REPORT INPUT FORM

CRIMINAL CONVICTION (GUILTY PLEA OR TRIAL)

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

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 0915-0239 (HIPDB). 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

Help ?

We have pre-populated the practitioner information from the most recent report. Please review all pre-populated information for accuracy.

Personal Information

Practitioner Name

Last Name	First Name	Middle Name	Suffix (Jr, III)
SMITH	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:

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: GENERAL HOSPITAL

Type: 301 General/Acute Care Hospital

Address

Street Address: 123 FAKE STREET

Address Line 2:

City: FAIRFAX

State: VA Virginia

ZIP Code: 22030 -

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

Social Security Numbers (SSN)

*****2333 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

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

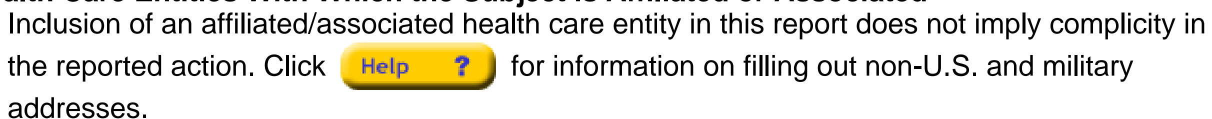
Occupation/Field of Licensure: Physician (MD)

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



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

INFORMATION DESCRIBING ACTION

Jurisdiction Information

Jurisdiction:

- Federal
- State/Local

Venue:
(Court Name)

City:

State: CHOOSE ONE FROM LIST

Docket/Court File Number:

Prosecuting Agency or Civil Plaintiff:

Prosecuting Agency or Plaintiff Case Number:

Investigating Agencies

Name	Case Number

Add another Investigating Agency

Statutory Offenses

Statute Title and Section (e.g., 18 USC. 287)	Statutory Offense (e.g., False Claim)	Count (e.g., 2)

Add another Statutory Offense

Act or Omission Codes

Act or Omission Code: CHOOSE ONE FROM LIST

Add another Act or Omission Code

Narrative Description of Act(s) or Omission(s)
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.

Spell Check

Sentence/Judgment Information

Date of Sentence or Judgment: (MMDDYYYY)

Is the Action on Appeal?

- Yes
- No
- Unknown

Restitution Amount: (Format NNNNN.NN) $

Other Sentence/Judgment Amount Ordered: (Format NNNNN.NN) $

Incarceration:	Years	Months	Days
Suspended Sentence:	Years	Months	Days
Home Detention:	Years	Months	Days
Probation:	Years	Months	Days
Community Service:	Hours		

Other Court Orders: (Describe)

More Sentence/Judgment Information

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: 01/31/2013

☐ 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

CRIMINAL CONVICTION (GUILTY PLEA OR TRIAL)

Report Correction

To submit a **correction** to previously submitted report DCN 7930000076905918, 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

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 0915-0239 (HIPDB). 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)
SMITH	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:

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: GENERAL HOSPITAL

Type: 301 General/Acute Care Hospital

Click Help for information on filling out non-U.S. and military addresses.

Address

Street Address: 123 FAKE STREET

Address Line 2:

City: FAIRFAX

State: VA Virginia

ZIP Code: 22030 -

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

Social Security Numbers (SSN)

*****2333 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

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

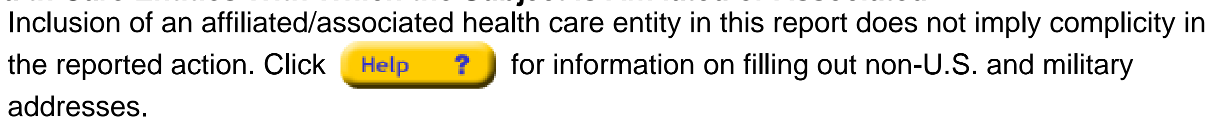
State of Licensure: AL Alabama

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

INFORMATION DESCRIBING ACTION

Jurisdiction Information

Jurisdiction:

- ○ Federal
- ◉ State/Local

Venue:
(Court Name) COURTHOUSE

City: FAIRFAX

State: VA Virginia

Docket/Court File Number: 123

Prosecuting Agency or Civil Plaintiff: SMITH

Prosecuting Agency or Plaintiff Case Number: 345

Investigating Agencies

Name	Case Number

Add another Investigating Agency

Statutory Offenses

Statute Title and Section (e.g., 18 USC. 287)	Statutory Offense (e.g., False Claim)	Count (e.g., 2)
18 USC. 287	FALSE CLAIM	2

Add another Statutory Offense

Act or Omission Codes

Act or Omission Code: 525 Research Fraud

Add another Act or Omission Code

Narrative Description of Act(s) or Omission(s)
Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

FRAUD

There are **3995** characters remaining for the description.

Spell Check

Sentence/Judgment Information

Date of Sentence or Judgment: (MMDDYYYY) 01012013

Is the Action on Appeal?

- ○ Yes
- ◉ No
- ○ Unknown

Restitution Amount: (Format NNNNN.NN) $

Other Sentence/Judgment Amount Ordered: (Format NNNNN.NN) $

Incarceration:	Years		Months		Days	
Suspended Sentence:	Years		Months		Days	
Home Detention:	Years		Months		Days	
Probation:	Years		Months		Days	
Community Service:	Hours	45				

Other Court Orders: (Describe)

More Sentence/Judgment Information

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:	02/01/2013

☐ 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

CRIMINAL CONVICTION (GUILTY PLEA OR TRIAL)

Organization 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.

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OMB # 0915-0239 expiration date 05/31/14

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SUBJECT INFORMATION Help ?

Organization Information

Organization Name

MEDICAL ORGANIZATION

Add another name used

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)

Type

Organization Type: CHOOSE ONE FROM LIST

Federal Employer Identification Numbers (FEIN)

Add another FEIN

Social Security Numbers (SSN)

Add another SSN

Individual Taxpayer Identification Numbers (ITIN)

Add another ITIN

Drug Enforcement Administration (DEA) Numbers

Add another DEA Number

National Provider Identifiers (NPI)

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 Number: OR ☐ No License

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 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

INFORMATION DESCRIBING ACTION Help ?

Jurisdiction Information

Jurisdiction:

- Federal
- State/Local

Venue:
(Court Name)

City:

State: CHOOSE ONE FROM LIST

Docket/Court File Number:

Prosecuting Agency or Civil Plaintiff:

Prosecuting Agency or Plaintiff Case Number:

Investigating Agencies

Name

Case Number

Add another Investigating Agency

Statutory Offenses

Statute Title and Section (e.g., 18 USC. 287)

Statutory Offense (e.g., False Claim)

Count (e.g., 2)

Add another Statutory Offense

Act or Omission Codes

Act or Omission Code: CHOOSE ONE FROM LIST

Add another Act or Omission Code

Narrative Description of Act(s) or Omission(s)
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.

Spell Check

Sentence/Judgment Information

Date of Sentence or Judgment: (MMDDYYYY)

Is the Action on Appeal?

- Yes
- No
- Unknown

Restitution Amount: (Format NNNNN.NN)	$		
Other Sentence/Judgment Amount Ordered: (Format NNNNN.NN)	$		
Suspended Sentence:	Years	Months	Days
Probation:	Years	Months	Days
Community Service:	Hours		
Other Court Orders: (Describe)			

More Sentence/Judgment Information

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:	02/01/2013

☐ 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

CRIMINAL CONVICTION (GUILTY PLEA OR TRIAL)

Report Correction

To submit a **correction** to previously submitted report DCN 7930000076905970, 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

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SUBJECT INFORMATION

Help ?

Organization Information

Organization Name

MEDICAL ORGANIZATION

Add another name used

Click Help ? for information on filling out non-U.S. and military addresses.

Address

Street Address: 123 MAIN STREET

Address Line 2:

City: FAIRFAX

State: VA Virginia

ZIP Code: 22033 -

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

Type

Organization Type: 361 Chiropractic Group/Practice

Federal Employer Identification Numbers (FEIN)

123456789

Add another FEIN

Social Security Numbers (SSN)

Add another SSN

Individual Taxpayer Identification Numbers (ITIN)

Add another ITIN

Drug Enforcement Administration (DEA) Numbers

Add another DEA Number

National Provider Identifiers (NPI)

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 Number: 123ABC OR ☐ No License

State of Licensure: AL Alabama

Add another License

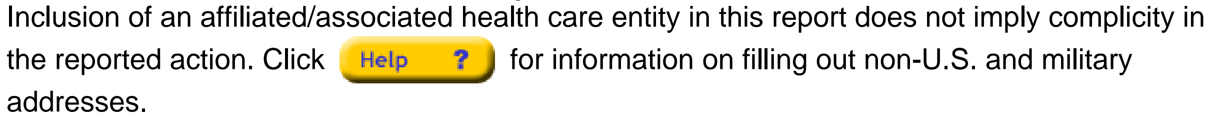
Principal Officers and Owners

Last Name	First Name	Middle Name	Suffix	Title

Add another Principal Officer or Owner

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

INFORMATION DESCRIBING ACTION

Jurisdiction Information

Jurisdiction:

- (•) Federal
- ( ) State/Local

Venue:
(Court Name) FEDERAL COURT

City: FAIRFAX

State: VA Virginia

Docket/Court File Number: 123ABC

Prosecuting Agency or Civil Plaintiff: PROSECUTING AGENCY

Prosecuting Agency or Plaintiff Case Number: PROSECUTING AGENCY

Investigating Agencies

Name	Case Number
INVESTIGATING AGENCIES	123

Add another Investigating Agency

Statutory Offenses

Statute Title and Section (e.g., 18 USC. 287)	Statutory Offense (e.g., False Claim)	Count (e.g., 2)
18 USC 287	FALSE CLAIM	2

Add another Statutory Offense

Act or Omission Codes

Act or Omission Code: 200 Fraudulent Billing/Cost Reporting

Add another Act or Omission Code

Narrative Description of Act(s) or Omission(s)
Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

NARRATIVE DESCRIPTION

There are **3979** characters remaining for the description.

Spell Check

Sentence/Judgment Information

Date of Sentence or Judgment: (MMDDYYYY) 01012013

Is the Action on Appeal?

○ Yes
◉ No
○ Unknown

Restitution Amount: (Format NNNNN.NN) $

Other Sentence/Judgment Amount Ordered: (Format NNNNN.NN) $

Suspended Sentence: Years Months Days

Probation: Years Months Days

Community Service: Hours 45

Other Court Orders: (Describe)

More Sentence/Judgment Information

Entity Internal Report Reference

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

Customer Use

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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: 02/01/2013

☐ 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