**REPORT INPUT FORM**

the DataBank
NATIONAL PRACTITIONER
HEALTHCARE INTEGRITY & PROTECTION

## DEA/FEDERAL LICENSURE

## Individual Subject: Initial Report

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Please provide as much of the following information as possible. Failure to provide sufficient information to permit identification of a single subject will result in the report being rejected, necessitating resubmission.

**Do not print this page.** A printable copy of your report submission will be provided after submission.

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OMB # 0915-0239 expiration date 05/31/14
OMB # 0915-0126 expiration date 12/31/13
OMB # 0915-0331 expiration date 12/31/13

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB), 0915-0126 (NPDB) and 0915-0331 (NPDB). Public reporting burden for this collection of information is estimated to average 45 minutes to complete the forms, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

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**PRACTITIONER INFORMATION** Help ?

## Personal Information

**Practitioner Name**

| Last Name | First Name | Middle Name | Suffix (Jr, III) |
|---|---|---|---|
| DOE | JOHN | | |

Add another name used

**Gender**

○ Male ○ Female ○ Unknown

**Birth Date** (MMDDYYYY)

**Is Subject Deceased?**

○ No ○ Unknown ○ Yes

## Home Address/Address of Record

| | |
|---|---|
| Street Address: | |
| Address Line 2: | |
| City: | |
| State: | 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:

Type: CHOOSE ONE FROM LIST

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)

## Social Security Numbers (SSN)

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

**Professional Schools Attended**

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

School Name: | Year of Graduation (YYYY)

Add another Professional School

**Occupation And State Licensure Information**

(Provide at least one license. Check **'No License'** if the subject does not have a State License Number. Use the **Add Additional License/Occupation** button to provide more than one license. Up to 60 licenses may be provided.)

1. State License Number: OR ☐ No License
   State of Licensure: CHOOSE ONE FROM LIST
   Occupation/Field of Licensure: Physician (MD)
   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.

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

**ADVERSE ACTION INFORMATION** Help ?

**Basis for Action**

Select a category and then choose a basis for action code that best describes the reason for the action. Click **Add Additional Basis For Action** to provide up to 5 basis for action selections. View a complete basis for action list.

1. ○ **Non-Compliance With Requirements**
   ○ **Criminal Conviction or Adjudication**
   ○ **Confidentiality, Consent or Disclosure Violations**
   ○ **Misconduct or Abuse**
   ○ **Fraud, Deception, or Misrepresentation**
   ○ **Unsafe Practice or Substandard Care**
   ○ **Improper Supervision or Allowing Unlicensed Practice**
   ○ **Improper Prescribing, Dispensing, Administering Medication/Drug Violation**
   ○ **Other**

Clear

Add Additional Basis for Action

## Adverse Action Information

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

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 Action on Appeal?

- Yes
- No
- Unknown

Description of Subject's Act(s) or Omission(s) or Other Reasons for Action(s) Taken and Description of Action(s) Taken by Reporting Entity

**Note**: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report. The description must include sufficient specificity to enable a knowledgeable reviewer to determine clearly the circumstances of the action(s) or surrender. Refer to Reporting, Submitting a Factually-Sufficient Narrative, for detailed information.

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

Spell Check

**Entity Internal Report Reference**

This optional field allows your entity to include an internal file number or other reference information to help you identify this report in your files. This information is not used by the Data Bank, but it will be provided on copies of the report sent to queriers.

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

**Customer Use**

This optional field may be used by the submitter to identify this transaction. This information is returned without modification and only appears on the response returned to your organization.

Customer Use:

**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: JOE DOE

Authorized Submitter's Title: TITLE

Authorized Submitter's Phone: 7031234567 Ext.

Date: 02/04/2013

☐ 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

**REPORT INPUT FORM**

the DataBank
NATIONAL PRACTITIONER
HEALTHCARE INTEGRITY & PROTECTION

## DEA/FEDERAL LICENSURE

### Report Correction

To submit a **correction** to previously submitted report DCN 7930000076906096, 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
OMB # 0915-0126 expiration date 12/31/13
OMB # 0915-0331 expiration date 12/31/13

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB), 0915-0126 (NPDB) and 0915-0331 (NPDB). Public reporting burden for this collection of information is estimated to average 15 minutes to complete the forms, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

**PRACTITIONER INFORMATION** Help ?

## Personal Information

**Practitioner Name**

| Last Name | First Name | Middle Name | Suffix (Jr, III) |
|---|---|---|---|
| DOE | JOHN | | |

Add another name used

**Gender**

(•) Male ( ) Female ( ) Unknown

**Birth Date** (MMDDYYYY)

01011970

**Is Subject Deceased?**

( ) No (•) Unknown ( ) Yes

## Home Address/Address of Record

| | |
|---|---|
| Street Address: | 1 MAIN ST |
| Address Line 2: | |
| City: | FAIRFAX |
| State: | VA Virginia |
| ZIP Code: | 22033 - |
| Country: (if U.S., leave blank) | |

## Work Information

☐ Check here if the practitioner's work information is the same as your organization.

### Organization

Name:

Type: CHOOSE ONE FROM LIST

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)

## Social Security Numbers (SSN)

Add another SSN

## Individual Taxpayer Identification Numbers (ITIN)

911111111

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

**Professional Schools Attended**

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

| School Name: | Year of Graduation (YYYY) |
|---|---|
| ABC | 1995 |

Add another Professional School

**Occupation And State Licensure Information**

(Provide at least one license. Check **'No License'** if the subject does not have a State License Number. Use the **Add Additional License/Occupation** button to provide more than one license. Up to 60 licenses may be provided.)

1. State License Number: OR ☑ No License
   State of Licensure: CHOOSE ONE FROM LIST
   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

**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**
   - Default on Health Education Loan or Scholarship Obligations
   - Drug Screening Violation
   - Failure to Comply With Continuing Education or Competency Requirements
   - Failure to Comply With Health and Safety Requirements
   - Failure to Cooperate With Board Investigation
   - Failure to Maintain Adequate or Accurate Records
   - Failure to Maintain Records or Provide Medical, Financial or Other Required Information
   - Failure to Meet Licensing Board Reporting Requirements
   - Failure to Meet the Initial Requirements of a License
   - Failure to Pay Child Support/Delinquent Child Support
   - License Revocation, Suspension or Other Disciplinary Action Taken by a Federal, State or Local Licensing Authority
   - Practicing Beyond the Scope of Practice
   - Practicing With an Expired License
   - Practicing Without a License
   - Practicing Without a Valid License
   - Violation of Federal or State Statutes, Regulations or Rules
   - Violation of Federal or State Tax Code
   - Violation of State Health Code
   - Violation of or Failure to Comply With Licensing Board Order

**Criminal Conviction or Adjudication**
**Confidentiality, Consent or Disclosure Violations**
**Misconduct or Abuse**
**Fraud, Deception, or Misrepresentation**
**Unsafe Practice or Substandard Care**
**Improper Supervision or Allowing Unlicensed Practice**
**Improper Prescribing, Dispensing, Administering Medication/Drug Violation**
**Other**

Clear

Add Additional Basis for Action

## Adverse Action Information

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

Date Action Was Taken: (MMDDYYYY) 01012010

Date Action Became Effective: (MMDDYYYY) 01012010

Length of Action:

- (•) Permanent
- ( ) Indefinite/Unspecified
- ( ) Specific Period

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 Action on Appeal?

- ( ) Yes
- (•) No
- ( ) Unknown

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.

TEST

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

Spell Check

**Entity Internal Report Reference**

This optional field allows your entity to include an internal file number or other reference information to help you identify this report in your files. This information is not used by the Data Bank, but it will be provided on copies of the report sent to queriers.

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

**Customer Use**

This optional field may be used by the submitter to identify this transaction. This information is returned without modification and only appears on the response returned to your organization.

Customer Use:

**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: JOE DOE

Authorized Submitter's Title: TITLE

Authorized Submitter's Phone: 7031234567 Ext.

Date: 02/04/2013

☐ 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**

the DataBank
NATIONAL PRACTITIONER
HEALTHCARE INTEGRITY & PROTECTION

## DEA/FEDERAL LICENSURE

## 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.

**Do not print this page.** A printable copy of your report submission will be provided after submission.

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OMB # 0915-0239 expiration date 05/31/14
OMB # 0915-0126 expiration date 12/31/13
OMB # 0915-0331 expiration date 12/31/13

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for this project are 0915-0239 (HIPDB), 0915-0126 (NPDB) and 0915-0331 (NPDB). Public reporting burden for this collection of information is estimated to average 45 minutes to complete the forms, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

---

**SUBJECT INFORMATION** Help ?

## Organization Information

### Organization Name

ABC

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

**Clinical Laboratory Improvement Act (CLIA) Numbers**

Add another CLIA Number

**Federal Food and Drug Administration (FDA) Numbers**

Add another FDA 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

**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**
   ○ **Conflict of Interest**
   ○ **Fraud, Deception, or Misrepresentation**
   ○ **Substandard Care or Patient Neglect/Abuse**
   ○ **Improper Supervision or Allowing Unlicensed Practice**
   ○ **Improper Prescribing, Dispensing, Administering Medication/Drug Violation**
   ○ **Other**

Clear

Add Additional Basis for Action

## Adverse Action Information

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

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 Action on Appeal?

- Yes
- No
- Unknown

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

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

Spell Check

**Entity Internal Report Reference**

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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: JOE DOE

Authorized Submitter's Title: TITLE

Authorized Submitter's Phone: 7031234567 Ext.

Date: 02/04/2013

☐ 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

**REPORT INPUT FORM**

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NATIONAL PRACTITIONER
HEALTHCARE INTEGRITY & PROTECTION

## DEA/FEDERAL LICENSURE

### Report Correction

To submit a **correction** to previously submitted report DCN 7930000076906098, complete all necessary modifications in the form below, and press **Submit to Data Bank**.

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**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
OMB # 0915-0126 expiration date 12/31/13
OMB # 0915-0331 expiration date 12/31/13

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**SUBJECT INFORMATION** Help ?

## Organization Information

### Organization Name

ABC

Add another name used

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

### Address

| | |
|---|---|
| Street Address: | 1 MAIN ST |
| Address Line 2: | |
| City: | FAIRFAX |
| State: | VA Virginia |
| ZIP Code: | 22033 - |
| Country: (if U.S., leave blank) | |

### Type

Organization Type: 365 Medical Group/Practice

## Federal Employer Identification Numbers (FEIN)

Add another FEIN

## Social Security Numbers (SSN)

Add another SSN

## Individual Taxpayer Identification Numbers (ITIN)

911111111

Add another ITIN

## Drug Enforcement Administration (DEA) Numbers

Add another DEA Number

**Clinical Laboratory Improvement Act (CLIA) Numbers**

Add another CLIA Number

**Federal Food and Drug Administration (FDA) Numbers**

Add another FDA 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: IA Iowa

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

**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**
   - Exclusion or Suspension From a Federal or State Health Care Program
   - Failure to Comply With Health and Safety Requirements
   - Failure to Maintain Adequate or Accurate Records
   - Failure to Maintain Equipment/Missing or Inadequate Equipment
   - Failure to Maintain Records or Provide Medical, Financial or Other Required Information
   - Failure to Maintain Supplies/Missing or Inadequate Supplies
   - Failure to Meet Licensing Board Reporting Requirements
   - Failure to Meet the Initial Requirements of a License
   - Failure to Take Corrective Action
   - Financial Insolvency
   - Lack of Appropriately Qualified Professionals
   - License Revocation, Suspension or Other Disciplinary Action Taken by a Federal, State or Local Licensing Authority
   - Operating Beyond Scope of License
   - Operating Without a License or Permits or on a Lapsed License
   - Violation of Federal or State Statutes, Regulations or Rules
   - Violation of State Health Code
   - Violation of or Failure to Comply With Licensing Board Order
2. **Criminal Conviction or Adjudication**
3. **Confidentiality, Consent or Disclosure Violations**
4. **Conflict of Interest**
5. **Fraud, Deception, or Misrepresentation**
6. **Substandard Care or Patient Neglect/Abuse**
7. **Improper Supervision or Allowing Unlicensed Practice**
8. **Improper Prescribing, Dispensing, Administering Medication/Drug Violation**
9. **Other**

Clear

Add Additional Basis for Action

## Adverse Action Information

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

Date Action Was Taken: (MMDDYYYY) 01012010

Date Action Became Effective: (MMDDYYYY) 01012010

Length of Action:

- (•) Permanent
- ( ) Indefinite/Unspecified
- ( ) Specific Period

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 Action on Appeal?

- ( ) Yes
- (•) No
- ( ) Unknown

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

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TEST

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

Spell Check

**Entity Internal Report Reference**

This optional field allows your entity to include an internal file number or other reference information to help you identify this report in your files. This information is not used by the Data Bank, but it will be provided on copies of the report sent to queriers.

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

**Customer Use**

This optional field may be used by the submitter to identify this transaction. This information is returned without modification and only appears on the response returned to your organization.

Customer Use:

**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: JOE DOE

Authorized Submitter's Title: TITLE

Authorized Submitter's Phone: 7031234567 Ext.

Date: 02/04/2013

☐ 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