

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 05/31/14

OMB # 0915-0126 expiration date 12/31/13

OMB # 0915-0331 expiration date 12/31/13

<u>Public Burden Statement:</u> An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239, 0915-0126 and 0915-0331. 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.

PRACTITIONER INFORMATION



Personal Information	n			
Practitioner Name				
Last Name	First Name	Middle Name	Suffix (Jr, III)	
SMITH	JOHN			
Add another nam	<u>e used</u>			
Gender				
Gender © Male © Fema	le © Unknown			
	le ○ Unknown			
○ Male ○ Fema				
○ Male ○ Fema				
○ Male ○ Fema				
© Male © Fema	YYYY)			
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Home Address/Address of Record		
Home Address/Address of Record		
Chroat Address.		
Street Address:		

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Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	
Country:	
(if U.S., leave blar	ık) ^L
Work Information ☐ Check here if the property of the propert	actitioner's work information is the same as your organization.
Organization	
Name:	
Type:	CHOOSE ONE FROM LIST
Click Help ? for	information on filling out non-U.S. and military addresses.
Address	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	-
Country: (if U.S., leave blar	nk)
Social Security Num	phore (SSN)
Oocial Security Num	
Add another SSN	
Individual Taxpaver	Identification Numbers (ITIN)
	• •
Add another ITIN	
Federal Employer Id	lentification Numbers (FEIN)

Add another FEIN			
National Provider Ide	entifiers (NPI)		
	, ,		
Add another NPI			
Drug Enforcement A	dministration (DEA) Numbers		
Add another DEA	Number		
			1
Unique Physician Ide	entification Numbers (UPIN)		
Add another UPIN			
Professional Schools	s Attended		
	chools as you type. Please choo	se the ma	tching school or enter the
complete school name.			Year of
School Name:			Graduation (YYYY)
Add another Profes	ssional School		
Occupation And Stat	e Licensure Information		
	ense. Check 'No License' if the		
Up to 60 licenses may l	Additional License/Occupation be provided.)	i bullon lo	provide more than one license.
•			
 State License Number: 		OR	☐ No License
State of Licensure:	CHOOSE ONE EDOM LIST		
Occupation/Field of			
Licensure:	Physician (MD)		
Specialty:	CHOOSE ONE FROM LIST		_
Add Additional Lice	,	_	

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. Name of Affiliated/Associate Health Care Entity:		
Address 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: Add another Affiliat	CHOOSE ONE FROM LIST	V



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. O 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

Clear

Adverse Action Information	
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	
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	
Is the Action on Appeal?	
○ Yes	
O No	
© Unknown	
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 Reporting, Submitting a Factually-Sufficient Narrative, for detailed information.	

There are 4000 characters rem	naining for the description.
Spell Check	
Entity Internal Report Reference	
information to help you identify	entity to include an internal file number or other reference this report in your files. This information is not used by the ed on copies of the report sent to queriers.
Entity Internal Report	
Reference: (e.g., claim number)	
Customer Use	
	by the submitter to identify this transaction. This information is
returned without modification a Customer Use:	nd only appears on the response returned to your organization.
Certification	submit this transaction and that all information is true and
correct to the best of my knowle	
Authorized Submitter's Name:	TEST 33333333333333
Authorized Submitter's Title:	
Authorized Submitter's Phone:	Ext.
Date:	11/30/2012

☐ Check this box if you wish to add/update this subject in your subject database for use in future queries and/or reports. Duplicate entries in your subject database may result in duplicate queries. You will be notified of potential duplicate entries prior to completing this subject entry.



Submit to Data Bank

Validate Without Submitting

Store as a Draft



STATE LICENSURE

Report Correction

To submit a **correction** to previously submitted report DCN 7930000076906084, complete all necessary modifications in the form below, and press **Submit to Data Bank**.

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 05/31/14

OMB # 0915-0126 expiration date 12/31/13

OMB # 0915-0331 expiration date 12/31/13

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PRACTITIONER INFORMATION



E	First Name JOHN	Middle Name	Suffix (Jr, III)
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Male C Fer	male C Unknown		
n Date (MMDI	DYYYY)		
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ubject Decea			

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1 MAIN ST
FAIRFAX
VA Virginia
22033 -

─Work Information ——	
☐ Check here if the pra	ctitioner's work information is the same as your organization.
Organization	
Name:	
Туре:	CHOOSE ONE FROM LIST
Click Help ? for in	nformation on filling out non-U.S. and military addresses.
Address	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	-
Country: (if U.S., leave blank)	
Social Security Number *****6789 Add another SSN	ers (SSN) Edit
∼Individual Taxpayer Id	entification Numbers (ITIN)
Add another ITIN	
Federal Employer Ider Add another FEIN	ntification Numbers (FEIN)
National Provider Ider	itifiers (NPI)
Add another NPI	
Drug Enforcement Ad	ministration (DEA) Numbers
Add another DEA N	<u>lumber</u>

−Un	ique Physician Ider	ntification Numbers (UPIN	1)		
	Add another UPIN				
-Pro	ofessional Schools	Attended			
	e form will suggest son plete school name.	chools as you type. Please	choose the m	atching school or enter the	
				Year of	
	School Name:			Graduation (YYYY)	
	ABC			1995	
	Add another Profes	sional School			
-Oc	cupation And State	Licensure Information —			
(Pr	ovide at least one lice	ense. Check 'No License'	if the subject	does not have a State License	
•			<u>-</u>	o provide more than one licens	e.
Up	to 60 licenses may b	e provided.)			
			-		
1.	State License Number:		OR	No License	
			_		
	State of Licensure:	CHOOSE ONE FROM LIST			
	Occupation/Field of Licensure:				
		Physician (MD)	_		
	Specialty:	Child Psychiatry			
	Add Additional Lice	nse/Occupation			

Health Care Entities V	Vith Which the Subject is Affiliated or Associated
Address	
Street Address: Address Line 2: City: State: ZIP Code: Country: (if U.S., leave	CHOOSE ONE FROM LIST
blank)	
Nature of Subject's Relationship to Affiliate: Add another Affiliat	CHOOSE ONE FROM LIST



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

- O Default on Health Education Loan or Scholarship Obligations
- O Drug Screening Violation
- Failure to Comply With Continuing Education or Competency Requirements
- Failure to Comply With Health and Safety Requirements
- © Failure to Cooperate With Board Investigation
- C Failure to Maintain Adequate or Accurate Records
- C Failure to Maintain Records or Provide Medical, Financial or Other Required Information
- C Failure to Meet Licensing Board Reporting Requirements
- Failure to Meet the Initial Requirements of a License
- © Failure to Pay Child Support/Delinquent Child Support
- C License Revocation, Suspension or Other Disciplinary Action Taken by a Federal, State or Local Licensing Authority
- O Practicing Beyond the Scope of Practice
- Practicing With an Expired License
- Practicing Without a License
- Practicing Without a Valid License
- O Violation of Federal or State Statutes, Regulations or Rules
- O Violation of Federal or State Tax Code
- Violation of State Health Code
- Violation of or Failure to Comply With Licensing Board Order
- 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

Clear

dverse Action Information—————		
Name of Agency or Program that Took the	e	
Adverse Action Specified in This Report:	ABC	
Date Action Was Taken: (MMDDYYYY)	01012011	
Date Action Became Effective: (MMDDYYYY)	01012011	
Length of Action:		
Permanent		
○ Indefinite/Unspecified		
C Specific Period		
Is Reinstatement Automatic at Completion		
Total Amount of Monetary Penalty, Assessment and/or Restitution or fine: \$ (Format NNNNN.NN)		, leave this field blank.
Is the Adverse Action Specified in This Re Competence or Conduct, Which Adversel Health or Welfare of the Patient?		
○ Yes		
No		
Is the Action on Appeal?		
○ Yes		
No		
○ Unknown		
Description of Subject's Act(s) or Omission and Description of Action(s) Taken by Rep Note : Do not reference any personal identifier than the subject of this report. The enable a knowledgeable reviewer to determine the surrender. Refer to Reporting, Submitting information.	porting Entity entification information description must incomine clearly the circ	on (e.g., names) of anyone clude sufficient specificity to cumstances of the action(s) or
TEST		

There are 3996 characters remaining for the description.

Entity Internal Report Reference: e.g., claim number)	
tomer Use	
	by the submitter to identify this transaction. This information and only appears on the response returned to your
Customer Use:	
correct to the best of my knowle	submit this transaction and that all information is true and edge. JOE GREEN
Authorized Submitter's Title:	TITLE
Authorized Submitter's Phone:	7031234567 Ext.
Addition2cd Odbinitter 3 i none.	



STATE LICENSURE

Organization Subject: Initial Report

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OMB # 0915-0331 expiration date 12/31/13

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SUBJECT INFORMATION



ABC	
Add another name	e used
Click Help ?	for information on filling out non-U.S. and military addresses.
ddress	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	-
Country: (if U.S., leave blank)	
/pe	
Organization Type	: CHOOSE ONE FROM LIST
ealth Care Entity	
Is the Subject a he	ealth care entity that provides health care services and engages in a process for the purpose of furthering quality health care?
Is the Subject a he formal peer review Yes No	process for the purpose of furthering quality health care? entification Numbers (FEIN)
Is the Subject a he formal peer review	process for the purpose of furthering quality health care? entification Numbers (FEIN)
Is the Subject a he formal peer review Yes O No	entification Numbers (FEIN)
Is the Subject a he formal peer review Yes No	entification Numbers (FEIN)
Is the Subject a he formal peer review Yes O No deral Employer Ide Add another FEIN cial Security Num	entification Numbers (FEIN)
Is the Subject a he formal peer review Yes O No	entification Numbers (FEIN)
Is the Subject a he formal peer review Yes No deral Employer Ide Add another FEIN cial Security Num Add another SSN	entification Numbers (FEIN)
Is the Subject a he formal peer review Yes No deral Employer Ide Add another FEIN cial Security Num Add another SSN	entification Numbers (FEIN)

Drug Enforcement Administration (DEA) Numbers
Add another DEA Number
Clinical Laboratory Improvement Act (CLIA) Numbers
Add another CLIA Number
Fadaral Faadar I Dura Adarinistation (FDA) Nambara
Federal Food and Drug Administration (FDA) Numbers
Add another FDA Number
Add another FDA Number
National Provider Identifiers (NPI)
National Floride Identifiers (NFI)
Add another NPI
Medicare Provider/Supplier Numbers
Add another Medicare Provider/Supplier Number
Organization State Licensure Information
(If no State License, check the 'No License' box.)
State License OR □ No License
Number:
State of Licensure: CHOOSE ONE FROM LIST
Add another License
Principal Officers and Owners
Last Name First Name Middle Name Suffix Title
Add another Principal Officer or Owner

Health Care Entities W	ith Which the Subject is Affiliated or Associated
Inclusion of an affili in the reported action addresses. Name of Affiliated/Associated Health Care Entity:	
Address	
Street Address: Address Line 2: City: State: ZIP Code: Country: (if U.S., leave blank)	CHOOSE ONE FROM LIST
Nature of Subject's Relationship to Affiliate: Add another Affiliate	CHOOSE ONE FROM LIST



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. O Non-Compliance With Requirements
 - Criminal Conviction or Adjudication
 - Confidentiality, Consent or Disclosure Violations
 - Conflict of Interest
 - Fraud, Deception, or Misrepresentation
 - Substandard Care or Patient Neglect/Abuse
 - Improper Supervision or Allowing Unlicensed Practice
 - O Improper Prescribing, Dispensing, Administering Medication/Drug

Violation

Other

Clear

Adverse Action	cy or Program that Specified in This			
Date Action W	·	toporti		1
(MMDDYYYY)	as lakell.			
	ecame Effective:			
Length of Action	on:			
© Permar	nent			
Indefini	te/Unspecified			
 Specific 	Period			
Yes	ent Automatic at Co	•		
○ Yes, wi ○ No	th conditions (requ	res a Revision	to Action Rep	port when status changes)
Assessment a	of Monetary Penalt and/or Restitution of			
(Format NNNN	,	Note:	If no amount	, leave this field blank.
Is the Action of	n Appeal?			
© Yes				
○ No				
Unknow	vn			
and Descriptio	n of Action(s) Take	n by Reporting	Entity	ons for Action(s) Taken
and Descriptio Note : Do not other than the enable a know surrender. Ref	n of Action(s) Take reference any per subject of this rep ledgeable reviewe	n by Reporting conal identificat ort. The descrip to determine o	Entity ion information information must in learly the cir	on (e.g., names) of anyone clude sufficient specificity to
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Entity Internal Report Reference: (e.g., claim number)	led on copies of the report sent to queriers.
Customer Use	
	d by the submitter to identify this transaction. This information and only appears on the response returned to your
Customer Use:	
correct to the best of my knowl Authorized Submitter's Name:	
Authorized Submitter's Title:	TITLE
Authorized Submitter's Phone:	7031234567 Ext.
Date:	02/04/2013
and a mail natification when this a	and any future responses are available.
end e-maii notincation when this a	·
	odate this subject in your subject database for Help



STATE LICENSURE

Report Correction

To submit a **correction** to previously submitted report DCN 7930000076906087, complete all necessary modifications in the form below, and press **Submit to Data Bank**.

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.

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SUBJECT INFORMATION



Organization Informa	ation
Organization Name	
ABC	
Add another name	e used
Click Help ?	for information on filling out non-U.S. and military addresses.
	To information on fining out non-o.o. and military addresses.
Address	
Street Address:	1 MAIN ST
Address Line 2:	
City:	FAIRFAX
State:	VA Virginia
ZIP Code:	22033 -
Country: (if U.S., leave	
blank)	
Type Organization Type	2: 361 Chiropractic Group/Practice
	ealth care entity that provides health care services and engages in a process for the purpose of furthering quality health care?
ederal Employer Ide	entification Numbers (FEIN)
ocial Security Num	bers (SSN)
Add another SSN	
dividual Taxpayer l	dentification Numbers (ITIN)
911111111 Add another ITIN	

Drug Enforcement Administration (DEA) Numbers
Add another DEA Number
Clinical Laboratory Improvement Act (CLIA) Numbers
Add another CLIA Number
← Federal Food and Drug Administration (FDA) Numbers
Add another FDA Number
National Provider Identifiers (NPI)
Add another NPI
Medicare Provider/Supplier Numbers
Add another Medicare Provider/Supplier Number
- Indiano include in the indiano ind
∼Organization State Licensure Information
(If no State License, check the 'No License' box.)
State License OR ✓ No License Number:
State of Licensure: AL Alabama
Add another License
- Principal Officers and Owners
Principal Officers and Owners
Last Name First Name Middle Name Suffix Title
Add on other Dringing Cofficer or Court and
Add another Principal Officer or Owner

Health Care Entities Wit	th Which the Subject is Affiliated or Associated
Inclusion of an affiliat in the reported action addresses. Name of Affiliated/Associated Health Care Entity:	ted/associated health care entity in this report does not imply complicity a. Click Help ? for information on filling out non-U.S. and military
Address	
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: Add another Affiliate	CHOOSE ONE FROM LIST



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

- © Exclusion or Suspension From a Federal or State Health Care Program
- © Failure to Comply With Health and Safety Requirements
- C Failure to Maintain Adequate or Accurate Records
- © Failure to Maintain Equipment/Missing or Inadequate Equipment
- Failure to Maintain Records or Provide Medical, Financial or Other Required Information
- C Failure to Maintain Supplies/Missing or Inadequate Supplies
- © Failure to Meet Licensing Board Reporting Requirements
- © Failure to Meet the Initial Requirements of a License
- C Failure to Take Corrective Action
- Financial Insolvency
- Clack of Appropriately Qualified Professionals
- C License Revocation, Suspension or Other Disciplinary Action Taken by a Federal, State or Local Licensing Authority
- Operating Beyond Scope of License
- Operating Without a License or Permits or on a Lapsed License
- O Violation of Federal or State Statutes, Regulations or Rules
- O Violation of State Health Code
- O Violation of or Failure to Comply With Licensing Board Order
- Criminal Conviction or Adjudication
- Confidentiality, Consent or Disclosure Violations
- Conflict of Interest
- Fraud, Deception, or Misrepresentation
- Substandard Care or Patient Neglect/Abuse
- Improper Supervision or Allowing Unlicensed Practice
- O Improper Prescribing, Dispensing, Administering Medication/Drug Violation

Other

Clear

•	ABC
Date Action Was Taken: (MMDDYYYY)	01012011
Date Action Became Effective: (MMDDYYYY)	01012011
Length of Action:	
Permanent	
○ Indefinite/Unspecified	
Specific Period	
Is Reinstatement Automatic at Completio O Yes	n of Adverse Action Period? evision to Action Report when status changes)
No	evision to Action Report when status changes)
Total Amount of Monetary Penalty,	Note: If no amount, leave this field blank.
Is the Action on Appeal?	
C Yes	
No	
○ Unknown	
and Description of Action(s) Taken by Re	. •
Note : Do not reference any personal identifier than the subject of this report. The enable a knowledgeable reviewer to determine the control of the contro	entification information (e.g., names) of anyone e description must include sufficient specificity to
Note : Do not reference any personal identifier than the subject of this report. The enable a knowledgeable reviewer to determine surrender. Refer to Reporting, Submitting information.	entification information (e.g., names) of anyone e description must include sufficient specificity to ermine clearly the circumstances of the action(s) of the

Entity Internal Report Reference: (e.g., claim number)	ed on copies of the report sent to queriers.
tomer Use	
	d by the submitter to identify this transaction. This information and only appears on the response returned to your
Customer Use:	
Loortify that Lam outhorized to	aubmit this transaction and that all information is true and
correct to the best of my knowl	
I certify that I am authorized to correct to the best of my knowl Authorized Submitter's Name: Authorized Submitter's Title:	edge. JOE GREEN
correct to the best of my knowl Authorized Submitter's Name:	edge. JOE GREEN TITLE
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