



ORGANIZATION SELF-QUERY INSTRUCTIONS

DO NOT PRINT OR NOTARIZE THIS FORM. If required, a printable copy will be made available to you later during the process.

[Hide](#) Confidentiality of Information Statement

Confidentiality of Information

Persons and entities that receive confidential information from the Data Bank, either directly or indirectly from another party, must use it solely with respect to the purpose for which it was provided. **Any person who violates the confidentiality provisions of the Data Bank shall be subject to a civil penalty for each violation.**

In compliance with the Privacy Act, the results of an organization self-query are sent only to the organization's address as certified on the self-query form. Health care organizations that obtain information about themselves from the Data Bank are permitted to share that information with anyone they choose.

[Hide](#) Public Burden Statement

Public Burden Statement

- 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 25 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

[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:

ZIP Code: -

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

Type

Organization Type:

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:

[Add another License](#)

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: 01/30/2013

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