

NOLO CONTENDERE (NO CONTEST) PLEA

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

<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 0915-0239 (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



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 SMITH	First Name JOHN	Middle Name	Suffix (Jr, III)	
Add another name	<u>used</u>			
Gender	e O Unknown			
Birth Date (MMDDY	YYY)			
05051950				
Is Subject Decease	d?			
• No Unknow				
	2 100			

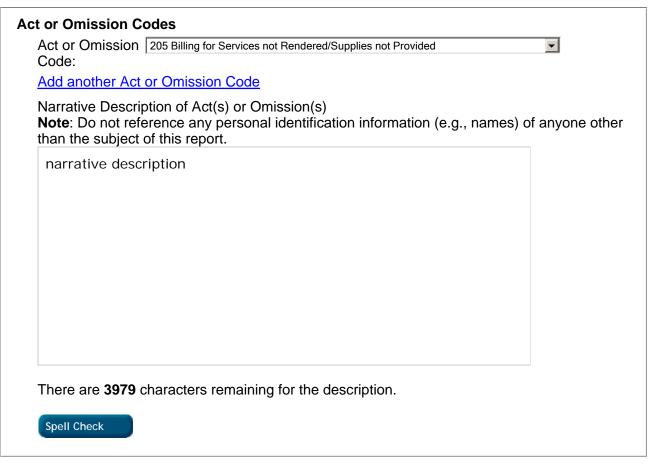
Home Address/Addr	ess of Record
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	-
Country: (if U.S., leave blan	k)
Work Information ☐ Check here if the pra	actitioner's work information is the same as your organization.
Organization	
Name:	GENERAL HOSPITAL
Type:	301 General/Acute Care Hospital
Click Help ? for Address	information on filling out non-U.S. and military addresses.
Street Address:	123 FAKE STREET
Address Line 2:	
City:	FAIRFAX
State:	VA Virginia
ZIP Code:	22030 -
Country: (if U.S., leave blan	k)
Social Security Num *****2333 Add another SSN	bers (SSN) <u>Edit</u>
Individual Taxpayer Add another ITIN	Identification Numbers (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
State of Licensure: AL Alabama
Occupation/Field of
Licensure: Physician (MD)
Specialty: Aerospace Medicine
Add Additional License/Occupation
- 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.
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 7 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	2		

IN

Jurisdiction: • Federal • State/Local			
© State/Local			
- 10.1101 - 0 0 0.11			
Venue: (Court Name)	court nam	e	
City:	fairfax		
State:	VA Virginia		
Docket/Court File Number:	123 abc		
Prosecuting Agency or Civil Plaintiff:	agency		
Number: nvestigating Agencie	case num		
Name		Case Number	$\overline{}$
investigating agency		123	
Add another Investig	ating Ager	<u>ncy</u>	
Statutory Offenses			
Statute Title and Sec (e.g., 18 USC. 287)	tion	Statutory Offense (e.g., False Claim)	Count (e.g., 2)
18 usc 287		false claim	2



Sentence/Judgment Informat Date of Sentence or Judgme (MMDDYYYY)	ent: 01022013		
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 56		
Other Court Orders: (Describe)		<u>~</u>	

More Sentence/Judgment Information

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Report Correction

To submit a **correction** to previously submitted report DCN 7930000076905966, 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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PRACTITIONER INFORMATION



Last Name	First Name	Middle Name	Suffix (Jr, III)	
SMITH	JOHN			
Add another nar	<u>ne used</u>			
S 1				
	nale Ollnknown			
	nale © Unknown			
	ale ິ Unknown			
Male ○ Fem				
Male ○ Fem				
Birth Date (MMDI				
● Male ○ Fem				

Ctroot Address.	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	
Country: (if U.S., leave blan	nk)
	actitioner's work information is the same as your organization.
Organization	
Name:	GENERAL HOSPITAL
Type:	301 General/Acute Care Hospital
Address Street Address: Address Line 2: City: State: ZIP Code: Country:	123 FAKE STREET FAIRFAX VA Virginia 22030
Social Security Num *****2333 Add another SSN	
Individual Taxpayer Add another ITIN	Identification Numbers (ITIN)

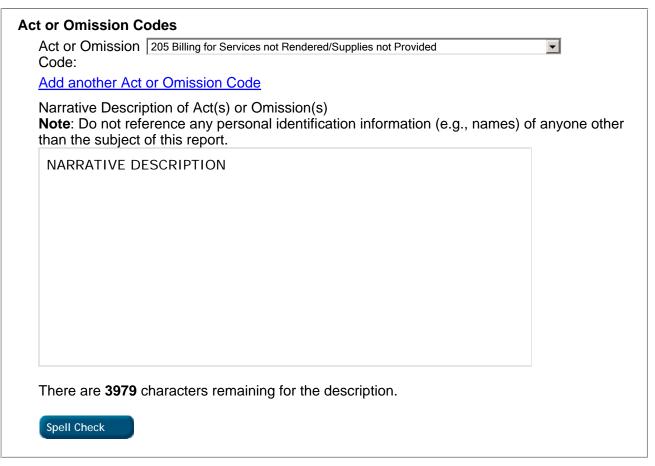
Federal Employer Identification Numbers (FEIN)

,	
Add another FEIN	
National Provider Iden Add another NPI	tifiers (NPI)
Drug Enforcement Adr	ministration (DEA) Numbers
Add another DEA Nu	<u>mber</u>
Unique Physician Iden Add another UPIN	tification Numbers (UPIN)
Number. Use the Add Ad Up to 60 licenses may be 1. State License Number:	nse. Check 'No License' if the subject does not have a State License dditional License/Occupation button to provide more than one license. provided.) 123ABC OR No License AL Alabama Physician (MD) Aerospace Medicine
Health Care Entities W	ith Which the Subject is Affiliated or Associated ted/associated health care entity in this report does not imply complicity in Click Help? for information on filling out non-U.S. and military
Address Street Address:	

Address Line 2:		
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		

IN

risdiction Informat	tion			
Jurisdiction:				
Federal				
○ State/Local				
Venue: (Court Name)	COURT N	IAME		
City:	FAIRFAX			
State:	VA Virginia			
Docket/Court File Number:	123 ABC			
Prosecuting Agence or Civil Plaintiff:	AGENCY			1
Prosecuting Agence or Plaintiff Case Number: nvestigating Agence	CASE NU	MBER 18		
Name		Case Number		
INVESTIGATING A	AGENCY	123		
Add another Invest	igating Ager	<u>ncy</u>		
Statutory Offenses				
Statute Title and So (e.g., 18 USC. 287 18 USC 287		Statutory Offense (e.g., False Claim) FALSE CLAIM	Count (e.g., 2	
1.0 000 -0.				



Sentence/Judgment Informat Date of Sentence or Judgme (MMDDYYYY)	ion ent: 01022013		
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 56		
Other Court Orders: (Describe)		<u></u>	

Entity Internal Report Reference	
information to help you identify	entity to include an internal file number or other reference this report in your files. This information is not used by the ed on copies of the report sent to queriers.
Entity Internal Report Reference: (e.g., claim number)	
Customer Use	
Customer use	
This optional field may be used	by the submitter to identify this transaction. This information is nd only appears on the response returned to your organization.
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This optional field may be used returned without modification a Customer Use: Certification I certify that I am authorized to correct to the best of my knowl	nd only appears on the response returned to your organization. submit this transaction and that all information is true and edge.
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More Sentence/Judgment Information

Submit to Data Bank

Validate Without Submitting

Store as a Draft



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Organization Subject: Initial Report

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SUBJECT INFORMATION

raanization Information



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

MEDICAL ORGA	NIZATION
Add another name	<u>s used</u>
lick Help ?	for information on filling out non-U.S. and military addresse
ddress	
Street Address:	123 MAIN STREET
Address Line 2:	
radioss Line 2.	,
City:	FAIRFAX
	FAIRFAX VA Virginia
City:	
ity: tate:	

Туре
Organization Type: 361 Chiropractic Group/Practice
Estant English Mark (FEIN)
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:
State of Licensure: AL Alabama
Add another License

Last Name	First Name Middle Name Suffix Title
Add another Prin	cipal Officer or Owner
Inclusion of an af	s With Which the Subject is Affiliated or Associated filiated/associated health care entity in this report does not imply complic
the reported action addresses.	on. Click Help ? for information on filling out non-U.S. and military
Name of Affiliated/Associa Health Care Entit	
Address	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	
Country: (if U.S., leave bla	ınk)
Nature of Subject Relationship to Affiliate:	t's CHOOSE ONE FROM LIST
Add another Affili	<u>ate</u>
RMATION DESCRIE	
Jurisdiction Inform	ation
Jurisdiction: © Federal	
© State/Loca	al
Venue:	~
(Court Name)	
City:	
State:	CHOOSE ONE FROM LIST

Prosecuting Agency or Civil Plaintiff:

or Plaintiff Case		
Number:		
vestigating Agencies		
Name	Case Number	7
Add another Investigating Ag	<u>ency</u>	
tatutory Offenses		
Statute Title and Section	Statutory Offense	Count
(e.g., 18 USC. 287)	(e.g., False Claim)	(e.g., 2)
Add another Statutory Offens	<u>e</u>	
t or Omission Codes		
Act or Omission CHOOSE ONE	FROM LIST	
Code:		
Add another Act or Omission	Code	
Narrative Description of Act(s	s) or Omission(s)	
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Cher Sentence/Judgment Amount Ordered: (Format NNNN.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 informat returned without modification and only appears on the response returned to your organiz 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 Phone: Tours of the province of th	© Yes	Restitution (Format NN	la.	
Other Sentence/Judgment Amount Ordered: (Format NNNNN.NN) Suspended Sentence: 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 informat returned without modification and only appears on the response returned to your organiz 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 Phone: 7035551212 Date: 702/01/2013	_			
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 informat returned without modification and only appears on the response returned to your organiz 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 Phone: 7035551212 Ext. Date: 02/01/2013	© Unknow	n		
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 informat returned without modification and only appears on the response returned to your organiz 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 Phone: 7035551212 Date: Developer In your subject detabage for support the pay if you wight to additurdate this subject in your subject detabage for support for pay subject detabage for support the box if you wight to additurdate this subject in your subject detabage for support in your subject detabage for your subjec				
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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 informat returned without modification and only appears on the response returned to your organiz 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: Date: Dat	Suspended Ser	ntence:	Years Months Days	
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 informat returned without modification and only appears on the response returned to your organiz 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 Date: 02/01/2013 Part of the par	Probation:		Years Months Days	
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 informat returned without modification and only appears on the response returned to your organiz 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 Date: 02/01/2013	Community Ser	vice:	Hours	
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 informat returned without modification and only appears on the response returned to your organiz 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 Phone: 7035551212 Ext. Date: 02/01/2013		ders:		
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neck this box if you wish to add/update this subject in your subject database for e in future queries and/or reports. Duplicate entries in your subject database may				

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Report Correction

To submit a **correction** to previously submitted report DCN 7930000076905977, 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

<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 0915-0239 (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.

SUBJECT INFORMATION



MEDICAL ORGAI	NIZATION
Add another name	e used
Click Help ?	for information on filling out non-U.S. and military addresses.
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Street Address:	123 MAIN STREET
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Address Line 2:	FAIRFAX
Address Line 2: City: State:	FAIRFAX VA Virginia
Address Line 2: City: State: ZIP Code:	FAIRFAX
Address Line 2: City: State:	FAIRFAX VA Virginia 22033

Туре
Organization Type: 361 Chiropractic Group/Practice
Estant English Mark (FEIN)
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:
State of Licensure: AL Alabama
Add another License

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	With Which the Subject is Affiliated or Associated ated/associated health care entity in this report does not imply complicity in	1
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	<u>2</u>	

INFORMATION DESCRIBING ACTION



Jurisdiction Informati	on
Federal	
○ State/Local	
Venue: (Court Name)	FEDERAL VENUE
City:	FAIRFAX
State:	VA Virginia
Docket/Court File Number:	123ABC
Prosecuting Agency or Civil Plaintiff:	PROSECUTING AGENCY

Prosecuting Agency or Plaintiff Case Number:		UTING CASE NUMBER		
nvestigating Agenci	ies			
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Act or Omission Codes	_
Act or Omission 220 Unbundling of Services Code:	▼
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 a than the subject of this report.	anyone other
NARRATIVE DESCRIPTION	
There are 3979 characters remaining for the description.	
Spell Check	

Sentence/Judgment Information
Date of Sentence or Judgment: 01082012
(MMDDYYYY)

Is the Action on Appeal?

© Yes (Format NNN)	nount: \$
© No	······································
○ Unknown	
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	<u>Information</u>
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