**REPORT INPUT FORM**

the DataBank NATIONAL PRACTITIONER

# TITLE IV CLINICAL PRIVILEGES

## 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
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, 0915-0126 and 0915-0331. 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

Help ?

#### Personal Information

**Practitioner Name**

| Last Name | First Name | Middle Name | Suffix (Jr, III) |
|---|---|---|---|
| SMITH | 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:

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

**Drug Enforcement Administration (DEA) Numbers**

Add another DEA Number

**Professional Schools Attended**

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

Year of

School Name: 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)

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**

Date Action Was Taken: (MMDDYYYY)

Date Action Became Effective: (MMDDYYYY)

Length of Action:

- ○ Permanent
- ○ Indefinite/Unspecified
- ○ Specific Period

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:

☐ 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 ?

Continue | Validate Without Submitting | Store as a Draft

Return to Options

**REPORT INPUT FORM**

the DataBank
NATIONAL PRACTITIONER
HEALTHCARE INTEGRITY & PROTECTION

## TITLE IV CLINICAL PRIVILEGES

### Correction of Revision to Action

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To submit a **correction** to previously submitted report DCN 7930000076905976, 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.

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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 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.

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**PRACTITIONER INFORMATION** Help ?

## Personal Information

**Practitioner Name**

| Last Name | First Name | Middle Name | Suffix (Jr, III) |
|---|---|---|---|
| GREEN | JOE | | |

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:

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)

*****6789 Edit

Add another SSN

## Drug Enforcement Administration (DEA) Numbers

Add another DEA Number

## 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)

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 ?

## Adverse Action Information

Date Action Was Taken: (MMDDYYYY) 02022010

Date Action Became Effective: (MMDDYYYY) 02022010

Length of Action:

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

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

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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:

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

Continue | Validate Without Submitting | Store as a Draft

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Return to Options