REPORT INPUT FORM

the DataBank
NATIONAL PRACTITIONER
HEALTHCARE INTEGRITY & PROTECTION

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

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 0915-0331 (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.

PRACTITIONER INFORMATION Help ?

Personal Information

Practitioner Name

Last Name	First Name	Middle Name	Suffix (Jr, III)
DOE	JOHN		

Add another name used

Gender

(•) Male ( ) Female ( ) Unknown

Birth Date (MMDDYYYY)

01011970

Is Subject Deceased?

( ) No (•) Unknown ( ) Yes

Home Address/Address of Record

Street Address:	1 MAIN ST
Address Line 2:	
City:	FAIRFAX
State:	VA Virginia
ZIP Code:	22033 -
Country: (if U.S., leave blank)	

Work Information

☐ Check here if the practitioner'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 blank)

Social Security Numbers (SSN)

*****6789 Edit

Add another SSN

Individual Taxpayer Identification Numbers (ITIN)

Add another ITIN

Federal Employer Identification Numbers (FEIN)

Add another FEIN

National Provider Identifiers (NPI)

Add another NPI

Drug Enforcement Administration (DEA) Numbers

Add another DEA Number

Unique Physician Identification Numbers (UPIN)

Add another UPIN

Professional Schools Attended

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

School Name:	Year of Graduation (YYYY)
ABC	1995

Add another Professional School

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: Physician (MD)
   Specialty: Child Psychiatry

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.

Name of Affiliated/Associated 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: CHOOSE ONE FROM LIST

Add another 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**
   - Default on Health Education Loan or Scholarship Obligations
   - 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
   - Failure to Maintain Adequate or Accurate Records
   - Failure to Maintain Records or Provide Medical, Financial or Other Required Information
   - Failure to Meet Licensing Board Reporting Requirements
   - Failure to Meet the Initial Requirements of a License
   - Failure to Pay Child Support/Delinquent Child Support
   - License Revocation, Suspension or Other Disciplinary Action Taken by a Federal, State or Local Licensing Authority
   - Practicing Beyond the Scope of Practice
   - Practicing With an Expired License
   - Practicing Without a License
   - Practicing Without a Valid License
   - Violation of Federal or State Statutes, Regulations or Rules
   - 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

Add Additional Basis for Action

Adverse Action Information

Name of Agency or Program that Took the 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
- ( ) 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
- (•) 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.

TEST

There are **3996** characters remaining for the description.

Spell Check

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 Bank, but it will be provided on copies of the report sent to queriers.

Entity Internal Report Reference:
(e.g., claim number)

Customer Use

This optional field may be used by the submitter to identify this transaction. This information is returned without modification and only appears on the response returned to your organization.

Customer Use:

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: JOE GREEN

Authorized Submitter's Title: TITLE

Authorized Submitter's Phone: 7031234567 Ext.

Date: 02/04/2013

☐ Send e-mail notification when this and any future responses are available.

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

Return to Options

REPORT INPUT FORM

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NATIONAL PRACTITIONER
HEALTHCARE INTEGRITY & PROTECTION

STATE LICENSURE

Revision to Action

To submit a **revision to action** on previously submitted report DCN 7930000076906084, enter all report data for the action, and press **Submit to Data Bank**.

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 05/31/14
OMB # 0915-0126 expiration date 12/31/13
OMB # 0915-0331 expiration date 12/31/13

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 0915-0331 (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.

PRACTITIONER INFORMATION Help ?

Personal Information

Practitioner Name

Last Name	First Name	Middle Name	Suffix (Jr, III)
DOE	JOHN		

Add another name used

Gender

(•) Male ( ) Female ( ) Unknown

Birth Date (MMDDYYYY)

01011970

Is Subject Deceased?

( ) No (•) Unknown ( ) Yes

Home Address/Address of Record

Street Address:	1 MAIN ST
Address Line 2:	
City:	FAIRFAX
State:	VA Virginia
ZIP Code:	22033 -
Country: (if U.S., leave blank)	

Work Information

☐ Check here if the practitioner'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 blank)

Social Security Numbers (SSN)

*****6789 Edit

Add another SSN

Individual Taxpayer Identification Numbers (ITIN)

Add another ITIN

Federal Employer Identification Numbers (FEIN)

Add another FEIN

National Provider Identifiers (NPI)

Add another NPI

Drug Enforcement Administration (DEA) Numbers

Add another DEA Number

Unique Physician Identification Numbers (UPIN)

Add another UPIN

Professional Schools Attended

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

School Name:	Year of Graduation (YYYY)
ABC	1995

Add another Professional School

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: Physician (MD)
   Specialty: Child Psychiatry

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.

Name of Affiliated/Associated 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: CHOOSE ONE FROM LIST

Add another Affiliate

ADVERSE ACTION INFORMATION Help ?

Adverse Action Information

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 (01/01/2011).

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
- ○ 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 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 Bank, but it will be provided on copies of the report sent to queriers.

Entity Internal Report Reference:
(e.g., claim number)

Customer Use

This optional field may be used by the submitter to identify this transaction. This information is returned without modification and only appears on the response returned to your organization.

Customer Use:

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: JOE GREEN

Authorized Submitter's Title: TITLE

Authorized Submitter's Phone: 7031234567 Ext.

Date: 02/04/2013

☐ Send e-mail notification when this and any future responses are available.

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

Return to Options

REPORT INPUT FORM

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NATIONAL PRACTITIONER
HEALTHCARE INTEGRITY & PROTECTION

STATE LICENSURE

Correction of Revision to Action

To submit a **correction** to previously submitted report DCN 7930000076906086, 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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OMB # 0915-0239 expiration date 05/31/14
OMB # 0915-0126 expiration date 12/31/13
OMB # 0915-0331 expiration date 12/31/13

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 0915-0331 (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.

PRACTITIONER INFORMATION Help ?

Personal Information

Practitioner Name

Last Name	First Name	Middle Name	Suffix (Jr, III)
DOE	JOHN		

Add another name used

Gender

(•) Male ( ) Female ( ) Unknown

Birth Date (MMDDYYYY)

01011970

Is Subject Deceased?

( ) No (•) Unknown ( ) Yes

Home Address/Address of Record

Street Address:	1 MAIN ST
Address Line 2:	
City:	FAIRFAX
State:	VA Virginia
ZIP Code:	22033 -
Country: (if U.S., leave blank)	

Work Information

☐ Check here if the practitioner'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 blank)

Social Security Numbers (SSN)

*****6789 Edit

Add another SSN

Individual Taxpayer Identification Numbers (ITIN)

Add another ITIN

Federal Employer Identification Numbers (FEIN)

Add another FEIN

National Provider Identifiers (NPI)

Add another NPI

Drug Enforcement Administration (DEA) Numbers

Add another DEA Number

Unique Physician Identification Numbers (UPIN)

Add another UPIN

Professional Schools Attended

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

School Name:	Year of Graduation (YYYY)
ABC	1995

Add another Professional School

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: Physician (MD)
   Specialty: Child Psychiatry

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.

Name of Affiliated/Associated 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: CHOOSE ONE FROM LIST

Add another Affiliate

ADVERSE ACTION INFORMATION Help ?

Adverse Action Information

Name of Agency or Program that Took the 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
- ( ) 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
- (•) 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.

TEST

There are **3996** characters remaining for the description.

Spell Check

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 Bank, but it will be provided on copies of the report sent to queriers.

Entity Internal Report Reference:
(e.g., claim number)

Customer Use

This optional field may be used by the submitter to identify this transaction. This information is returned without modification and only appears on the response returned to your organization.

Customer Use:

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: JOE GREEN

Authorized Submitter's Title: TITLE

Authorized Submitter's Phone: 7031234567 Ext.

Date: 02/04/2013

☐ Send e-mail notification when this and any future responses are available.

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

Return to Options

REPORT CERTIFICATION

the DataBank
NATIONAL PRACTITIONER
HEALTHCARE INTEGRITY & PROTECTION

Please provide the following information to void the action reported in DCN 7930000076907009 about subject DOE, JOHN. A printable copy of your report submission will be provided after submission.

Notice: The unauthorized or unjustified removal of a report from the Data Bank is punishable under Federal Statute.

Void Reason

- ○ The report was erroneously submitted (e.g., wrong practitioner named; duplicate report, payment not delivered; action never finalized).
- ○ The report was not required to be filed; the action does not meet the legal reporting criteria.
- ○ The action was reversed because the original action should never have been taken (e.g., overturned on appeal).

Customer Use

This optional field may be used by the submitter to identify this transaction. This information is returned without modification and only appears on the response returned to your organization.

Customer Use: [ ]

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: 03/18/2013

This form will be submitted to the appropriate Data Bank. Note: You have not met your obligation under the law until the submitted report is accepted by the Data Bank and a Report Verification is returned.

Submit to Data Bank

Return to Options

REPORT CERTIFICATION

the DataBank
NATIONAL PRACTITIONER
HEALTHCARE INTEGRITY & PROTECTION

Please provide the following information to submit a notice that the action reported in DCN 7930000076907009 about subject DOE, JOHN has been appealed. A printable copy of your report submission will be provided after submission.

Appeal Date

Date of Appeal:
(MMDDYYYY)

Customer Use

This optional field may be used by the submitter to identify this transaction. This information is returned without modification and only appears on the response returned to your organization.

Customer Use:

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: 03/18/2013

This form will be submitted to the appropriate Data Bank. Note: You have not met your obligation under the law until the submitted report is accepted by the Data Bank and a Report Verification is returned.

Submit to Data Bank

Return to Options