REPORT INPUT FORM



Medical Malpractice Payment Report 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 # 0915-0126 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 number for this project is 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.

PRACTITIONER INFORMATION



Personal Information	1			
Practitioner Name	•			
Last Name SMITH	First Name JOHN	Middle Name	Suffix (Jr, III)	
Add another name	used	,		
Is Subject Decease				
Gender ○ Male ○ Female	e C Unknown			
Birth Date (MMDD)	YYY)			

—Home Address/Addre	ss of Record	
Street Address:		

_	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	-
Country: (if U.S., leave blan	k)
Work Information ☐ Check here if the pr	actitioner's work information is the same as your organization.
Organization	
Name:	
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 blan	k)
Social Security Num	bers (SSN)
Add another SSN	
Drug Enforcement A Add another DEA	Administration (DEA) Numbers Number
Professional School The form will suggest s complete school name	schools as you type. Please choose the matching school or enter the

School Name:	Graduation (YYYY)	
Professional School		<u>another</u>

	ense. Check 'No License/	nation cense' if the subject does not have a State License /Occupation button to provide more than one license.
State License Number:		OR
State of Licensure:	CHOOSE ONE FROM L	LIST
Occupation/Field of Licensure:	Physician (MD)	▼
Add Additional Lice	nse/Occupation	
Hospital Affiliation(s)		
Name	City	State
		CHOOSE ONE FROM LIST
Add another Hospit	tal Affiliate	
D () TI' D		
Payments by This Pa Amount of This Pay Practitioner: (Format NNNNN.N	yment for This	\$
Date of This Payme (MMDDYYYY)	ent:	
This Payment Rep	esents:	A Single Final PaymentOne of Multiple Payments
Total Amount Paid Payer for This Prac (Format NNNNN.N		s \$
Payment Result of:		JudgmentSettlementPayment Prior to Settlement
Date of Judgment of If any (MMDDYYY)		
Adjudicative Body (Case Number:	
Adjudicative Body I (If applicable)	Name:	

Description of Judgment or Settlement and Any Conditions, Including Terms of Payment Note: Do not reference any personal identification information (e.g., names) of anyone of than the subject of this report. There are 4000 characters remaining for the description. Spell Check There are 4000 characters remaining for the description. Spell Check Total Amount Paid or to Be Paid by This Payer for All Practitioners in This Case: (Format NNNN.NN) (Including the Amount Specified Above for This Practitioner) Number of Practitioners for Whom This Payer Has Paid or Will Pay in This Case: Syment Information Relationship of Entity to This Practitioner: CHOOSE ONE FROM LIST Patient's Age at Time of Initial Event: Days (if less than 1 month) Months (if less than 1 year)	eference any personal identification information (e.g., names) of anyone other ct of this report. O characters remaining for the description. is Payer for Other Practitioners in This Case Paid or to Be Paid by This ractitioners in This Case: NI,NN (Including the Amount Specified Above for This Practitioner) in this Case: Including the Amount Specified Above for This Practitioner (Including the Amount Specified Above for This Practitioner) in this Case: Including the Amount Specified Above for This Practitioner (Including the Amount Specified Above for This Practitioner) in the company of t	(If applicable)			
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○ Male
© Female
© Unknown
Patient Type:
© Inpatient
O Outpatient
O Both
O Unknown
Description of the Medical Condition With Which the Patient Presented for Treatment (Prior to the Event That Led to the Malpractice Allegation) Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.
There are 4000 characters remaining for the description.
ŭ '
Spell Check
Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

There are $4000\ \mbox{characters}$ remaining for the description.

A.11			
Allegation			
Nature of Allegation:	CHOOSE ONE FROM LIST	▼	
Specific Allegation:	CHOOSE ONE FROM LIST		<u> </u>
Date of Event Associated With			
Allegation or Incident: (MMDDYYYY)			
Add another Allegation			
Outcome			
Outcome:			
CHOOSE ONE FROM LIST			V
Description of the Allegations a	nd Injuries or Illnesses U	pon Which the Action	n or Claim Was
Based	-		
Note: Do not reference any per than the subject of this report.	rsonal identification inforr	mation (e.g., names)	of anyone other
than the subject of this report.			
There are 4000 characters rem	aining for the description	ı.	
	5		
Spell Check			
Entity Internal Report Reference)		
This optional field allows your e information to help you identify	this report in your files. T	his information is no	
Data Bank, but it will be provide	ed on copies of the repor	t 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:			
	Send e-mail notification when this an	nd any future responses are ava	ailable.	
	Check this box if you wish to add/upouse in future queries and/or reports. I result in duplicate queries. You will be completing this subject entry.	Duplicate entries in your subjec	t database may	lelp ?
Co	ontinue Validate Without Submitting	Store as a Draft		

Return to Options

REPORT INPUT FORM



Medical Malpractice Payment Report Report Correction

To submit a correction to previously submitted report DCN 7930000076906092, 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 # 0915-0126 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 number for this project is 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.

PRACTITIONER INFORMATION



	First Name JOHN	Middle Name	Suffix (Jr, III)	
Add another name us	sed			
. Cultipat Daggard				
S Subject Deceased? ■ No □ Unknown				
Gender	ි Unknown			
o maio o i omaio				

123 FAKE STREET
FAIRFAX
VA Virginia
20120 -
titioner's work information is the same as your organization.
CHOOSE ONE FROM LIST
ers (SSN) Edit ministration (DEA) Numbers umber
1

Professional Schools AttendedThe form will suggest schools as you type. Please choose the matching school or enter the

2000

complete school name.

COLLEGE LIMIN/EDGITY

School Name: Year of Graduation (YYYY)

<u>Add</u>

another

Professional School

	ense. Check 'No Lion License/	cense' if the subject does not have a State License (Occupation button to provide more than one license.
State License Number:	123 ABC	OR □ No License
State of Licensure:	AK Alaska	<u> </u>
Occupation/Field of		_
Licensure:	Physician (MD)	
Add Additional Lice	nse/Occupation	
Hospital Affiliation(s)		
Name	City	State
		CHOOSE ONE FROM LIST
Add another Hospita	al Affiliate	
Payments by This Pa	yer for This Practit	tioner
Amount of This Pay	ment for This	
Practitioner:		\$ 500.00
(Format NNNNN.NI	N)	· 1
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		 One of Multiple Payments
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(If applicable)	Court File Number: (If applicable)			
Description of Judgment or Settlement and Any Conditions, Including Terms of Payment Note: Do not reference any personal identification information (e.g., names) of anyone othe than the subject of this report.				
DESCRIPTION				
There are 3989 characters	remaining for the description.			
Spell Check				
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Relationship of Entity to This	ce Company - Primary Insurer			
Practitioner:	ce Company - Primary Insurer			
ayments by Others for Th	is Practitioner			
	n Insurance Company or a Self-Insured Organization. Has a S			
	cess Judgment Fund Made a Payment for This Practitioner in yment Expected to Be Made?:			
© Yes	yment Expected to be made			
© No				
Unknown				
	n Insurance Company, an Insurance Guaranty Fund or a State			
Medical Malpractice Payme	ent Fund. Has a Self-Insured Organization and/or Other Insura	าทเ		

Payment(s) Expected to Be Made?:	
© Yes	
O No	
Unknown	
Classification of Act(s) or Omission(s)	
Patient Information Patient's Age at Time of Initial Event:	
Days (if less than 1 month)	
Months (if less than 1 year)	
© Years	
Unknown	
Patient's Gender:	
O Male	
© Female	
Unknown Deticant Type:	
Patient Type:	
 Inpatient 	
Outpatient	
© Both	
Unknown	
Description of the Medical Condition With Which the Patient Presented for Treatment (Prior to the Event That Led to the Malpractice Allegation) Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.	
DESCRIPTION OF THE MEDICAL CONDITION	

There are **3964** characters remaining for the description.

Spell Check

Description of the Procedure Performed

Note: Do not reference any personal identification information (e.g., names) of anyone other

DESCRIPTION OF THE PROC	EDURE PERFORMED
There are 3962 characters rem	aining for the description.
Spell Check	
legation	
Nature of Allegation:	010 Anesthesia Related
Specific Allegation:	100 Failure to Use Aseptic Technique
Date of Event Associated With	
Allegation or Incident:	01012013
(MMDDYYYY)	01012013
Add another Allegation	
riad another rinegation	
utcome	
Outcome:	
01 Emotional injury only	
	nd Injuries or Illnesses Upon Which the Action or Claim Was
Based	sonal identification information (e.g., names) of anyone othe
than the subject of this report.	sonal identification information (e.g., flames) of anyone office
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DESCRIPTION OF THE ALLEGATIONS AND INJURIES OR ILLNESSES UPON WHICH THE ACTION OR CLAIM WAS BASED
There are 3903 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:
Send e-mail notification when this and any future responses are available.
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Return to Options