REPORT INPUT FORM

the DataBank NATIONAL PRACTITIONER

PEER REVIEW ORGANIZATION

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 # 0915-0331 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 number for this project is 0915-0331. 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.

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)

Is Subject Deceased?

○ No ○ Unknown ○ Yes

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 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)

Add another SSN

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)

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: CHOOSE ONE FROM LIST

Add Additional License/Occupation

Health Care Entities With Which the Subject is Affiliated or Associated

Inclusion of an affiliated/associated health care entity in this report does not imply complicity in the reported action. Click Help ? for information on filling out non-U.S. and military addresses.

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

FINDING INFORMATION

Help ?

Basis for Finding

Select a category and then choose a basis for finding code that best describes the reason for the action. Click **Add Additional Basis For Finding** to provide up to 2 basis for finding selections. View a complete basis for action list.

1. ○ **Fraud, Deception, or Misrepresentation**
   ○ **Unsafe Practice or Substandard Care**
   ○ **Other**

Clear

Add Additional Basis for Action

Finding Information

Type of Negative Finding:
☐ 1830 - Recommendation to Sanction
☐ 1889 - Other Finding - Not Classified, Specify

Date of Finding:
(MMDDYYYY)

Description of Finding:
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.

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: DEVELOPER

Authorized Submitter's Title: DEVELOPER

Authorized Submitter's Phone: 7035551212 Ext.

Date: 12/03/2012

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

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

Help ?

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

Return to Options

REPORT INPUT FORM

the DataBank NATIONAL PRACTITIONER

PEER REVIEW ORGANIZATION

Report Correction

To submit a **correction** to previously submitted report DCN 7940000075353282, 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 # 0915-0331 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 number for this project is 0915-0331. 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.

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)

05051950

Is Subject Deceased?

(•) No ( ) Unknown ( ) Yes

Home Address/Address of Record

Street Address: 123 FAKE STREET

Address Line 2:

City: FAIRFAX

State: VA Virginia

ZIP Code: 22030 -

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

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)
COLLEGE	2000

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: 123ABC OR ☐ No License

   State of Licensure: AL Alabama

   Occupation/Field of Licensure: Physician (MD)

   Specialty: Aerospace Medicine

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

FINDING INFORMATION

Help ?

Basis for Finding

Select a category and then choose a basis for finding code that best describes the reason for the action. Click **Add Additional Basis For Finding** to provide up to 2 basis for finding selections. View a complete basis for action list.

1. ◉ **Fraud, Deception, or Misrepresentation**
   - ◉ Improper or Abusive Billing Practices
   - ○ Submitting False Claims
   - ○ **Unsafe Practice or Substandard Care**
   - ○ **Other**

Clear

Add Additional Basis for Action

Finding Information

Type of Negative Finding:
- ☑ 1830 - Recommendation to Sanction
- ☐ 1889 - Other Finding - Not Classified, Specify

Date of Finding: (MMDDYYYY) 05052012

Description of Finding:
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.

DESCRIPTION OF FINDING

There are **3978** characters remaining for the description.

Spell Check

Entity Internal Report Reference

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(e.g., claim number)

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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: DEVELOPER

Authorized Submitter's Title: DEVELOPER

Authorized Submitter's Phone: 7035551212 Ext.

Date: 12/03/2012

☐ 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