

GOVERNMENT ADMINISTRATIVE

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

<u>Public Burden Statement:</u> 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.

PRACTITIONER INFORMATION

Help 🛛 📍

Personal Information	on			
Practitioner Name				
Last Name	First Name	Middle Name	Suffix (Jr, III)	
GREEN	JOHN			
Add another nan	ne used			
Gender				
	-			
OMale OFem	ale OUnknown			
Birth Date (MMDD)	YYYY)			
	_			
Is Subject Deceas	ed?			
	C \/			
○No ○Unkn	iown OYes			

Street Address:		
Address Line 2:		
City:		
State:	CHOOSE ONE FROM LIST	
ZIP Code:	-	
Country:		
(if U.S., leave blank)		

Name: Type: CHOOSE ONE FROM LIST Sk Memp for information on filling out non-U.S. and military addresses. ddress Street Address: Address Line 2: City: State: CHOOSE ONE FROM LIST ZIP Code: Country: (f U.S., leave blank) dividual Taxpayer Identification Numbers (ITIN) Add another FEIN tional Provider Identifiers (NPI)	Check hara if the pr	ractitioner's work information is the same as your organization.
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Inclusion of an aff in the reported act	iliated/associated health care entity in this report does not imply complicition. Click Help ?) for information on filling out non-U.S. and militar
addresses.	
Name of Affiliated/Associate 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	
Relationship to Affiliate:	CHOOSE ONE FROM LIST
Add another Affilia	<u>ate</u>

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. O 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

<u>Clear</u>

Add Additional Basis for Action

Adverse Action St	or Program that Took t becified in This Report	
Date Action Was	•	
(MMDDYYYY)		
Date Action Becar (MMDDYYYY)	me Effective:	
_ength of Action:		
O Permanen	t	
Indefinite/l	Jnspecified	
C Specific Pe	eriod	
s Reinstatement	Automatic at Completi	ion of Adverse Action Period?
	conditions (requires a l	Revision to Action Report when status changes)
Total Amount of M Assessment and/	Ionetary Penalty, or Restitution or fine:	\$
Format NNNNN.	NN)	Note: If no amount, leave this field blank.
s the Action on A	ppeal?	
○ Yes		
○ No		
O Unknown		
and Description o	f Action(s) Taken by R	
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Entity Internal Report Reference	
information to help you identify	entity to include an internal file number or other reference this report in your files. This information is not used by the ed on copies of the report sent to queriers.
Entity Internal Report Reference:	
(e.g., claim number)	
Customer Use	
	d by the submitter to identify this transaction. This information and only appears on the response returned to your
Customer Use:	
Certification	
	submit this transaction and that all information is true and edge.
Authorized Submitter's Name:	
Authorized Submitter's Title:	

Date:

Authorized Submitter's Phone:

□ 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.

02/01/2013

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?

Help



GOVERNMENT ADMINISTRATIVE

Revision to Action

To submit a **revision to action** on previously submitted report DCN 7930000076906044, enter all report data for the action, and press **Submit to Data Bank**.

Enter all known data in its entirety. Failure to provide sufficient information to permit identification of a single subject may result in the report being rejected, necessitating resubmission.

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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

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PRACTITIONER INFORMATION



-Personal Information	ı			
	•			
Practitioner Name				
Last Name WHITE	First Name JOE	Middle Name	Suffix (Jr, III)	
Add another name	<u>e used</u>			
Gender Male	le ^O Unknown			
Birth Date (MMDDY	YYY)			
Is Subject Decease				

treet 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 p	ractitioner's work information is the same as your organization.
Organization	
Name:	
Туре:	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:	
ZIP Code:	
Country: (if U.S., leave blank)	
Social Security Num *****6789 Add another SSN	bers (SSN)
ndividual Taxpayer I	dentification Numbers (ITIN)
Add another ITIN	
Federal Employer Ide Add another FEIN	entification Numbers (FEIN)
National Provider Ide	entifiers (NPI)
Add another NPI	
Drug Enforcement A	dministration (DEA) Numbers
Add another DEA	Number

	Add another UPIN					
Pro	ofessional Schools	Attended				
	e form will suggest so nplete school name.	chools as you type. Ple	ase choose t	ne mat	ching school or	enter the
					Year of	
	School Name:				Graduation (Y	YYY)
	Add another Profess	nional Cahaal				I
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Health Care Entities	Nith Which the Subject is Affiliated or Associated
Inclusion of an affil in the reported acti addresses. Name of Affiliated/Associate Health Care Entity:	d
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 Affilia	t <u>e</u>

ADVERSE ACTION INFORMATION



Name of Agency or Program that Toc Adverse Action Specified in This Rep	
Date Action Was Taken:	
(MMDDYYYY)	Note: Date must be on or after Date Action Was Taken of related report (03/03
Date Action Became Effective: (MMDDYYYY)	/2011).
Length of Action:	
© Permanent	
Indefinite/Unspecified	
Specific Period	
Is Reinstatement Automatic at Comp	letion of Adverse Action Period?
 Yes, with conditions (requires No 	a Revision to Action Report when status changes)
Total Amount of Monetary Penalty, Assessment and/or Restitution or fine (Format NNNNN.NN)	e: \$ Note: If no amount, leave this field blank.
Is the Action on Appeal?	
○ Yes	
○ No	
O Unknown	
other than the subject of this report. enable a knowledgeable reviewer to surrender. Refer to <u>Reporting</u> , Subm	A Reporting Entity al identification information (e.g., names) of anyone The description must include sufficient specificity to determine clearly the circumstances of the action(s) itting a Factually-Sufficient Narrative, for detailed
information.	
There are 4000 characters remaining	for the description

Entity Internal Report Reference	
information to help you identify	entity to include an internal file number or other reference y this report in your files. This information is not used by the led on copies of the report sent to queriers.
Entity Internal Report Reference:	
(e.g., claim number)	
is returned without modification organization.	d by the submitter to identify this transaction. This information n and only appears on the response returned to your
Customer Use:	
Contification	
Certification	
I certify that I am authorized to correct to the best of my know	submit this transaction and that all information is true and ledge.
Authorized Submitter's Name:	
Authorized Submitter's Title:	

Authorized Submitter's Phone:	
Date:	02/01/2013

 $\hfill\square$ Send e-mail notification when this and any future responses are available.

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Ext.

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GOVERNMENT ADMINISTRATIVE

Organization Subject: Initial Report

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SUBJECT INFORMATION

Help ?

ganization Name		
ABC		
Add another name	e used	
Click Help ?	for information on filling out non-U.S. and mil	itary addresses.
Street Address:		
Address Line 2:		
City:		
State:	CHOOSE ONE FROM LIST	
ZIP Code:	-	
Country: (if U.S., leave blank)		
Organization Type	CHOOSE ONE FROM LIST	
leral Employer Ide	entification Numbers (FEIN)	
Add another FEIN		
Add another FEIN		
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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	
lational Provider Identifiers (NPI)	
Add another NPI	
ledicare Provider/Supplier Numbers	
Add another Medicare Provider/Supplier Number	
organization State Licensure Information	
f no State License, check the 'No License' box.)	
State License OR Number:	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

addresses.	
Name of	
Affiliated/Associat Health Care Entit	
Address	y.
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 Affilia	<u>ate</u>

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. O Non-Compliance With Requirements
 - Criminal Conviction or Adjudication
 - Confidentiality, Consent or Disclosure Violations
 - Conflict of Interest
 - Fraud, Deception, or Misrepresentation
 - O Substandard Care or Patient Neglect/Abuse
 - Improper Prescribing, Dispensing, Administering Medication/Drug Violation
 - Other

<u>Clear</u>

Add Additional Basis for Action

Adverse Action St	or Program that Took t becified in This Report	
Date Action Was	•	
(MMDDYYYY)		
Date Action Becar (MMDDYYYY)	me Effective:	
_ength of Action:		
O Permanen	t	
Indefinite/l	Jnspecified	
C Specific Pe	eriod	
s Reinstatement	Automatic at Completi	ion of Adverse Action Period?
	conditions (requires a l	Revision to Action Report when status changes)
Total Amount of M Assessment and/	Ionetary Penalty, or Restitution or fine:	\$
Format NNNNN.	NN)	Note: If no amount, leave this field blank.
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○ Yes		
○ No		
O Unknown		
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(e.g., claim number)	
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	d by the submitter to identify this transaction. This information and only appears on the response returned to your
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Certification	
	submit this transaction and that all information is true and edge.
Authorized Submitter's Name:	
Authorized Submitter's Title:	

Date:

Authorized Submitter's Phone:

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GOVERNMENT ADMINISTRATIVE

Report Correction

To submit a **correction** to previously submitted report DCN 7930000076906045, 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

<u>Public Burden Statement:</u> 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.

SUBJECT INFORMATION



ABC	
Add another name	used
Click Help ?	for information on filling out non-U.S. and military addresses.
dress	
Street Address:	1 MAIN ST
Address Line 2:	
City:	FAIRFAX
State:	VA Virginia
ZIP Code:	22033 -
Country:	
(if U.S., leave plank)	
Jianky	
be	
Jiganization Type:	361 Chiropractic Group/Practice

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	
lational Provider Identifiers (NPI)	
Add another NPI	
ledicare Provider/Supplier Numbers	
Add another Medicare Provider/Supplier Number	
organization State Licensure Information	
f no State License, check the 'No License' box.)	
State License OR Number:	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

lealth 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 CHOOSE ONE FROM LIST Affiliate:
Add another Affiliate

ADVERSE ACTION INFORMATION



-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

- Debarment From Federal or State Program
- C Employing or Contracting With Individuals or Entities Excluded From a Federal or State Health Care Program
- © Exclusion or Suspension From a Federal or State Health Care Program
- ^O Failure to Comply With Health and Safety Requirements
- ^O Failure to Comply With the Composition of Enrollment Requirements
- C Failure to Maintain Adequate or Accurate Records
- ^O Failure to Maintain Equipment/Missing or Inadequate Equipment
- ^C Failure to Maintain Records or Provide Medical, Financial or Other Required Information
- ^O Failure to Obtain a Surety Bond
- C Failure to Perform Contractual Obligations
- ^O Failure to Repay Overpayment
- C Failure to Take Corrective Action
- ^C Financial Insolvency
- C Lack of Appropriately Qualified Professionals
- ^C License Revocation, Suspension or Other Disciplinary Action Taken by a Federal, State or Local Licensing Authority
- O Violation of Federal or State Statutes, Regulations or Rules
- ^O Violation of State Health Code
- Criminal Conviction or Adjudication
- Confidentiality, Consent or Disclosure Violations
- Conflict of Interest
- Fraud, Deception, or Misrepresentation
- Substandard Care or Patient Neglect/Abuse
- ^O Improper Prescribing, Dispensing, Administering Medication/Drug Violation
- Other

<u>Clear</u>

Add Additional Basis for Action

Adverse Action Specified in This Rep	ort: ABC
Date Action Was Taken: MMDDYYYY)	01012011
Date Action Became Effective: MMDDYYYY)	01012011
ength of Action:	
Permanent	
Indefinite/Unspecified	
C Specific Period	
s Reinstatement Automatic at Compl	letion of Adverse Action Period?
Yes, with conditions (requires No	a Revision to Action Report when status changes)
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?	
O Yes	
• No	
and Description of Action(s) Taken by	nission(s) or Other Reasons for Action(s) Taken / Reporting Entity al identification information (e.g., names) of anyone
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Customer Use:	
Certification	
I certify that I am authorized to correct to the best of my know	submit this transaction and that all information is true and ledge.
Authorized Submitter's Name:	
Authorized Submitter's Title:	

Authorized Submitter's Phone:	
Date:	02/01/2013

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