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 10/31/10
OMB # 0915-0126 expiration date 07/31/10
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 are 0915-0239 (HIPDB), 0915-0126 (NPDB) and 0915-xxxx (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):

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 your account has been deactivated, do not complete this form. Call the Customer Service Center to request a new password.

If you **received a notice to renew your registration, do not complete this form.** Your Entity Data Bank Administrator must log in to the IQRS to renew your entity's registration.

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	No Requirement
○ Peer Review Organization	Prohibited	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 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.

- ○ **Hospitals [100-109]**
- ○ **Other Health Care Service Providers [120-169]**
- ○ **Health Plans or Health Insurance Companies [200-259]**
- ○ **Licensing Agencies [300-349]**
- ○ **Survey and Certification Agencies [350]**
- ○ **Professional Societies [400-409]**
- ○ **Malpractice Payers [500-519]**
- ○ **Law Enforcement Agencies [600-629]**
- ○ **Government Health Care Program Administration [650-689]**
- ○ **Utilization and Quality Control Peer Review Organizations [700-710]**
- ○ **Private Accreditation Organizations [800]**

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). 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, Telephone, and E-mail Address information below.

Name:

Title:

Telephone: Ext.

E-mail Address to Which Correspondence Should be Sent:

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

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): 07162009

Continue

Return to NPDB-HIPDB Home Page

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 10/31/10
OMB # 0915-0126 expiration date 07/31/10

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):

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, Telephone, and E-mail Address information below.

Name:

Title:

Telephone: Ext.

E-mail Address to Which Correspondence Should be Sent:

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

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): 01042008

Continue

Return to NPDB-HIPDB Home Page

UPDATE ENTITY PROFILE

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

Entity: TEST ENTITY (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 10/31/10
OMB # 0915-0126 expiration date 07/31/10
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 are 0915-0239 (HIPDB), 0915-0126 (NPDB) and 0915-xxxx (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:	TEST ENTITY
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):	
Department Fax Number:	
Taxpayer Identification Number (TIN):	777777772
National Crime Information Center Originating Agency Identifier (ORI) (For law enforcement only):	VA3254345
Ownership of the Entity:	Federal Government Agency
If Federal, Specify Department:	Centers for Medicare & Medicaid Services

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	No Requirement

○ Peer Review Organization	Prohibited	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 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.

◉ **Hospitals [100-109]**

- ○ General/Acute Care Hospital (100)
- ◉ Children's Hospital (101)
- ○ Psychiatric Hospital (102)
- ○ Rehabilitation Hospital (103)
- ○ Long Term Care Hospital (104)
- ○ Specialty Hospital (105)
- ○ Critical Access Hospital (106)

○ Other Hospital, Specify (109)

- ○ **Other Health Care Service Providers [120-169]**
- ○ **Health Plans or Health Insurance Companies [200-259]**
- ○ **Licensing Agencies [300-349]**
- ○ **Survey and Certification Agencies [350]**
- ○ **Professional Societies [400-409]**
- ○ **Malpractice Payers [500-519]**
- ○ **Law Enforcement Agencies [600-629]**
- ○ **Government Health Care Program Administration [650-689]**
- ○ **Utilization and Quality Control Peer Review Organizations [700-710]**
- ○ **Private Accreditation Organizations [800]**

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). 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:	JACK SMITH
Title or Department:	DIRECTOR
Telephone:	7035552323 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, Telephone, and E-mail Address information below.

Name:	JANE SMITH
Title:	ADMINISTRATOR

Telephone:	7035554545	Ext.	111
E-mail Address to Which Correspondence Should be Sent:	Test_001@deve-npdb-hipdb.sra.com		

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

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:	TEST		
Title of Certifying Official:	TEST		
Telephone:	239872948274928	Ext.	
Certification Date (MMDDYYYY):	07132009		

Submit to Data Bank(s)

Return to Administrator Options | Log Out

UPDATE AGENT PROFILE

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

Entity: HR TEST, INC (ARLINGTON, 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 10/31/10
OMB # 0915-0126 expiration date 07/31/10

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:	HR TEST, INC
Department or Office to Which Mail Should be Addressed:	
Street Address:	123 WEST OX DR
Address Line 2:	
City:	ARLINGTON
State:	VA Virginia
ZIP Code:	22011 -
Country (if U.S., leave blank):	
Department Fax Number:	
Taxpayer Identification Number (TIN):	123456789

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, Telephone, and E-mail Address information below.

Name:	SIMON TEST2
Title:	ACCOUNT ASSISTANT
Telephone:	7032222222 Ext.
E-mail Address to Which Correspondence Should be Sent:	test123@sra.com

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

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): 01042008

Submit to Data Bank(s)

Return to Administrator Options | Log Out

RENEW ENTITY REGISTRATION

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

Entity: TEST ENTITY (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 10/31/10
OMB # 0915-0126 expiration date 07/31/10

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:	TEST ENTITY
Department or Office to Which Mail Should be Addressed:	
Street Address:	4350 FAIRLAKES COURT
Address Line 2:	
City:	FAIRFAX
State:	VA Virginia
ZIP Code:	22033 -
Country (if U.S., leave blank):	
Department Fax Number:	
Taxpayer Identification Number (TIN):	234123451
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	No Requirement
○ Peer Review Organization	Prohibited	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:	POC NAME
Title or Department:	POC TITLE
Telephone:	2341234123 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, Telephone, and E-mail Address information below.

Name:	ADMIN NAME
Title:	ADMINISTRATOR
Telephone:	2412341243 Ext.
E-mail Address to Which Correspondence Should be Sent:	admin@test.com

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

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):	01072008

Submit to Data Bank(s)

Return to Previous Page | Log Out

RENEW AGENT REGISTRATION

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

Entity: TEST AGENT (FAIRFAX, VA)

Complete this form to renew your registration as an authorized agent to query and/or report to the NPDB, the HIPDB, or both, on behalf of eligible, registered entities. Help ?

After completing this form, you must print the Agent 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.

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 renewal.

OMB # 0915-0239 expiration date 10/31/10
OMB # 0915-0126 expiration date 07/31/10

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 IDENTIFICATION INFORMATION

Agent Organization Name:	TEST AGENT
Department or Office to Which Mail Should be Addressed:	
Street Address:	4350 FAIRLAKES CT
Address Line 2:	
City:	FAIRFAX
State:	VA Virginia
ZIP Code:	22033 -
Country (if U.S., leave blank):	
Department Fax Number:	
Taxpayer Identification Number (TIN):	324124124

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, Telephone, and E-mail Address information below.

Name:	ADMIN NAME
Title:	ADMINISTRATOR
Telephone:	2341234123 Ext.
E-mail Address to Which Correspondence Should be Sent:	admin@agent.com

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

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):	01072008

Submit to Data Bank(s)

Return to Previous Page | Log Out

STATE 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 10/31/10
OMB # 0915-0126 expiration date 07/31/10

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 and First Name Required):

	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

The form will suggest medical schools as you type. Please choose the matching school or enter the complete school name.

	School Name:	Year of Graduation (Format YYYY):
1.		
2.		
3.		
4.		
5.		

OCCUPATION AND STATE LICENSURE INFORMATION

(Provide at least one license. Check **'No License'** if the subject does not have a State License Number. Use the **Add Additional License/Occupation** button to provide more than one license. Up to 60 licenses may be provided.)

---

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

Add Additional License/Occupation

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):

Add Additional Affiliate

ADVERSE ACTION INFORMATION Help ?

BASIS FOR ACTION

Select a category and then choose a basis for action code that best describes the reason for the action. Click **Add Additional Basis For Action** to provide up to 5 basis for action selections. View a complete basis for action list.

1.
- **Non-Compliance With Requirements**
- **Criminal Conviction or Adjudication**
- **Confidentiality, Consent or Disclosure Violations**
- **Misconduct or Abuse**
- **Fraud, Deception, or Misrepresentation**
- **Unsafe Practice or Substandard Care**
- **Improper Supervision or Allowing Unlicensed Practice**
- **Improper Prescribing, Dispensing, Administering Medication/Drug Violation**
- **Other**

Add Additional Basis for Action

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
- Yes, with conditions (requires a Revision to Action Report when status changes)
- 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 Subject's Act(s) or Omission(s) or Other Reasons for Action(s) Taken and Description of Action(s) Taken by Reporting Entity

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report. The description must include sufficient specificity to enable a knowledgeable reviewer to determine clearly the circumstances of the action(s) or surrender. Refer to the Fact Sheet on Submitting a Factually Sufficient Narrative Description for detailed information.

There are **4000** characters remaining for the description.

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: TEST 333333333333333

Authorized Submitter's Title:

Authorized Submitter's Phone: Ext.

Date: 08/25/2009

☐ 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 | Log Out

STATE LICENSURE

Report Correction

To submit a **correction** to previously submitted report DCN 7910000057666471, 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 10/31/10
OMB # 0915-0126 expiration date 07/31/10

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)

Other Names Used (Last Name and First Name Required):

	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. 000000000 Undo 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

The form will suggest medical schools as you type. Please choose the matching school or enter the complete school name.

	School Name:	Year of Graduation (Format YYYY):
1.		
2.		
3.		
4.		
5.		

OCCUPATION AND STATE LICENSURE INFORMATION
(Provide at least one license. Check **'No License'** if the subject does not have a State License Number. Use the **Add Additional License/Occupation** button to provide more than one license. Up to 60 licenses may be provided.)

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

Add Additional License/Occupation

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):

Add Additional Affiliate

ADVERSE ACTION INFORMATION

Help ?

BASIS FOR ACTION

Select a category and then choose a basis for action code that best describes the reason for the action. Click **Add Additional Basis For Action** to provide up to 5 basis for action selections. View a complete basis for action list.

1.
- Non-Compliance With Requirements
- **Criminal Conviction or Adjudication**
- **Confidentiality, Consent or Disclosure Violations**
- **Misconduct or Abuse**
- **Fraud, Deception, or Misrepresentation**
- **Unsafe Practice or Substandard Care**
- **Improper Supervision or Allowing Unlicensed Practice**
- **Improper Prescribing, Dispensing, Administering Medication/Drug Violation**
- **Other**

○ Other - Not Classified, Specify (99)

Add Additional Basis for Action

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

○ Yes, with conditions (requires a Revision to Action Report when status changes)

◉ 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 Subject's Act(s) or Omission(s) or Other Reasons for Action(s) Taken and Description of Action(s) Taken by Reporting Entity

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report. The description must include sufficient specificity to enable a knowledgeable reviewer to determine clearly the circumstances of the action(s) or surrender. Refer to the Fact Sheet on Submitting a Factually Sufficient Narrative Description for detailed information.

There are **4000** characters remaining for the description.

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: 10/19/2009

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

Return to Options | Log Out

Adverse Action Report Legacy

Report Correction

To submit a **correction** to previously submitted report DCN 5500000056940157, 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 10/31/10
OMB # 0915-0126 expiration date 07/31/10

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)
MOUSE	MARY		

Other Name Used:

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

Gender: ○ Male ◉ Female ○ Unknown

Birth Date (MMDDYYYY): 07071977

Work Organization Name:

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:	ALEXANDRIA
State:	VA Virginia
ZIP Code:	22222 -
Country (if U.S., leave blank):	

Home Address/Address of Record

Street Address:	222 MAPLE ST.
Address Line 2:	
City:	ALEXANDRIA
State:	VA Virginia
ZIP Code:	22222 -
Country (if U.S., leave blank):	

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

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN): 222222222

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. 2.
3. 4.

PROFESSIONAL SCHOOLS ATTENDED

School Name:	Year of Graduation (Format YYYY):
1. MICKEY UNIVERSITY	2000
2.	
3.	
4.	
5.	

OCCUPATION AND STATE LICENSURE INFORMATION

(Provide at least one license. Check **'No License'** if the subject does not have a State License Number. Use the **Add Additional License/Occupation** button to provide more than one license. Up to 60 licenses may be provided.)

---

1. State License Number: 123ABC OR ☐ No License

   State of Licensure: VA Virginia

   Occupation/Field of Licensure: 100 Registered (Professional) Nurse

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

---

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):

Add Additional License/Occupation

ADVERSE ACTION INFORMATION

Type of Action Taken (select one):

◉ Licensure ○ Clinical Privileges ○ Society Membership

Action Classification: 320.00 Mental Disorder

Date of the Action: 08212009

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

Effective Date: 08212009

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

Reporter's Description of Action

There are **3968** characters remaining for the description.

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): ER1234

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: TEST 333333333333333

Authorized Submitter's Title: TESTER

Authorized Submitter's Phone: 1234567890 Ext.

Date: 08/26/2009

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

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Return to Options | Log Out

STATE LICENSURE

Revision to Action

To submit a **revision to action** on previously submitted report DCN 7910000057666471, 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 10/31/10
OMB # 0915-0126 expiration date 07/31/10

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)

Other Names Used (Last Name and First Name Required):

	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. 000000000 Undo 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

School Name:	Year of Graduation (Format YYYY):
1.	
2.	
3.	
4.	
5.	

OCCUPATION AND STATE LICENSURE INFORMATION

(Provide at least one license. Check **'No License'** if the subject does not have a State License Number. Use the **Add Additional License/Occupation** button to provide more than one license. Up to 60

licenses may be provided.)

1. State License Number: OR No License

State of Licensure: CHOOSE ONE FROM LIST

Occupation/Field of Licensure: 603 Chiropractor

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

Specialty: CHOOSE ONE FROM LIST

Add Additional License/Occupation

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):

Add Additional Affiliate

ADVERSE ACTION INFORMATION

Help ?

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

Date Action Was Taken (MMDDYYYY): **Note:** Date must be on or after Date Action Was Taken of related report (03/03/2003).

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
- Yes, with conditions (requires a Revision to Action Report when status changes)

○ 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 Subject's Act(s) or Omission(s) or Other Reasons for Action(s) Taken and Description of Action(s) Taken by Reporting Entity

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report. The description must include sufficient specificity to enable a knowledgeable reviewer to determine clearly the circumstances of the action(s) or surrender. Refer to the Fact Sheet on Submitting a Factually Sufficient Narrative Description for detailed information.

There are **4000** characters remaining for the description.

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: 10/19/2009

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

Return to Options Log Out