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

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:

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 Reporting, Submitting a Factually-Sufficient Narrative, 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: DEVELOPER

Authorized Submitter's Title: DEVELOPER

Authorized Submitter's Phone: 7035551212 Ext.

Date: 11/02/2010

☐ 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