF GRADUATION** (Format YYYY)
1.	
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: [ ] 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 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

---

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 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

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 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):

ADVERSE ACTION INFORMATION 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:

- ○ Permanent
- ○ Indefinite/Unspecified
- ○ Specific Period
  - Years:
  - Months:
  - Days:

Is Reinstatement Automatic at Completion of Adverse Action Period? ○ Yes ○ No

Total Amount of Monetary Penalty, Assessment and/or Restitution or fine (Format NNNNN.NN):
Note: If no amount, leave this field blank.

$

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 ○ 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

Other Description (complete only if 'Other' is selected above):

3. CHOOSE ONE FROM THE LIST

Other Description (complete only if 'Other' is selected above):

4. CHOOSE ONE FROM THE LIST

Other Description (complete only if 'Other' is selected above):

5. CHOOSE ONE FROM THE LIST

Other Description (complete only if 'Other' is selected above):

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.

Authorized Submitter's Name:

Authorized Submitter's Title:

Authorized Submitter's Phone: Ext.

Date (MMDDYYYY): 02052007

☐ 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.

Help ?


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

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 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 INFORMATION

Help ?

Subject Name:

Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
2074	SUBJECT		

Other Names Used:

	Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
1.	DEVB	VERSION		
2.				
3.				
4.				
5.				

Gender: ○ Male ○ Female ◉ Unknown

Birth Date (MMDDYYYY): 10101910

Work Organization Name:

Organization Type: CHOOSE ONE FROM LIST

Description (if 'Other' was selected above):

ADDRESSES

Click Help ? for information 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? ○ No ◉ Unknown ○ Yes--Deceased Date (MMDDYYYY)

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN)

1. 666888777 2.
3. 4.

INDIVIDUAL TAXPAYER IDENTIFICATION NUMBERS (ITIN) (FORMAT 9NNNNNNNN)

1. 2.
3. 4.

FEDERAL EMPLOYER IDENTIFICATION NUMBERS (FEIN)

1. 2.
3. 4.

NATIONAL PROVIDER IDENTIFIERS (NPI)

1. 2.
3. 4.

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. 2.
3. 4.

UNIQUE PHYSICIAN IDENTIFICATION NUMBERS (UPIN)

1. 2.
3. 4.

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 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

---

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

---

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 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

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 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):

ADVERSE ACTION INFORMATION Help ?

Name of Agency or Program that Took the Adverse Action Specified in This Report: DEPT A

Date Action Was Taken (MMDDYYYY): 12022002

Date Action Became Effective (MMDDYYYY): 12022002

Length of Action:
- ○ Permanent ◉ Indefinite/Unspecified
- ○ Specific Period
  - Years:
  - Months:
  - Days:

Is Reinstatement Automatic at Completion of Adverse Action Period? ◉ Yes ○ No

Total Amount of Monetary Penalty, Assessment and/or Restitution or fine (Format NNNNN.NN):
Note: If no amount, leave this field blank.

$ 1.02

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.

LGKJOIJOIAJFIWUHFIUHVUI IUVHSIUHVNISHNVI

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 . 44 Default on Health Education Loan or Scholarship Obligations

Other Description (complete only if 'Other' is selected above):

2 . CHOOSE ONE FROM THE LIST

Other Description (complete only if 'Other' is selected above):

3 . CHOOSE ONE FROM THE LIST

Other Description (complete only if 'Other' is selected above):

4 . CHOOSE ONE FROM THE LIST

Other Description (complete only if 'Other' is selected above):

5 . CHOOSE ONE FROM THE LIST

Other Description (complete only if 'Other' is selected above):

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.

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

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

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 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 INFORMATION Help ?

Subject Name:

Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
Smith	John	M	

Other Name Used:

Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)

Gender: (•) Male ( ) Female ( ) Unknown

Birth Date (MMDDYYYY): 08241956

Work Organization Name: Medical Center of Virginia

ADDRESSES

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

Work Address

Street Address: 123 Department of Emergency Medicine

Address Line 2:

City: Woodbridge

State: VA Virginia

ZIP Code: 22191 -

Country (if U.S., leave blank):

Home Address/Address of Record

Street Address: 123 Somewhere Street

Address Line 2:

City: Woodbridge

State: VA Virginia

ZIP Code: 22191 -

Country (if U.S., leave blank):

Is Subject Deceased? (•) No ( ) Unknown ( ) Yes

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN): 050505050

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. BP7777777777
2.
3.
4.

PROFESSIONAL SCHOOLS ATTENDED	**YEAR OF GRADUATION** (Format YYYY)
1. VIRGINIA UNIV. SCHOOL OF MEDI	1989
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: 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

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

Description (complete only if 'Other' is selected above):

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):

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):

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):

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):

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):

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):

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):

ADVERSE ACTION INFORMATION

Type of Action Taken (select one):

○ Licensure ◉ Clinical Privileges ○ Society Membership

Action Classification: 630.10 Unprofessional Conduct

Date of the Action: 12161994

Length of Action: ○ Permanent ○ Indefinite
◉ Specific Period -- Months: 6 Days: 0

Effective Date: 12161994

Reporter's Description of Action:

DURING THIS SIX-MONTH PERIOD, DR. SMITH WILL BE REQUIRED TO UNDERGO PSYCHOTHERAPY.

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.

Authorized Submitter's Name: Susan Smith

Authorized Submitter's Title: Supervisor

Authorized Submitter's Phone: 7777777777 Ext.

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

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 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 INFORMATION

Help ?

Subject Name:

Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
SMITH	JOHN		

Other Names Used:

	Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
1.				
2.				
3.				
4.				
5.				

Gender: ○ Male ○ Female ◉ Unknown

Birth Date (MMDDYYYY): 10101955

Work Organization Name:

Organization Type: CHOOSE ONE FROM LIST

Description (if 'Other' was selected above):

ADDRESSES

Click Help ? for information 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? ○ No ◉ Unknown ○ Yes--Deceased Date (MMDDYYYY)

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN)

1. 223366998	2.
3.	4.

INDIVIDUAL TAXPAYER IDENTIFICATION NUMBERS (ITIN) (FORMAT 9NNNNNNNN)

1.	2.
3.	4.

FEDERAL EMPLOYER IDENTIFICATION NUMBERS (FEIN)

1.	2.
3.	4.

NATIONAL PROVIDER IDENTIFIERS (NPI)

1.		2.	
3.		4.	

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1.	AK556677	2.	
3.		4.	

UNIQUE PHYSICIAN IDENTIFICATION NUMBERS (UPIN)

1.		2.	
3.		4.	

PROFESSIONAL SCHOOLS ATTENDED	**YEAR OF GRADUATION** (Format YYYY)
1. UNIVERSITY	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: 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/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

---

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

---

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 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

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 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):

ADVERSE ACTION INFORMATION 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:

- ○ Permanent ○ Indefinite/Unspecified
- ○ Specific Period
  - Years:
  - Months:
  - Days:

Is Reinstatement Automatic at Completion of Adverse Action Period? ○ Yes ○ No

Total Amount of Monetary Penalty, Assessment and/or Restitution or fine (Format NNNNN.NN):
Note: If no amount, leave this field blank.

$

Is the Adverse Action Specified in This Report Based on the Subject's Professional Competence or Conduct, Which Adversely Affected, or Could Have Adversely Affected, the Health or Welfare of the Patient? ◉ Yes ○ No

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 ○ 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., 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.

Authorized Submitter's Name:

Authorized Submitter's Title:

Authorized Submitter's Phone: Ext.

Date (MMDDYYYY): 02052007

Submit to Data Bank(s) | Validate Without Submitting | Store as a Draft

Return to Options

Explicit Query

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

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.

SUBJECT INFORMATION Help ?

Subject Name:

Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)

Other Names Used:

	Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
1.				
2.				
3.				
4.				
5.				

Gender: ○ Male ○ Female ○ Unknown

Birth Date (MMDDYYYY):

PIN:

Work Organization Name:

Organization Type: CHOOSE ONE FROM LIST

Description (if 'Other' was selected above):

ADDRESSES

Click Help ? for information 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):

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN)

1. 2.
3. 4.

INDIVIDUAL TAXPAYER IDENTIFICATION NUMBERS (ITIN) (FORMAT 9NNNNNNNN)

1. 2.
3. 4.

FEDERAL EMPLOYER IDENTIFICATION NUMBERS (FEIN)

1. 2.
3. 4.

NATIONAL PROVIDER IDENTIFIERS (NPI)

1. 2.
3. 4.

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. 2.

3. 4.

UNIQUE PHYSICIAN IDENTIFICATION NUMBERS (UPIN)

1. 2.
3. 4.

PROFESSIONAL SCHOOLS ATTENDED	**YEAR OF GRADUATION** (Format YYYY)
1.	
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: 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

---

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

---

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

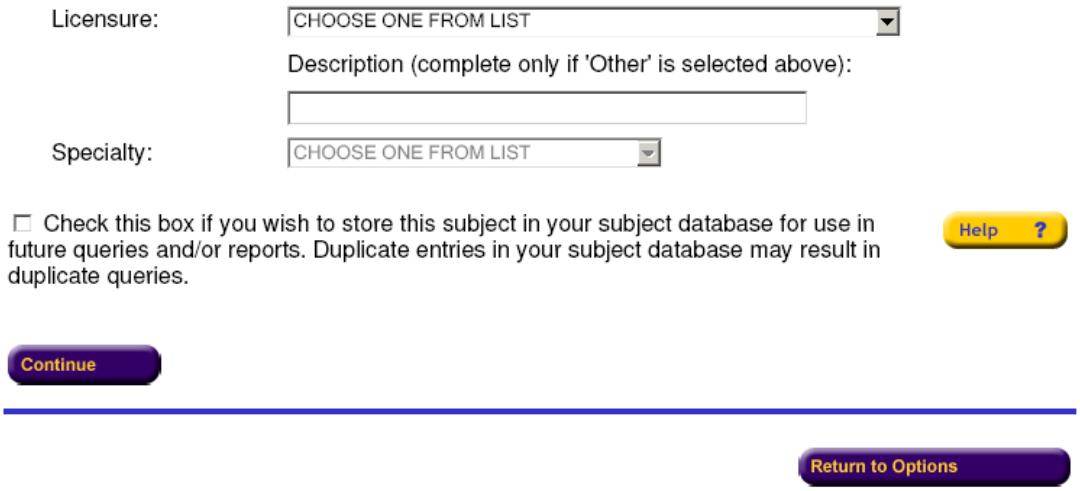
Additional State Licenses/Occupations

---

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 if 'Other' is selected above):
Specialty:
CHOOSE ONE FROM LIST
Check this box if you wish to store 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.
Help ?
Continue
Return to Options

Subject Database (individual)

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.

SUBJECT INFORMATION Help ?

Subject Name:

Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)

Other Names Used:

	Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
1.				
2.				
3.				
4.				
5.				

Gender: ○ Male ○ Female ○ Unknown

Birth Date (MMDDYYYY):

Work Organization Name:

Organization Type: CHOOSE ONE FROM LIST

Description (if 'Other' was selected above):

Department: CHOOSE ONE FROM LIST

ADDRESSES

Click Help ? for information 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? ○ No ○ Unknown ○ Yes--Deceased Date (MMDDYYYY)

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN)

1. 2.
3. 4.

INDIVIDUAL TAXPAYER IDENTIFICATION NUMBERS (ITIN) (FORMAT 9NNNNNNNN)

1. 2.
3. 4.

FEDERAL EMPLOYER IDENTIFICATION NUMBERS (FEIN)

1. 2.
3. 4.

NATIONAL PROVIDER IDENTIFIERS (NPI)

1. 2.
3. 4.

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. 2.
3. 4.

UNIQUE PHYSICIAN IDENTIFICATION NUMBERS (UPIN)

1. 2.
3. 4.

PROFESSIONAL SCHOOLS ATTENDED	**YEAR OF GRADUATION** (Format YYYY)
1.	
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: 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: ☐ 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: ☐ 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: ☐ 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: ☐ 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 if 'Other' is selected above):

Specialty: CHOOSE ONE FROM LIST

Validate Without Storing | Store

Return to Previous Page

Subject Database (organization)

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.

SUBJECT INFORMATION Help ?

Organization Name:

Other Organization Names Used:

1.
2.
3.
4.
5.

Click Help ? for information 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):

Department: CHOOSE ONE FROM LIST

FEDERAL EMPLOYER IDENTIFICATION NUMBERS (FEIN)

1. 2.

3. 4.

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN)

1. 2.
3. 4.

INDIVIDUAL TAXPAYER IDENTIFICATION NUMBERS (ITIN) (FORMAT 9NNNNNNNN)

1. 2.
3. 4.

PRINCIPAL OFFICERS AND OWNERS

	Last Name	First Name	Middle Name	Suffix (e.g., Jr., III)	Title
1.					
2.					
3.					
4.					
5.					

ORGANIZATION STATE LICENSURE INFORMATION

(If no State License, check the 'No License' box.)

1. State License Number: OR ☐ No License
   State of Licensure: CHOOSE ONE FROM LIST

2. State License Number: OR ☐ No License
   State of Licensure: CHOOSE ONE FROM LIST

3. State License Number: OR ☐ No License
   State of Licensure: CHOOSE ONE FROM LIST

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. [ ] 2. [ ]
3. [ ] 4. [ ]

CLINICAL LABORATORY IMPROVEMENT ACT (CLIA) NUMBERS

1. [ ] 2. [ ]
3. [ ] 4. [ ]
5. [ ] 6. [ ]

FEDERAL FOOD AND DRUG ADMINISTRATION (FDA) NUMBERS

1. [ ] 2. [ ]
3. [ ] 4. [ ]
5. [ ] 6. [ ]

NATIONAL PROVIDER IDENTIFIERS (NPI)

1. [ ] 2. [ ]
3. [ ] 4. [ ]

MEDICARE PROVIDER/SUPPLIER NUMBERS

1. [ ] 2. [ ]
3. [ ] 4. [ ]

Validate Without Storing | Store

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

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 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

Subject Name:

Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)

Other Names Used:

	Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
1.				
2.				
3.				
4.				
5.				

Gender: ○ Male ○ Female

Birth Date (MMDDYYYY):

Work Organization Name:

Organization Type: CHOOSE ONE FROM LIST

Description (if 'Other' was selected above):

HOME OR WORK ADDRESS Help ?

Enter the address (home or work) to which you would like your response sent:

Note: If specifying a work address, be sure to include the employer name in the first line of the address.

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

ZIP Code: -

Country (if U.S., leave blank):

Telephone: Ext.

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN) Help ?

1. 2.
3. 4.

INDIVIDUAL TAXPAYER IDENTIFICATION NUMBERS (ITIN) (FORMAT 9NNNNNNNN)

1. 2.

3. 4.

FEDERAL EMPLOYER IDENTIFICATION NUMBERS (FEIN)

1. 2.
3. 4.

NATIONAL PROVIDER IDENTIFIERS (NPI)

1. 2.
3. 4.

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. 2.
3. 4.

UNIQUE PHYSICIAN IDENTIFICATION NUMBERS (UPIN)

1. 2.
3. 4.

PROFESSIONAL SCHOOLS ATTENDED	YEAR OF GRADUATION (Format YYYY)
1.	
2.	
3.	
4.	
5.	

OCCUPATION AND STATE LICENSURE INFORMATION Help ?

(At least one licensure entry 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

---

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

---

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 if 'Other' is selected above):

Specialty: 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

☐ Check here if your credit card billing information is the same as the Subject Name and Home or Work Address entered above; otherwise, enter the billing information for this credit card below. This information is required to process 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):

☐ Continue without credit card information. **If you choose this option, be sure to write your credit card information on the formatted copy of your self-query, or your self-query will be rejected.**

To learn about how we keep your personal data secure, click here

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

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 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 Names Used:

1.

2.
3.
4.
5.

Click Help ? for information 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):

FEDERAL EMPLOYER IDENTIFICATION NUMBERS (FEIN)

1. 2.
3. 4.

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN)

1. 2.
3. 4.

INDIVIDUAL TAXPAYER IDENTIFICATION NUMBERS (ITIN) (FORMAT 9NNNNNNNN)

1. 2.
3. 4.

ORGANIZATION STATE LICENSURE INFORMATION

(If no State License, check the 'No License' box.)

1. State License Number: OR ☐ No License

State of Licensure: CHOOSE ONE FROM LIST

2. State License Number: _____ OR ☐ No License

State of Licensure: CHOOSE ONE FROM LIST

3. State License Number: _____ OR ☐ No License

State of Licensure: CHOOSE ONE FROM LIST

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. _____ 2. _____
3. _____ 4. _____

CLINICAL LABORATORY IMPROVEMENT ACT (CLIA) NUMBERS

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

FEDERAL FOOD AND DRUG ADMINISTRATION (FDA) NUMBERS

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

NATIONAL PROVIDER IDENTIFIERS (NPI)

1. _____ 2. _____
3. _____ 4. _____

MEDICARE PROVIDER/SUPPLIER NUMBERS

1. _____ 2. _____
3. _____ 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.

Credit Card Number:

Expiration Date: Month / Year

- Check here if your credit card billing information is the same as the Subject Name and Home or Work Address entered above; otherwise, enter the billing information for this credit card below. This information is required to process 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): [ ]

☐ Continue without credit card information. **If you choose this option, be sure to write your credit card information on the formatted copy of your self-query, or your self-query will be rejected.**

To learn about how we keep your personal data secure, click here

Continue

Return to 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.

Report Type:	**MEDICAL MALPRACTICE PAYMENT REPORT**
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 HRSA 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

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.

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

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 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 Help ?

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 Help ?

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 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):	11202006


Continue


Return to Report Response Options

Authorized Agent Designation

DESIGNATE AUTHORIZED AGENT

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

Help ?

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

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.

AGENT INFORMATION

Data Bank Identification Number (last 4 digits):
Agent Organization Name:
City:
State: CHOOSE ONE FROM LIST
ZIP Code: -
Country (if U.S., leave blank):

Allow Agent to:
☐ Query
☐ Report

Route Query/Report Responses to:
○ Agent
○ Entity

NOTE: Both the agent and the entity must have access to the Internet if the agent queries/reports via the Internet and the responses are sent to the entity.

☐ I give permission for this agent to charge to my EFT account.

NOTE: When an entity designates an authorized agent to query and/or report on behalf of the entity, the entity is ultimately responsible for payment (even if EFT charges are directed to that agent). Payment may also be made by credit card at the time of querying, regardless of EFT routing assignment.

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.

Name of Certifying Official:	
Title of Certifying Official:	
Telephone:	Ext.
Certification Date (MMDDYYYY):	03232006

Continue

Return to Administrator Options

Authorized Agent Designation (update)

DESIGNATE AUTHORIZED AGENT

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

Help ?

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:	AGENT SERVICES INC
Address:	123 ANYWHERE STREET
City, State, Zip	HOMETOWN, VA 22191

Allow Agent to:
- ☐ Query
- ☐ Report

Route Query/Report Responses to:
- ○ Agent
- ○ Entity

NOTE: Both the agent and the entity must have access to the Internet if the agent queries/reports via the Internet and the responses are sent to the entity.

☐ I give permission for this agent to charge to my EFT account.

NOTE: When an entity designates an authorized agent to query and/or report on behalf of the entity, the entity is ultimately responsible for payment (even if EFT charges are directed to that agent). Payment may also be made by credit card at the time of querying, regardless of EFT routing assignment.

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.

Name of Certifying Official: _____

Title of Certifying Official:

Telephone: Ext.

Certification Date (MMDDYYYY): 11232006

Continue

Return to Administrator Options

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 your responses to the number of characters, including spaces and punctuation, specified in parentheses for each field.

Help ?

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.

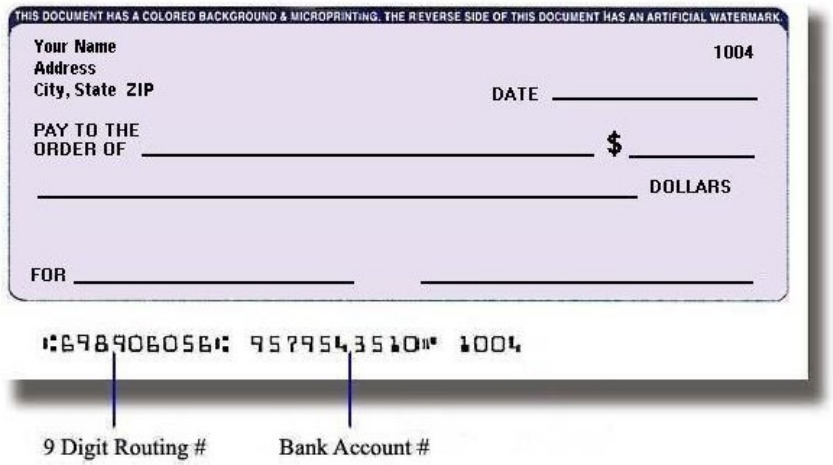
ACCOUNT INFORMATION

Bank Routing Number (9 digits): _____

Bank Account Number (max 17 digits): _____

Bank Account Type:
- ○ Checking
- ○ 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

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832, Chantilly, Virginia 20153-0832 • www.npdb-hipdb.hrsa.gov

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.

Data Bank Identification Number (DBID) (15): |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Telephone: Area Code (3) _____ Number (7) _____ Extension (5) _____

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:

_____

_____

_____

_____

Attach a copy of your credit card statement or EFT account statement and the charge receipt. Highlight the charge(s) that you 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.

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

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 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 INFORMATION

Help ?

Organization Name:

Other Organization Names Used:

1.
2.
3.
4.
5.

Click Help ? for information 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):

FEDERAL EMPLOYER IDENTIFICATION NUMBERS (FEIN)

1. 2.
3. 4.

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN)

1. 2.
3. 4.

PRINCIPAL OFFICERS AND OWNERS

	Last Name	First Name	Middle Name	Suffix (e.g., Jr., III)	Title
1.					
2.					
3.					
4.					
5.					

ORGANIZATION STATE LICENSURE INFORMATION

(If no State License, check the 'No License' box.)

1. State License Number: OR ☐ No License
   State of Licensure: CHOOSE ONE FROM LIST

2. State License Number: OR ☐ No License
   State of Licensure: CHOOSE ONE FROM LIST

3. State License Number: OR ☐ No License
   State of Licensure: CHOOSE ONE FROM LIST

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. 2.
3. 4.

CLINICAL LABORATORY IMPROVEMENT ACT (CLIA) NUMBERS

1. 2.
3. 4.
5. 6.

FEDERAL FOOD AND DRUG ADMINISTRATION (FDA) NUMBERS

1. 2.
3. 4.
5. 6.

NATIONAL PROVIDER IDENTIFIERS (NPI)

1. 2.
3. 4.

MEDICARE PROVIDER/SUPPLIER NUMBERS

1. 2.
3. 4.

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
   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 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):

ADVERSE ACTION INFORMATION 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:

- ○ Permanent
- ○ Indefinite/Unspecified
- ○ Specific Period
  - Years:
  - Months:
  - Days:

Is Reinstatement Automatic at Completion of Adverse Action Period? ○ Yes ○ No

Total Amount of Monetary Penalty, Assessment and/or Restitution or fine (Format NNNNN.NN):
Note: If no amount, leave this field blank.
$

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 ○ 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

Other Description (complete only if 'Other' is selected above):

3 . CHOOSE ONE FROM THE LIST

Other Description (complete only if 'Other' is selected above):

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.

Authorized Submitter's Name:

Authorized Submitter's Title:

Authorized Submitter's Phone: Ext.

Date (MMDDYYYY): 12062005

☐ 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

Help ?

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

Submit to Data Bank(s) | Validate Without Submitting | Store as a Draft

Return to Options

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

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 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 INFORMATION

Help ?

Organization Name: ORGNAME

Other Organization Names Used:

1.
2.
3.
4.
5.

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

Street Address:	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):

FEDERAL EMPLOYER IDENTIFICATION NUMBERS (FEIN)

1.	452353563	2.	
3.		4.	

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN)

1.		2.	
3.		4.	

PRINCIPAL OFFICERS AND OWNERS

	Last Name	First Name	Middle Name	Suffix (e.g., Jr., III)	Title
1.					
2.					
3.					
4.					
5.					

ORGANIZATION STATE LICENSURE INFORMATION

(If no State License, check the 'No License' box.)

1. State License Number: ASDF2345235 OR ☐ No License
   State of Licensure: DC District of Columbia

2. State License Number: OR ☐ No License
   State of Licensure: CHOOSE ONE FROM LIST

3. State License Number: OR ☐ No License
   State of Licensure: CHOOSE ONE FROM LIST

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. 2.
3. 4.

CLINICAL LABORATORY IMPROVEMENT ACT (CLIA) NUMBERS

1. 2.
3. 4.
5. 6.

FEDERAL FOOD AND DRUG ADMINISTRATION (FDA) NUMBERS

1. 2.
3. 4.
5. 6.

NATIONAL PROVIDER IDENTIFIERS (NPI)

1. 2.
3. 4.

MEDICARE PROVIDER/SUPPLIER NUMBERS

1. 2.
3. 4.

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

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 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):

ADVERSE ACTION INFORMATION Help ?

Name of Agency or Program that Took the Adverse Action Specified in This Report: AGENCY2
Date Action Was Taken (MMDDYYYY): 10102006
Date Action Became Effective (MMDDYYYY): 10102006
Length of Action: (•) Permanent ( ) Indefinite/Unspecified ( ) Specific Period
Years:
Months:
Days:

Is Reinstatement Automatic at Completion of Adverse Action Period? (•) Yes ( ) No
Total Amount of Monetary Penalty, Assessment and/or Restitution or fine (Format NNNNN.NN):
Note: If no amount, leave this field blank.
$2500.00

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.

TEST

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 . 91 Noncompliance With Private Accreditation Standards

Other Description (complete only if 'Other' is selected above):

2 . CHOOSE ONE FROM THE LIST

Other Description (complete only if 'Other' is selected above):

3 . CHOOSE ONE FROM THE LIST

Other Description (complete only if 'Other' is selected above):

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.

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

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 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 INFORMATION

Help ?

Organization Name: ORGNAME

Other Organization Names Used:

1.
2.
3.
4.
5.

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

Street Address: 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):

FEDERAL EMPLOYER IDENTIFICATION NUMBERS (FEIN)

1. 452353563 2.
3. 4.

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN)

1. 2.
3. 4.

PRINCIPAL OFFICERS AND OWNERS

	Last Name	First Name	Middle Name	Suffix (e.g., Jr., III)	Title
1.					
2.					
3.					
4.					
5.					

ORGANIZATION STATE LICENSURE INFORMATION

(If no State License, check the 'No License' box.)

1. State License Number: ASDF2345235 OR ☐ No License
   State of Licensure: DC District of Columbia

2. State License Number: OR ☐ No License
   State of Licensure: CHOOSE ONE FROM LIST

3. State License Number: OR ☐ No License
   State of Licensure: CHOOSE ONE FROM LIST

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. 2.

3. 4.

CLINICAL LABORATORY IMPROVEMENT ACT (CLIA) NUMBERS

1. 2.
3. 4.
5. 6.

FEDERAL FOOD AND DRUG ADMINISTRATION (FDA) NUMBERS

1. 2.
3. 4.
5. 6.

NATIONAL PROVIDER IDENTIFIERS (NPI)

1. 2.
3. 4.

MEDICARE PROVIDER/SUPPLIER NUMBERS

1. 2.
3. 4.

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 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

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 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):

ADVERSE ACTION INFORMATION 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:

- Permanent
- Indefinite/Unspecified
- Specific Period

Years:

Months:

Days:

Is Reinstatement Automatic at Completion of Adverse Action Period? Yes No

Total Amount of Monetary Penalty, Assessment and/or Restitution or fine (Format NNNNN.NN):
Note: If no amount, leave this field blank.

$

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 ○ 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., 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.

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

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

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 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 INFORMATION

Help ?

Subject Name:

Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)

Other Names Used:

	Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
1.				
2.				
3.				
4.				
5.				

Gender: ○ Male ○ Female ○ Unknown

Birth Date (MMDDYYYY):

Work Organization Name:

Organization Type: CHOOSE ONE FROM LIST

Description (if 'Other' was selected above):

ADDRESSES

Click Help ? for information 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? ○ No ○ Unknown ○ Yes--Deceased Date (MMDDYYYY)

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN)

1. 2.
3. 4.

FEDERAL EMPLOYER IDENTIFICATION NUMBERS (FEIN)

1. 2.
3. 4.

NATIONAL PROVIDER IDENTIFIERS (NPI)

1. 2.
3. 4.

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. 2.

3. [ ] 4. [ ]

UNIQUE PHYSICIAN IDENTIFICATION NUMBERS (UPIN)

1. [ ] 2. [ ]
3. [ ] 4. [ ]

PROFESSIONAL SCHOOLS ATTENDED	**YEAR OF GRADUATION** (Format YYYY)
1.	
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: [ ] 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

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 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

---

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 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

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 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 ?

Name of Agency or Program that Authorized the Quality Improvement Review :

Type of Negative Finding:

- ☐ 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):

Description of Finding:
Note: Do not reference any personal identification information (e.g., names) of anyone other than the subje
of this report.

BASIS FOR FINDING

1 . 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):

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.

Authorized Submitter's Name:

Authorized Submitter's Title:

Authorized Submitter's Phone: Ext.

Date (MMDDYYYY): 12062005

☐ 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.

Help ?

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

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 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 INFORMATION Help ?

Subject Name:

Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
SMITH	JOHN		

Other Names Used:

	Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
1.				
2.				
3.				
4.				
5.				

Gender: (•) Male ( ) Female ( ) Unknown

Birth Date (MMDDYYYY): 10101966

Work Organization Name: MEDICAL CENTER MD

Organization Type: 361 Chiropractic Group/Practice

Description (if 'Other' was selected above):

ADDRESSES

Click Help ? for information 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 ○ Unknown ○ Yes--Deceased Date (MMDDYYYY)

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN)

1. 433252342	2.
3.	4.

FEDERAL EMPLOYER IDENTIFICATION NUMBERS (FEIN)

1.	2.
3.	4.

NATIONAL PROVIDER IDENTIFIERS (NPI)

1.	2.
3.	4.

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. [ ] 2. [ ]
3. [ ] 4. [ ]

UNIQUE PHYSICIAN IDENTIFICATION NUMBERS (UPIN)

1. [ ] 2. [ ]
3. [ ] 4. [ ]

PROFESSIONAL SCHOOLS ATTENDED	YEAR OF GRADUATION (Format YYYY)
1. MASON	2006
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: 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/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

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

---

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 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

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 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 ?

Name of Agency or Program that Authorized the Quality Improvement Review : AGENCY2

Type of Negative Finding:

- [x] 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 personal identification information (e.g., names) of anyone other than the subject of this report.

TEST

BASIS FOR FINDING

1 . FD Gross or Flagrant Violation Presenting Imminent Danger to the Health, Safety or Well-Being of Patient or

Other Description (complete only if 'Other' is selected above):

2 . CHOOSE ONE FROM THE LIST

Other Description (complete only if 'Other' is selected above):

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.

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

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

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 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 INFORMATION

Help ?

Subject Name:

Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
SMITH	JOHN		

Other Names Used:

	Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
1.				
2.				
3.				
4.				
5.				

Gender: (•) Male ( ) Female ( ) Unknown

Birth Date (MMDDYYYY): 10101966

Work Organization Name: MEDICAL CENTER MD

Organization Type: 361 Chiropractic Group/Practice

Description (if 'Other' was selected above):

ADDRESSES

Click Help ? for information 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 ○ Unknown ○ Yes--Deceased Date (MMDDYYYY)

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN)

1. 433252342	2.
3.	4.

FEDERAL EMPLOYER IDENTIFICATION NUMBERS (FEIN)

1.	2.
3.	4.

NATIONAL PROVIDER IDENTIFIERS (NPI)

1.	2.
3.	4.

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. 2.
3. 4.

UNIQUE PHYSICIAN IDENTIFICATION NUMBERS (UPIN)

1. 2.
3. 4.

PROFESSIONAL SCHOOLS ATTENDED	YEAR OF GRADUATION (Format YYYY)
1. MASON	2006
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: 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/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

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

---

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 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

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 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 ?

Name of Agency or Program that Authorized the Quality Improvement Review :

Type of Negative Finding:

- ☐ 1840 - Withdrawal of Recommendation to Sanction from Participating in Medicare, Medicaid
- ☐ 1841 - Withdrawal of Recommendation to Exclude from Participating in Medicare, Medicaid

Date of Finding (MMDDYYYY):

Description of Finding:
Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

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.

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