

## REPORT INPUT FORM

**PROFESSIONAL SOCIETY****Individual Subject: Initial Report**

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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.

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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 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.

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**PRACTITIONER INFORMATION**[Help ?](#)

## Personal Information

### Practitioner Name

Last Name	First Name	Middle Name	Suffix (Jr, III)
<input type="text" value="WHITE"/>	<input type="text" value="GREEN"/>	<input type="text"/>	<input type="text"/>

[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:

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:

Click [Help ?](#) for information on filling out non-U.S. and military addresses.

### Address

Street Address:

Address Line 2:

City:

State:

ZIP Code:

 - 

Country:

(if U.S., leave blank)

## Social Security Numbers (SSN)

[Add another SSN](#)

## Drug Enforcement Administration (DEA) Numbers

[Add another DEA Number](#)

## 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:
- Occupation/Field of Licensure:

[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:

ZIP Code:  -

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


Nature of Subject's Relationship to Affiliate:

[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**
  - 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

Date Action Was Taken:  
(MMDDYYYY)

Date Action Became Effective:  
(MMDDYYYY)

Length of Action:

- Permanent
- Indefinite/Unspecified
- Specific Period

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.

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.

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.



Continue

Validate Without Submitting

Store as a Draft

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Return to Options

## REPORT INPUT FORM

## PROFESSIONAL SOCIETY

## Report Correction

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To submit a **correction** to previously submitted report DCN 7930000076906061, 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.

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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.

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## PRACTITIONER INFORMATION

[Help ?](#)



## Personal Information

### Practitioner Name

Last Name First Name Middle Name Suffix (Jr, III)  
GREEN JOE

[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: 111 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:

Click [Help ?](#) for information on filling out non-U.S. and military addresses.

### Address

Street Address:

Address Line 2:

City:

State:

ZIP Code:

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Country:

(if U.S., leave blank)

## Social Security Numbers (SSN)

[Add another SSN](#)

## Drug Enforcement Administration (DEA) Numbers

[Add another DEA Number](#)

## 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:
- Occupation/Field of Licensure:

[Add Additional License/Occupation](#)

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### Address

Street Address:

Address Line 2:

City:

State:

ZIP Code:  -

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


Nature of Subject's Relationship to Affiliate:

[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**

- Clinical Privileges Restricted, Suspended or Revoked by Another Hospital or Health Care Facility
- Failure to Comply With Corrective Action Plan
- Failure to Comply With Terms of Probation or other Previously Imposed Requirements
- Failure to Maintain Adequate or Accurate Records
- Failure to Maintain Records or Provide Medical, Financial or Other Required Information
- License Revocation, Suspension or Other Disciplinary Action Taken by a Federal, State or Local Licensing Authority
- Practicing Beyond the Scope of Practice
- Practicing Beyond the Scope of Privileges
- Practicing With an Expired License
- Practicing Without a License
- Practicing Without a Valid License
- Surrendered License to Practice
- Violation of By-Laws, Protocols or Guidelines
- Violation of Code of Ethics
- 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](#)

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TEST

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

Spell Check

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Reference:  
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Customer Use:

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

Continue

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