REPORT INPUT FORM

the DataBank
NATIONAL PRACTITIONER
HEALTHCARE INTEGRITY & PROTECTION

ACCREDITATION

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.

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 number for this project is 0915-0331 (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 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

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 2 basis for action selections. View a complete basis for action list.

1. ○ **Non-Compliance**
   ○ **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.

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:

Authorized Submitter's Title:

Authorized Submitter's Phone: Ext.

Date: 02/01/2013

☐ Send e-mail notification when this and any future responses are available.

☐ Check this box if you wish to add/update this subject in your subject database for use in future queries and/or reports. Duplicate entries in your subject database may result in duplicate queries. You will be notified of potential duplicate entries prior to completing this subject entry.

Help ?

Submit to Data Bank | Validate Without Submitting | Store as a Draft

Return to Options

REPORT INPUT FORM

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ACCREDITATION

Report Correction

To submit a **correction** to previously submitted report DCN 7930000076906058, 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 # 0915-0331 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 number for this project is 0915-0331 (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.

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: 361 Chiropractic Group/Practice

Federal Employer Identification Numbers (FEIN)

Add another FEIN

Social Security Numbers (SSN)

*****6789 Edit

Add another SSN

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: AL Alabama

Add another License

Principal Officers and Owners

Last Name	First Name	Middle Name	Suffix	Title

Add another Principal Officer or Owner

Health Care Entities With Which the Subject is Affiliated or Associated

Inclusion of an affiliated/associated health care entity in this report does not imply complicity in the reported action. Click Help ? for information on filling out non-U.S. and military addresses.

Name of Affiliated/Associated Health Care Entity:

Address

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

ZIP Code: -

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

Nature of Subject's Relationship to Affiliate: CHOOSE ONE FROM LIST

Add another Affiliate

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 2 basis for action selections. View a complete basis for action list.

1. **Non-Compliance**
   - Noncompliance with Private Accreditation Standards That Indicate a Risk to the Safety of Patient(s) or Quality of Health Care Services
   - **Other**

Clear

Add Additional Basis for Action

Adverse Action Information

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

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.

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

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(e.g., claim number)

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Customer Use:

Certification

I certify that I am authorized to submit this transaction and that all information is true and correct to the best of my knowledge.

Authorized Submitter's Name:

Authorized Submitter's Title:

Authorized Submitter's Phone: Ext.

Date: 02/01/2013

☐ Send e-mail notification when this and any future responses are available.

Submit to Data Bank | Validate Without Submitting | Store as a Draft

Return to Options