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 07/31/10

SUBJECT INFORMATION

Help ?

Subject Name:

Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)

Other Names Used (Last Name and First Name Required):

	Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
1.				
2.				
3.				
4.				

5.

Gender: ○ Male ○ Female ○ Unknown

Birth Date (MMDDYYYY):

Work Organization Name:

ADDRESSES

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

Work Address

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

ZIP Code: -

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

Home Address/Address of Record

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

ZIP Code: -

Country (if U.S., leave

blank):

Is Subject Deceased? ○ No ○ Unknown ○ Yes--Deceased Date (MMDDYYYY)

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN)

1. 2.
3. 4.

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. 2.
3. 4.

PROFESSIONAL SCHOOLS ATTENDED

The form will suggest medical schools as you type. Please choose the matching school or enter the complete school name.

	School Name:	Year of Graduation (Format YYYY):
1.		
2.		
3.		
4.		
5.		

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: 010 Physician (MD)

Description (complete only if 'Other' is selected above):

Add Additional License/Occupation

HOSPITAL AFFILIATION(S)	City	State
1.		CHOOSE ONE FROM LIST
2.		CHOOSE ONE FROM LIST
3.		CHOOSE ONE FROM LIST
4.		CHOOSE ONE FROM LIST
5.		CHOOSE ONE FROM LIST

PAYMENT INFORMATION

Relationship of Entity to This Practitioner: CHOOSE ONE FROM LIST

Payments by This Payer for This Practitioner

Amount of This Payment for This Practitioner (Format NNNNN.NN): $

Date of This Payment (MMDDYYYY):

This Payment Represents: ○ A Single Final Payment ○ One of Multiple Payments

Total Amount Paid or to Be Paid by This Payer for This Practitioner $

(Format NNNNN.NN):

Payment Result of: ○ Judgment ○ Settlement ○ Payment Prior to Settlement

Date of Judgment or Settlement, if Any (MMDDYYYY):

Adjudicative Body Case Number (if Applicable):

Adjudicative Body Name (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 other than the subject of this report.

There are **4000** characters remaining for the description.

Payments by This Payer for Other Practitioners in This Case

Total Amount Paid or to Be Paid by This Payer for All Practitioners in This Case (Including the Amount Specified Above for This Practitioner) $
(Format NNNNN.NN):

Number of Practitioners for Whom This Payer Has Paid or Will Pay in This Case:

Payments by Others for This Practitioner

Complete if your entity is an Insurance Company or a Self-Insured Organization.

Has a State Guaranty Fund or State Excess Judgment Fund Made a ○ Yes

Payment for This Practitioner in This Case, or Is Such a Payment Expected to Be Made?:
- ○ No
- ○ Unknown

Amount Paid or Expected to Be Paid by the State Fund (Format NNNNN.NN): $

Complete if your entity is an Insurance Company, an Insurance Guaranty Fund or a State Medical Malpractice Payment Fund.

Has a Self-Insured Organization and/or Other Insurance Company/Companies Made Payment(s) for This Practitioner in This Case, or Is/Are Such Payment(s) Expected to Be Made?:
- ○ Yes
- ○ No
- ○ Unknown

Amount Paid or Expected to Be Paid by Self-Insured Organization(s) and/or Other Insurance Company/Companies (Format NNNNN.NN): $ _____

CLASSIFICATION OF ACT(S) OR OMISSION(S)

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: ○ Male ○ Female ○ Unknown

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.

There are **4000** characters remaining for the description.

Description of the Procedure Performed

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.

Nature of Allegation: CHOOSE ONE FROM LIST

1. Specific Allegation: CHOOSE ONE FROM LIST

Description (complete only if 'Not Classified' is selected above):

Date of Event Associated With Allegation or Incident (MMDDYYYY):

2. Specific Allegation: CHOOSE ONE FROM LIST

Description (complete only if 'Not Classified' is selected above):

Date of Event Associated With Allegation or Incident (MMDDYYYY):

Outcome: CHOOSE ONE FROM LIST

Description of the Allegations and Injuries or Illnesses Upon Which the Action or Claim Was Based

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.

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 Banks, 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:

Authorized Submitter's Title:

Authorized Submitter's Phone: Ext.

Date: 06/18/2010

☐ 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(s) | Validate Without Submitting | Store as a Draft


Return to Options
Log Out

STATE LICENSURE

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 10/31/10
OMB # 0915-0126 expiration date 07/31/10

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) and 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.

SUBJECT INFORMATION

Subject Name:

Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)

Other Names Used (Last Name and First Name Required):

	Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
1.				
2.				
3.				

4.

5.

Gender: ○ Male ○ Female ○ Unknown

Birth Date (MMDDYYYY):

Work Organization Name:

Organization Type: CHOOSE ONE FROM LIST

Description (if 'Other' was selected above):

ADDRESSES

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

Work Address

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

ZIP Code: -

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

Home Address/Address of Record

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

ZIP Code: -

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

Is Subject Deceased? ○ No ○ Unknown ○ Yes--Deceased Date (MMDDYYYY)

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN)

1. 2.
3. 4.

INDIVIDUAL TAXPAYER IDENTIFICATION NUMBERS (ITIN) (FORMAT 9NNNNNNNN)

1. 2.
3. 4.

FEDERAL EMPLOYER IDENTIFICATION NUMBERS (FEIN)

1. 2.
3. 4.

NATIONAL PROVIDER IDENTIFIERS (NPI)

1. 2.
3. 4.

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. 2.

3. 4.

UNIQUE PHYSICIAN IDENTIFICATION NUMBERS (UPIN)

1. 2.

3. 4.

PROFESSIONAL SCHOOLS ATTENDED

The form will suggest medical schools as you type. Please choose the matching school or enter the complete school name.

	School Name:	Year of Graduation (Format YYYY):
1.		
2.		
3.		
4.		
5.		

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: 010 Physician (MD)

Description (complete only if 'Other' is selected above):

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.

1. Name of Affiliated/Associated Health Care Entity:

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

Other Description (complete only if 'Other' is selected above):

Add Additional 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

Name of Agency or Program that Took the Adverse Action Specified in This Report:

Date Action Was Taken (MMDDYYYY):

Date Action Became Effective (MMDDYYYY):

Length of Action: ○ Permanent ○ Indefinite/Unspecified

Specific Period

Years:

Months:

Days:

Is Reinstatement Automatic at Completion of Adverse Action Period?

Yes

Yes, with conditions (requires a Revision to Action Report when status changes)

No

Total Amount of Monetary Penalty, Assessment and/or Restitution or fine (Format NNNNN.NN):
Note: If no amount, leave this field blank.

$

Is the Adverse Action Specified in This Report Based on the Subject's Professional Competence or Conduct, Which Adversely Affected, or Could Have Adversely Affected, the Health or Welfare of the Patient? Yes No

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 the Fact Sheet on Submitting a Factually Sufficient Narrative Description for detailed information.

There are **4000** characters remaining for the description.

Is the Action on Appeal? ○ Yes ○ No ○ Unknown

Date of Appeal (MMDDYYYY):

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 Banks, 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:

Authorized Submitter's Title:

Authorized Submitter's Phone: Ext.

Date: 06/18/2010

☐ 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(s) | Validate Without Submitting | Store as a Draft

Return to Options | Log Out

To submit a query, enter all known subject data.

OMB # 0915-0239 expiration date 10/31/10
OMB # 0915-0126 expiration date 07/31/10

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) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 5 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.

SUBJECT INFORMATION

Help ?

Subject Name:

Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)

Other Names Used (Last Name and First Name Required):

	Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
1.				
2.				
3.				
4.				
5.				

Gender: ○ Male ○ Female ○ Unknown

Birth Date (MMDDYYYY):

PIN:

Work Organization Name:

Organization Type: CHOOSE ONE FROM LIST

Description (if 'Other' was selected above):

ADDRESSES

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

Work Address

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

ZIP Code: -

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

Home Address/Address of Record

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

ZIP Code: -

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

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN)

1. 2.
3. 4.

INDIVIDUAL TAXPAYER IDENTIFICATION NUMBERS (ITIN) (FORMAT 9NNNNNNNN)

1. 2.
3. 4.

FEDERAL EMPLOYER IDENTIFICATION NUMBERS (FEIN)

1. 2.
3. 4.

NATIONAL PROVIDER IDENTIFIERS (NPI)

1. 2.
3. 4.

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. 2.

3. 4.

UNIQUE PHYSICIAN IDENTIFICATION NUMBERS (UPIN)

1. 2.
3. 4.

PROFESSIONAL SCHOOLS ATTENDED

	School Name:	Year of Graduation (Format YYYY):
1.		
2.		
3.		
4.		
5.		

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: CHOOSE ONE FROM LIST

Description (complete only if 'Other' is selected above):

Specialty: CHOOSE ONE FROM LIST

Add Additional License/Occupation

☐ Check this box if you wish to store 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.

Help ?

Continue

Return to Options Log Out

INDIVIDUAL SELF-QUERY INSTRUCTIONS

Complete the Individual Self-Query form on-line, review the information entered on the form for completeness and accuracy, click **Continue,** and print the formatted copy of your self-query. Sign the formatted copy **in ink** and in the presence of a Notary Public, and mail the notarized copy to the address printed at the top of the page.

DO NOT PRINT OR NOTARIZE THIS FORM. A printable copy will be made available to you upon transmission of this form.

FEE AND PAYMENT INFORMATION

All individual self-queries are automatically sent to both the NPDB and the HIPDB. An $8.00 fee per self-query is assessed by the NPDB; an $8.00 fee per self-query is also assessed by the HIPDB. Fees must be paid by credit card (VISA, MasterCard, Discover or American Express). Cash and checks are not accepted.

CONFIDENTIALITY OF INFORMATION

Persons and entities that receive confidential information from the NPDB-HIPDB, either directly or indirectly from another party, must use it solely with respect to the purpose for which it was provided. **Any person who violates the confidentiality provisions of the Data Bank(s) shall be subject to a civil penalty for each violation.**

In compliance with the Privacy Act, the results of an individual self-query are sent only to the practitioner's home or work address as certified on the self-query form. Individual health care practitioners who obtain information about themselves from the NPDB-HIPDB are permitted to share that information with anyone they choose.

OMB # 0915-0239 expiration date 10/31/10
OMB # 0915-0126 expiration date 07/31/10

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) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 25 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.

Subject Name:

Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)

Other Names Used (Last Name and First Name Required):

	Last Name	First Name	Middle Name	Suffix (e.g., Jr, III)
1.				
2.				
3.				
4.				
5.				

Gender: ○ Male ○ Female

Birth Date (MMDDYYYY):

Work Organization Name:

Organization Type: CHOOSE ONE FROM LIST

Description (if 'Other' was selected above):

HOME OR WORK ADDRESS Help ?

Enter the address (home or work) to which you would like your response sent:

Note: If specifying a work address, be sure to include the employer name in the first line of the address.

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

ZIP Code: -

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

Telephone: Ext.

SOCIAL SECURITY NUMBERS (SSN) (FORMAT NNNNNNNNN) Help ?

1. 2.

3. 4.

INDIVIDUAL TAXPAYER IDENTIFICATION NUMBERS (ITIN) (FORMAT 9NNNNNNNN)

1. 2.
3. 4.

FEDERAL EMPLOYER IDENTIFICATION NUMBERS (FEIN)

1. 2.
3. 4.

NATIONAL PROVIDER IDENTIFIERS (NPI)

1. 2.
3. 4.

DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBERS

1. 2.
3. 4.

UNIQUE PHYSICIAN IDENTIFICATION NUMBERS (UPIN)

1. 2.
3. 4.

PROFESSIONAL SCHOOLS ATTENDED

	School Name:	Year of Graduation (Format YYYY):
1.		
2.		
3.		
4.		
5.		

OCCUPATION AND STATE LICENSURE INFORMATION Help ?

(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: CHOOSE ONE FROM LIST

Description (complete only if 'Other' is selected above):

Specialty: CHOOSE ONE FROM LIST

Add Additional License/Occupation

Continue

Return to Previous Page

ENTITY REGISTRATION

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

Provide Entity Information → Establish Administrator Account → Print Registration → Final Steps

Complete this form with information about your organization and click **Continue**. Help ?

OMB # 0915-0239 expiration date 10/31/10
OMB # 0915-0126 expiration date 07/31/10

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) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 1 hour 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.

ENTITY IDENTIFICATION INFORMATION Help ?

Name of Entity:
Department or Office to Which Mail Should be Addressed:
Street Address:
Address Line 2:
City:
State: CHOOSE ONE FROM LIST
ZIP Code: -
Country (if U.S., leave blank):

Department Fax Number:
Taxpayer Identification Number (TIN):
National Crime Information Center Originating Agency Identifier (ORI) (For law enforcement only):
Ownership of the Entity: CHOOSE ONE FROM LIST
If Federal, Specify Department: CHOOSE ONE FROM LIST

EXISTING REGISTRATION Help ?

Is your organization already registered with the Data Banks? ○ Yes ◉ No

ELIGIBILITY/STATUTORY AUTHORITY Help ?

For each of the three statutes below, entities must select the most appropriate function/service category

based on their primary function or service. Review each of these statutes and regulations prior to submitting your entity registration.

1. Title IV of Public Law 99-660, the *Health Care Quality Improvement Act of 1986*, as amended;
2. Public Law 100-93, Section 5[b] of the *Medicare and Medicaid Patient and Program Protection Act of 1987*, [Section 1921 of the *Social Security Act*]; and
3. Section 221[a], Public Law 104-191, the *Health Insurance Portability and Accountability Act of 1996*, more commonly referred to as Section 1128E of the *Social Security Act.*

Each entity is responsible for determining its legal obligation or eligibility under the applicable laws and regulations, and must register accordingly. For a complete description of the requirements and penalties of each authority, follow the links at the top of each authority selection list. You may wish to seek advice from legal counsel before specifying your statutory authority(ies). **If no function/service applies to you in the block, select "None of These."**

Title IV Statutory Authority Selections

National Practitioner Data Bank - Title IV Statutory Function/Service Categories More information about Title IV querying eligibility and reporting requirements	***Statutory Requirements***	
Function/Service (select one)	**Querying**	**Reporting**
○ Board of Medical/Dental Examiners*	Optional	Mandatory
○ Other State Practitioner Licensing Board	Optional	No Requirement
○ Hospital**	Mandatory	Mandatory
○ Professional Society**	Optional	Mandatory
○ Other Health Care Entity**	Optional	Mandatory
○ Medical Malpractice Payer	Prohibited	Mandatory
○ None of These	Prohibited	Prohibited

* Includes Composite Boards for physicians or dentists and other health care practitioners.

** Must provide health care services directly or indirectly and must follow a formal peer review process for the furthering of quality health care.

Section 1921 Statutory Authority Selections

National Practitioner Data Bank - Section 1921 Statutory Function/Service Categories More information about Section 1921 querying eligibility and reporting requirements	***Statutory Requirements***	
Function/Service (select one)	**Querying**	**Reporting**
○ State Health Care Practitioner Licensing Board	Optional	Mandatory
○ State Health Care Entity Licensing Board	Optional	Mandatory
○ Quality Improvement Organization under Contract with the Centers for Medicare & Medicaid Services (CMS)	Optional	No Requirement
○ Peer Review Organization	Prohibited	Mandatory
○ Private Accreditation Organization	Prohibited	Mandatory
○ Hospital*	Optional	No Requirement
○ Other Health Care Entity, including Professional Society*	Optional	No Requirement
○ Agency Administering a Federal Health Care	Optional	No Requirement

Program, including Private Entities Under Contract		
○ State Agency Administering or Supervising the Administration of a State Health Care Program	Optional	No Requirement
○ State Medicaid Fraud Control Unit	Optional	No Requirement
○ Attorney General/Other Law Enforcement Agency	Optional	No Requirement
○ None of These	Prohibited	Prohibited

* Must provide health care services directly or indirectly and must follow a formal peer review process for the furthering of quality health care.

Section 1128E Statutory Authority Selections

Healthcare Integrity and Protection Data Bank - Section 1128e Statutory Function/Service Categories **More information about Section 1128e querying eligibility and reporting requirements**	***Statutory Requirements***	
Function/Service (select one)	**Querying**	**Reporting**
○ Federal Government Agency	Optional	Mandatory
○ State Government Agency	Optional	Mandatory
○ Health Plan	Optional	Mandatory
○ None of These	Prohibited	Prohibited

PRIMARY FUNCTION Help ?

Select the category that best describes the primary function that your organization performs. Make only one selection from this list. If the code says "specify," describe the function. Entities that provide health care services and are self-insured for malpractice liability should register as health care service providers, not as malpractice payers.

- ○ **Hospitals [100-109]**
- ○ **Other Health Care Service Providers [120-169]**
- ○ **Health Plans or Health Insurance Companies [200-259]**
- ○ **Licensing Agencies [300-349]**
- ○ **Survey and Certification Agencies [350]**
- ○ **Professional Societies [400-409]**
- ○ **Malpractice Payers [500-519]**
- ○ **Law Enforcement Agencies [600-629]**
- ○ **Government Health Care Program Administration [650-689]**
- ○ **Utilization and Quality Control Peer Review Organizations [700-710]**
- ○ **Private Accreditation Organizations [800]**

QUERY OPTIONS FOR ENTITIES AUTHORIZED BY LAW TO QUERY BOTH THE NPDB AND THE HIPDB Help ?

Select the Data Bank(s) you elect to query. Fees are assessed for each Data Bank you choose to query (except for Federal agencies, which, by law, are exempt from HIPDB query fees). Hospitals MUST query the NPDB under Title IV.

- ○ Query the NPDB and the HIPDB for each query submitted.

- ○ Query only the NPDB for each query submitted.
- ○ Query only the HIPDB for each query submitted.
- ○ Do not query either the NPDB or the HIPDB.

POINT OF CONTACT FOR REPORTS

Help ?

A report point of contact is applicable only if the entity is eligible under law to submit reports. You may designate an individual or office to be the point of contact to be included on all reports submitted by your organization to the NPDB and/or the HIPDB. If your entity does not designate a point of contact, the submitter of each individual report will be listed as the point of contact for that report.

Name or Office:

Title or Department:

Telephone: Ext.

CERTIFICATION

Help ?

I certify that the entity identified above qualifies under law as specified in the ELIGIBILITY/STATUTORY AUTHORITY section and is eligible to perform the querying and/or reporting functions. I understand that the entity may be subject to sanctions under Federal statute for failure to report final adverse actions as required in the statutes and regulations or for the use of information obtained from the NPDB or the HIPDB other than the purposes for which it was provided. I further certify that I am authorized to submit this registration information to the NPDB-HIPDB and that the information provided is true, correct, and complete. If I become aware that any information in this form is not true, correct, or complete, I agree to notify the NPDB-HIPDB of this fact immediately. I understand that any omission, misrepresentation, or falsification of any information contained in this form or contained in any communication supplying information to the NPDB-HIPDB to complete or clarify this form may be punishable by criminal, civil, or other administrative actions including fines, penalties, and/or imprisonment under Federal law.

Name of Certifying Official:

Title of Certifying Official:

Telephone: Ext.

Date: 02/03/2010

Continue

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DESIGNATE AUTHORIZED AGENT

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

Entity: TEST ENTITY (FAIRFAX, VA)

Help ?

Complete this form to select an authorized agent who can query and/or report on your behalf. Specify (1) the last four digits of the agent's Data Bank Identification Number, (2) the Agent Organization Name, City, State, ZIP Code, and Country (if applicable), (3) whether to allow the agent to query or report, (4) whether query and/or report responses will be routed to the agent or the entity, and (5) whether the agent's or the entity's EFT account will be charged when EFT is the method of payment used for a query submission. Once the data provided here is validated, you will be instructed to print the Agent Designation Request for your records. This document will serve as the sole record of your request.

OMB # 0915-0239 expiration date 10/31/10
OMB # 0915-0126 expiration date 07/31/10

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) and 0915-0126 (NPDB). 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.

AGENT INFORMATION

Data Bank Identification Number (last 4 digits):
Agent Organization Name:
City:
State: CHOOSE ONE FROM LIST
ZIP Code: -
Country (if U.S., leave blank):

CONFIGURATION

I authorize my agent to submit the following transactions on my behalf:

- ☐ Query
- ☐ Report
- ☐ Proactive Disclosure Service (PDS)

I authorize my agent to use my entity's EFT account to pay for queries submitted on my entity's behalf:
NOTE: When an entity designates an authorized agent to query and/or report on behalf of the entity, the entity is ultimately responsible for payment (even if EFT charges are directed to that agent). Payment may also be made by credit card at the time of querying, regardless of EFT routing assignment.

- ○ Yes

- ○ No

Route responses to my agent's submission to:

- ○ Only my entity
- ○ Only my agent
- ○ Both my entity and my agent

Return responses to my entity via:

- ○ IQRS
- ○ ITP
- ○ QRXS

CERTIFICATION

I certify that I am authorized to designate the authorized agent identified above to report to and/or query the NPDB-HIPDB on my behalf.

Name of Certifying Official:	
Title of Certifying Official:	
Telephone:	Ext.
Certification Date (MMDDYYYY):	03282008

Continue

Return to Administrator Options | Log Out

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

ACCOUNT DISCREPANCY

If you cannot reconcile your credit card account statement or Electronic Funds Transfer (EFT) account statement, and determine that your account should be reviewed, please provide the information requested below. Type or print legibly in ink. Numbers in parentheses indicate the maximum number of characters including spaces and punctuation allowed per field.

OMB # 0915-0239 expiration date 10/31/10

OMB # 0915-0126 expiration date 07/31/10

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) and 0915-0126 (NPDB). 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.

Data Bank Identification Number (DBID) (15): |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Telephone: Area Code (3) _____ Number (7) _____ Extension (5) _____

Printed Name of Entity Representative (40): _____

Signature of Entity Representative: _____

Signature Date: _____

Credit Card Number (if applicable): |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Credit Card Expiration Date (MM/YY): |___|___|___|___|

Dollar Amount of the Suspected Error(s): $ _____

Please provide an explanation of your discrepancy and include the Data Bank Control Number (DCN), if applicable:

_____

_____

_____

_____

Attach a copy of your credit card statement or EFT account statement and the charge receipt. Highlight the charge(s) that you believe you were charged in error.

For additional information, visit the NPDB-HIPDB Web site at *www.npdb-hipdb.hrsa.gov*. If you need assistance, contact the NPDB-HIPDB Customer Service Center by e-mail at *help@npdb-hipdb.hrsa.gov* or by phone at 1-800–767–6732 (TDD 703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB-HIPDB Customer Service Center is closed on all Federal holidays.

EFT AUTHORIZATION

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

Help ?

Complete this form to authorize payment of user fees directly from your bank account. Limit your responses to the number of characters, including spaces and punctuation, specified in parentheses for each field.

OMB # 0915-0239 expiration date 10/31/10
OMB # 0915-0126 expiration date 07/31/10

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) and 0915-0126 (NPDB). 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.

ACCOUNT INFORMATION

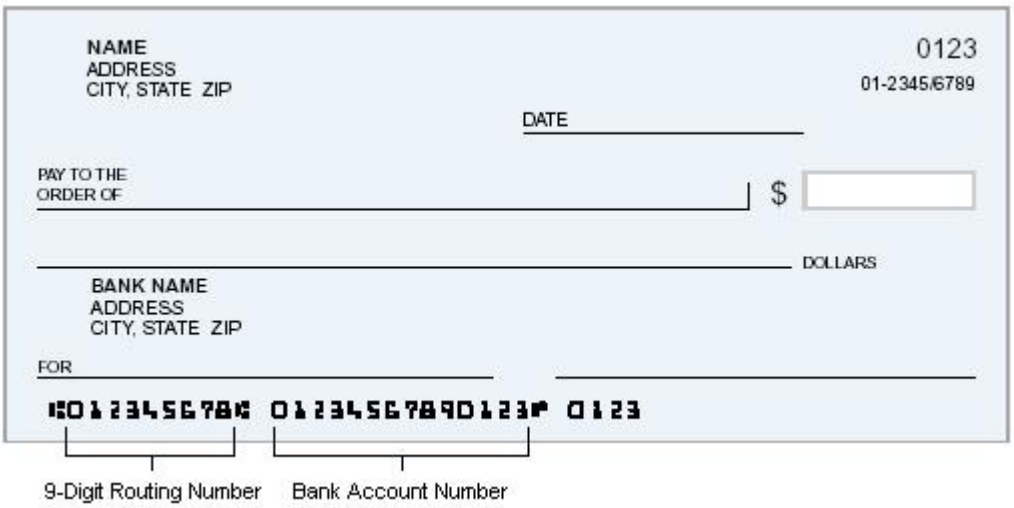
Bank Routing Number (9 digits):

Bank Account Number (max 17 digits):

Bank Account Type:

- ○ Checking
- ○ Savings

Bank routing information can be found on your check. See picture below.



CERTIFICATION

Name of Certifying Official:

Title of Certifying Official:

Telephone: Ext.

Certification Date (MMDDYYYY): 11182008

Submit to Data Bank(s)

Return to Administrator Options | Log Out

SUBJECT STATEMENT AND DISPUTE

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

To add, modify, or remove a statement to the report referenced below, and/or to place the report in, or withdraw the report from, disputed status, complete the appropriate section(s) below, and click **Submit To Data Bank(s)**. You will receive an on-line confirmation message regarding this transaction. The reporting entity and any queriers who received a previous version of the report will receive a copy noting the modifications.

Report Type:	**STATE LICENSURE ACTION**
Report Number:	**7930000052539805**
Subject's Name:	**MOOSE, JOHN**
Report Maintained Under:	**[X] Title IV (NPDB)**
	[X] Section 1128E (HIPDB)

SUBJECT STATEMENT Help ?

As the subject of the referenced report, you have the right to include a statement expressing your view of the action described in the report. The statement becomes part of the report and is disclosed to authorized queriers. To add a statement, type the statement in the designated area below exactly as you wish it to appear in the report. To substitute an existing statement with a new one, modify the statement in the designated area below exactly as you wish it to appear in the report. (If you have a statement on file, it will appear below.) Your statement must be in English and may not exceed **4,000 characters**, including spaces and punctuation. If you add a statement to the report, it will be formatted in a block style; paragraph breaks cannot be included.

Note:Patient information is confidential. Do NOT include identifying information (names, addresses, etc.) about patients or other persons in your statement. All Subject Statements are reviewed by the Data Banks to determine whether they include individual names, addresses, or telephone numbers. If this information is discovered, it will be removed and you will be sent an amended version.

OMB # 0915-0239 expiration date 10/31/10
OMB # 0915-0126 expiration date 07/31/10

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) and 0915-0126 (NPDB). 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.

Subject Statement

There are **4000** characters remaining for the statement.

DISPUTE Help ?

You may dispute either the factual accuracy of the action described in the referenced report or whether the report was submitted in accordance with Data Bank reporting requirements (e.g., was a reportable event). You may NOT dispute the appropriateness of any action, finding or judgment, or information regarding the facts or circumstances that led to the reported action. You also must contact the reporting entity or its agent, identified in Section A of the report, to attempt to resolve disputed issues. (Do not contact the reporting entity for information about Data Bank reporting requirements or operational procedures.) The report will remain in disputed status until either you take action to elevate the report for Secretarial Review or you withdraw the report from disputed status.

Information in Data Bank reports can be changed only by the entity that submitted the report or by the Secretary of the U.S. Department of Health and Human Services following review. The report will remain in the Data Bank(s) unchanged until the reporting entity or the Secretary changes it.

OMB # 0915-0239 expiration date 10/31/10
OMB # 0915-0126 expiration date 07/31/10

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) and 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 5 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.

The referenced report is currently NOT in disputed status.

☐ Check here if you wish to place the referenced report in disputed status. If you wish to add a statement to the report only and do not wish to place the report in disputed status then do not check the box.

CURRENT ADDRESSES Help ?

Future correspondence from the Data Bank(s) will be mailed to the address specified. **Note:** If you provide both your home and work addresses, the Data Bank(s) will send correspondence to your home

address. You may update the addresses that the Data Bank(s) have on file below. However, this does not change your addresses as reflected in the report filed with the Data Bank(s). Only the entity that originally submitted the report can modify or correct information provided in the report. You should contact the entity identified in Section A of the report and request that it make the address correction.

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 Address

Street Address:	123 MAIN STREET
Address Line 2:	
City:	FAIRFAX
State:	VA Virginia
ZIP Code:	22033 -
Country (if U.S., leave blank):	

CERTIFICATION Help ?

I certify that I am the individual subject identified in Section B of the referenced report, or that I am the designated employee representing the organization subject referenced in Section B, and I request that the action(s) above be taken.

Authorized Submitter's Name:	
Authorized Submitter's Title:	
Authorized Submitter's Phone:	Ext.
Date (MMDDYYYY):	03032009

Continue

Return to Report Response Options | Log Out