To submit a query, enter all known subject data. Explicit Query (Individual)

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.

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):

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

	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: CHOOSE ONE FROM LIST

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

Specialty: CHOOSE ONE FROM LIST

Add Additional License/Occupation

☐ 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 Log Out

To submit a query, enter all known subject data. Explicit Query (Organization)

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.

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.

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 Log Out

Subject Database (Individual)

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

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.				

ENTITY SUBJECT IDENTIFICATION NUMBER

This optional field allows your entity to include a unique number or other reference information to help you identify this subject. This information is not used by the Data Banks.

Subject ID: (e.g., employee number)

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

	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: CHOOSE ONE FROM LIST

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

   Specialty: CHOOSE ONE FROM LIST

Add Additional License/Occupation

Validate Without Storing | Store

Return to Previous Page | Log Out

Subject Database (Organization)

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.

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

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 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 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 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

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

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

OCCUPATION AND STATE LICENSURE INFORMATION Help ?

(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: CHOOSE ONE FROM LIST

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

Specialty: CHOOSE ONE FROM LIST

Add Additional License/Occupation

Continue

Return to Previous Page

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 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 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 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 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.

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 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:	11/18/2009

Continue

Return to Previous Page

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: **STATE LICENSURE ACTION**
Report Number: **7930000059491279**
Subject's Name: **PAUL, GEORGE**
Report Maintained Under: **[ ] Title IV (NPDB)**
[X] Section 1921 (NPDB)
[X] Section 1128E (HIPDB)

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 **4,000 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 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 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

There are **4000** characters remaining for the 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.) The report will remain in disputed status until either you take action to elevate the report for Secretarial Review or you withdraw the report from disputed status.

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 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.

The referenced report is currently NOT in disputed status.

☐ Check here if you wish to place the referenced report in disputed status. If you wish to add a statement to the report only and do not wish to place the report in disputed status then do not check the box.

CURRENT ADDRESSES Help ?

Future correspondence from the Data Bank(s) will be mailed to the address specified. **Note:** If you provide both your home and work addresses, the Data Bank(s) will send correspondence to your home address. You may update the addresses that the Data Bank(s) have on file below. However, this does

not change your addresses as reflected in the report filed with the Data Bank(s). Only the entity that originally submitted the report can modify or correct information provided in the report. You should contact the entity identified in Section A of the report and request that it make the address correction.

Home Address/Address of Record

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

ZIP Code: -

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

Work Address

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

ZIP Code: -

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

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):

Submit to Data Bank(s)

Return to Report Response Options | Log Out

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 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 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:	**7930000059491279**
Subject's Name:	**PAUL, GEORGE**
Report Maintained Under:	**[ ] Title IV (NPDB)**
	[X] Section 1921 (NPDB)
	[X] Section 1128E (HIPDB)

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.

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 **4,000 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.

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

- ○ 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.

CURRENT ADDRESSES Help ?

Future correspondence from the Data Bank(s) will be mailed to the address specified. **Note:** If you provide both your home and work addresses, the Data Bank(s) will send correspondence to your home address. You may update the addresses that the Data Bank(s) have on file below. However, this does

not change your addresses as reflected in the report filed with the Data Bank(s). Only the entity that originally submitted the report can modify or correct information provided in the report. You should contact the entity identified in Section A of the report and request that it make the address correction.

Home Address/Address of Record

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

ZIP Code: -

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

Work Address

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

ZIP Code: -

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

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):

Continue

Return to Report Response Options | Log Out

DESIGNATE AUTHORIZED AGENT

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

Entity: TEST ENTITY (FAIRFAX, VA)

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 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 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):

CONFIGURATION

I authorize my agent to submit the following transactions on my behalf:

- ☐ Query
- ☐ Report
- ☐ Proactive Disclosure Service (PDS)

I authorize my agent to use my entity's EFT account to pay for queries submitted on my entity's behalf:
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.

- ○ Yes

- ○ No

Route responses to my agent's submission to:

- ○ Only my entity
- ○ Only my agent
- ○ Both my entity and my agent

Return responses to my entity via:

- ○ IQRS
- ○ ITP
- ○ QRXS

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):	03282008

Continue

Return to Administrator Options | Log Out

DESIGNATE AUTHORIZED AGENT

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

Entity: TEST ENTITY (FAIRFAX, VA)

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 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 INFORMATION

Agent Organization Name:	TEST AGENT
Address:	123 MAPLE STREET
City, State, Zip	FAIRFAX, VA 22033

CONFIGURATION

I authorize my agent to submit the following transactions on my behalf:

- [x] Query
- [x] Report
- [ ] Proactive Disclosure Service (PDS)

I authorize my agent to use my entity's EFT account to pay for queries submitted on my entity's behalf:
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.

- (•) Yes
- ( ) No

Route responses to my agent's submission to:

- ( ) Only my entity
- ( ) Only my agent
- (•) Both my entity and my agent

Return responses to my entity via:

- (•) IQRS

- ITP
- QRXS

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):	03282008

Continue

Return to Administrator Options | Log Out

EFT AUTHORIZATION

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

Help ?

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.

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.

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): 11182008

Submit to Data Bank(s)

Return to Administrator Options | Log Out

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

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 *help@npdb-hipdb.hrsa.gov* 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.