REPORT INPUT FORM

theDataBank
NATIONAL PRACTITIONER

STATE LICENSURE: Initial Report

Hide Public Burden Statement
OMB # 0915-0126 expiration date 05/31/16

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 0915-0126. 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 10-29, Rockville, Maryland, 20857.

1. Subject Information | 2. Action Information | 3. Certification

PRACTITIONER INFORMATION

Help ?

Please provide as much information as possible to make your report easier for other registered organizations to find. Your report may help inform decisions about practitioners under consideration for actions such as employment, licensing or privileging.

We have pre-populated the practitioner information from the most recent report. Please review all pre-populated information for accuracy.

Personal Information

Practitioner Name

Last Name	First Name	Middle Name	Suffix (Jr, III)
MANN	ANITTA		

Add another name used

Gender

○ Male ◉ Female ○ Unknown

Birth Date

01 / 01 / 1982

Is Subject Deceased?

◉ No ○ Unknown ○ Yes

Entity: LICENSING BOARD (ROCKVILLE, MD) | **User:** boardadmin   Sign Out

REPORT INPUT FORM

Home Address/Address of Record

Street Address: 5600 FISHERS LN
Address Line 2:
City: ROCKVILLE
State: MD Maryland
ZIP Code: 20852 - 1750
Country:
(if U.S., leave blank)

Work Information

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

Organization

Name: GENERAL HOSPITAL
Type: 301 General/Acute Care Hospital

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

Address

Street Address: 123 CEDAR LANE
Address Line 2:
City: ROCKVILLE
State: MD Maryland
ZIP Code: 20857 - 0001
Country:
(if U.S., leave blank)

Social Security Numbers (SSN)

*****1111 Edit

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

AM111111111

Add another DEA Number

Unique Physician Identification Numbers (UPIN)

Add another UPIN

Entity: LICENSING BOARD (ROCKVILLE, MD) | **User:** boardadmin Sign Out

REPORT INPUT FORM

Occupation And State Licensure Information

Add information for at least one state license.

License 1

Occupation/Field of Licensure: Podiatrist

Other Name for Occupation (Optional):

State: MD Maryland

License Number: SL56

☐ Unlicensed / No license number for this occupation

Add occupation/field of licensure

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

Entity: LICENSING BOARD (ROCKVILLE, MD) | **User:** boardadmin [Sign Out]

REPORT INPUT FORM

[Add another UPIN]

Occupation And State Licensure Information

Select an Occupation or Field of Licensure
Enter a keyword or phrase to find matching occupations. (Example: "counselor")

Search

Recently Used
- Podiatrist

Physician
- Physician (MD)
- Physician Resident (MD)
- Osteopathic Physician (DO)
- Osteopathic Physician Resident (DO)

Nurse - Advanced, Registered, Vocational or Practical
- Registered Nurse
- Nurse Anesthetist
- Nurse Midwife
- Nurse Practitioner
- Licensed Practical or Vocational Nurse
- Clinical Nurse Specialist
- Other Nurse Occupation - Not Classified, Specify

Nurse Aide, Home Health Aide And Other Aide

[Don't see what you're looking for?]

REPORT INPUT FORM

theDataBank NATIONAL PRACTITIONER

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)
KENT STATE UNIVERSITY COLLEGE OF PODIATRIC MEDICI	2000

Add another Professional School

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: Test

Address

Street Address: 4350 Fair Lakes Ct Ste 100

Address Line 2:

City: Fairfax

State: VA Virginia

ZIP Code: 22033-4233

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

How is the subject of this report related to the affiliated entity?

The subject is a Employee

Add another Affiliate

☐ 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 to Action Information → | Store as a Draft →

Entity: LICENSING BOARD (ROCKVILLE, MD) | User: boardadmin Sign Out

REPORT INPUT FORM

STATE LICENSURE: Initial Report

Show Public Burden Statement

1. Subject Information | 2. Action Information | 3. Certification

ADVERSE ACTION INFORMATION

Help ?

Adverse Action Classification Codes

Select up to five adverse action classification codes from one of the action categories and click **Continue**.
Note: Any existing selections can be changed.

- [x] Revocation of License (1110)
- [ ] Probation of License (1125)
- [ ] Suspension of License (1135)
- [ ] Summary or Emergency Limitation or Restriction on License (1138)
- [ ] Summary or Emergency Suspension of License (1139)
- [ ] Reprimand or Censure (1140)
- [ ] Voluntary Surrender of License (1145)
- [ ] Voluntary Limitation or Restriction on License (1146)
- [ ] Limitation or Restriction on License (1147)
- [ ] Denial of License Renewal (1148)
- [ ] Denial of Initial License (1149)
- [ ] Interim Action - Voluntary Agreement to Refrain from Practice or to Suspend License Pending Completion of an Investigation (1150)
- [ ] Cease and Desist (1151)
- [ ] Publicly Available Fine/Monetary Penalty (1173)
- [x] Prescriptive Authority Action, Specify (1179)
  test
- [x] Publicly Available Negative Action or Finding, Specify (1189)
  test
- [x] Other Licensure Action - Not Classified, Specify (1199)
  test

Basis for Action

Choose a basis for action that best describes the reason for the action.

Basis for Action 1

Basis for Action

Default on Health Education Loan or Scholarship Obligations

Add basis for action

Entity: LICENSING BOARD (ROCKVILLE, MD) | **User:** boardadmin Sign Out

REPORT INPUT FORM

Basis for Action

Choose a basis for action that best describes the reason for the action.

Basis for Action 1

Select a Basis for Action
Enter a keyword or phrase to find matching bases. (Example: "failure")

Search

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

Don't see what you're looking for?

Entity: LICENSING BOARD (ROCKVILLE, MD) | **User:** boardadmin Sign Out

REPORT INPUT FORM

Adverse Action Information

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

Date action was taken (When was the order issued, filed, or signed by the board?)

11 / 11 / 2014

Date action became effective (When did the action start?)

11 / 11 / 2014

Length of Action:

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

Years: 2

Months: 6

Days:

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) $2,000.00

Note: If no amount, leave this field blank.

Is the Action on Appeal?

- ◉ Yes
- ○ No
- ○ Unknown

Date of Appeal: 02 / 12 / 2015

REPORT INPUT FORM

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:

Continue to Certification → Store as a Draft →

Entity: LICENSING BOARD (ROCKVILLE, MD) | **User:** boardadmin Sign Out

REPORT INPUT FORM

STATE LICENSURE: Initial Report

Show Public Burden Statement

1. Subject Information | 2. Action Information | 3. Certification

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: JANET DOE

Authorized Submitter's Title: SUBMITTER

Authorized Submitter's Phone: 3013013011 Ext.

Date: 12/11/2014

Submit to Data Bank → | Store as a Draft →

MANN, ANITTA

LICENSING BOARD

STATE LICENSURE ACTION — Date of Action: 11/11/2014

Initial Action	Basis for Initial Action
- REVOCATION OF LICENSE - PRESCRIPTIVE AUTHORITY ACTION, SEE SECTION C. OF THE REPORT FOR DETAILS - PUBLICLY AVAILABLE NEGATIVE ACTION OR FINDING, SEE SECTION C. OF THE REPORT FOR DETAILS - OTHER LICENSURE ACTION, SEE SECTION C. OF THE REPORT FOR DETAILS	- DEFAULT ON HEALTH EDUCATION LOAN OR SCHOLARSHIP OBLIGATIONS

A. REPORTING ENTITY

Field	Value
Entity Name:	LICENSING BOARD
Address:	123 CEDAR LANE
City, State, Zip:	ROCKVILLE, MD 20857-0001
Country:	
Name or Office:	JANET DOE
Title or Department:	BOARD OFFICIAL
Telephone:	(555) 555-5555
Entity Internal Report Reference:	
Type of Report:	INITIAL

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Field	Value
Subject Name:	MANN, ANITTA
Other Name(s) Used:	
Gender:	FEMALE
Date of Birth:	01/01/1982
Organization Name:	GENERAL HOSPITAL
Work Address:	123 CEDAR LANE
City, State, ZIP:	ROCKVILLE, MD 20857-0001
Organization Type:	GENERAL/ACUTE CARE HOSPITAL (301)
Home Address:	5600 FISHERS LN
City, State, ZIP:	ROCKVILLE, MD 20852-1750
Deceased:	NO
Federal Employer Identification Numbers (FEIN):	
Social Security Numbers (SSN):	***-**-1111
Individual Taxpayer Identification Numbers (ITIN):	
National Provider Identifiers (NPI):	
Professional School(s) & Year(s) of Graduation:	KENT STATE UNIVERSITY COLLEGE OF PODIATRIC MEDICINE (2000)
Occupation/Field of Licensure (Code):	PODIATRIST
State License Number, State of Licensure:	SL56, MD
Drug Enforcement Administration (DEA) Numbers:	AM111111111
Unique Physician Identification Numbers (UPIN):	
Name(s) of Health Care Entity (Entities) With Which Subject Is Affiliated or Associated (Inclusion Does Not Imply Complicity in the Reported Action.):	TEST
Business Address of Affiliate:	4350 FAIR LAKES CT STE 100
City, State, ZIP:	FAIRFAX, VA 22033-4233

Nature of Relationship(s): SUBJECT IS EMPLOYEE OF AFFILIATE OR ASSOCIATE (200)

C. INFORMATION REPORTED

Type of Adverse Action: STATE LICENSURE
Basis for Action: DEFAULT ON HEALTH EDUCATION LOAN OR SCHOLARSHIP OBLIGATIONS (44)
Name of Agency or Program That Took the Adverse Action Specified in This Report: INTEGRITY PROGRAM
Adverse Action Classification Code(s): REVOCATION OF LICENSE (1110)
PRESCRIPTIVE AUTHORITY ACTION, SPECIFY (1179)
Other, as Specified: TEST
PUBLICLY AVAILABLE NEGATIVE ACTION OR FINDING, SPECIFY (1189)
Other, as Specified: TEST
OTHER LICENSURE ACTION - NOT CLASSIFIED, SPECIFY (1199)
Other, as Specified: TEST
Date Action Was Taken: 11/11/2014
Date Action Became Effective: 11/11/2014
Length of Action: SPECIFIC PERIOD
Years: 2
Months: 6
Days:
Total Amount of Monetary Penalty, Assessment and/or Restitution: $ 2,000.00
Is Subject Automatically Reinstated After Adverse Action Period Is Completed?: YES, WITH CONDITIONS (REQUIRES A REVISION TO ACTION REPORT WHEN STATUS CHANGES)
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: TEST

[X] Subject identified in Section B has appealed the reported adverse action.

Date of Appeal: 02/12/2015

D. SUBJECT STATEMENT

If the subject identified in Section B of this report has submitted a statement, it appears in this section.

E. REPORT STATUS

Unless a box below is checked, the subject of this report identified in Section B has not contested this report.

[ ] This report has been disputed by the subject identified in Section B.

[ ] At the request of the subject identified in Section B, this report is being reviewed by the Secretary of the U.S. Department of Health and Human Services to determine its accuracy and/or whether it complies with reporting requirements. No decision has been reached.

[ ] At the request of the subject identified in Section B, this report was reviewed by the Secretary of the U.S. Department of Health and Human Services and a decision was reached. The subject has requested that the Secretary reconsider the original decision.

[ ] At the request of the subject identified in Section B, this report was reviewed by the Secretary of the U.S. Department of Health and Human Services. The Secretary's decision is shown below:

Date of Original Submission: 12/11/2014
Date of Most Recent Change: 12/11/2014

This report is maintained under the provisions of: Section 1921

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Section 1921 of the Social Security Act, and 45 CFR Part 60. All information is confidential and may be used only for the purpose for which it was disclosed. Disclosure or use of confidential information for other purposes is a violation of federal law. For additional information or clarification, contact the reporting entity identified in Section A.

END OF REPORT

Entity: LICENSING BOARD (ROCKVILLE, MD) | User: boardadmin Sign Out

REPORT INPUT FORM

theDataBank NATIONAL PRACTITIONER

STATE LICENSURE: Initial Report

Hide Public Burden Statement
OMB # 0915-0126 expiration date 05/31/16

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 0915-0126. 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 10-29, Rockville, Maryland, 20857.

1. Subject Information | 2. Action Information | 3. Certification

SUBJECT INFORMATION Help ?

We have pre-populated the practitioner information from the most recent report. Please review all pre-populated information for accuracy.

Organization Information

Organization Name

FOOTCAREINC.

Add another name used

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

Address

Street Address: 5600 Fishers Ln

Address Line 2:

City: Rockville

State: MD Maryland

ZIP Code: 20852 -1750

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

Type

Organization Type: 381 Chiropractic Group/Practice

Health Care Entity

Is the Subject a health care entity that provides health care services and engages in a formal peer review process for the purpose of furthering quality health care?

(•) Yes ( ) No

REPORT INPUT FORM

Federal Employer Identification Numbers (FEIN)

111111111

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: SL89 OR ☐ No License

State of Licensure: MD Maryland ▼

Add another License

REPORT INPUT FORM

the DataBank NATIONAL PRACTITIONER

Principal Officers and Owners

Last Name	First Name	Middle Name	Suffix	Title
MANN	ANITTA			

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: FOOTCAREINC2

Address

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

ZIP Code: -

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

How is the subject of this report related to the affiliated entity?

The subject is a Subsidiary

Add another Affiliate

☐ 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 to Action Information → Store as a Draft →

STATE LICENSURE: Initial Report

Show Public Burden Statement

1. Subject Information | 2. Action Information | 3. Certification

ADVERSE ACTION INFORMATION

Help ?

Adverse Action Classification Codes

Select up to five adverse action classification codes from one of the action categories and click **Continue**.
Note: Any existing selections can be changed.

- [x] Revocation of License or Certificate (3111)
- [x] Suspension of License or Certificate (3136)
- [x] Reprimand or Censure (3138)
- [ ] Voluntary Surrender of License or Certificate (3141)
- [ ] Conditional, Provisional, or Probationary License or Certificate (3143)
- [ ] Denial of License or Certificate Renewal (3144)
- [ ] Denial of Initial License or Certificate (3145)
- [ ] Directed Plan of Correction (3202)
- [ ] On-Site Monitoring (3203)
- [ ] Monitoring (3204)
- [ ] Directed In-Service Training (3205)
- [ ] Appointment of Temporary Management (3206)
- [ ] Restrictions on Admissions or Services (3207)
- [ ] Closure of Facility (3210)
- [ ] Transfer of Residents to Other Facilities Without Closure of the Facility (3212)
- [ ] Receivership (3220)
- [ ] Liquidation (3225)
- [ ] Civil Money Penalty (3230)
- [ ] Publicly Available Fine/Monetary Penalty (3233)
- [ ] Summary or Emergency Action, Specify (3238)
- [x] Other Licensure Action - Not Classified, Specify (3239)

test

Basis for Action

Choose a basis for action that best describes the reason for the action.

Basis for Action 1

Basis for Action

Exclusion or Suspension From a Federal or State Health Care Program

Add basis for action

Entity: LICENSING BOARD (ROCKVILLE, MD) | User: boardadmin Sign

REPORT INPUT FORM

the DataBank NATIONAL PRACTITIONER

Basis for Action

Choose a basis for action that best describes the reason for the action.

Basis for Action 1

Basis for Action

Select a Basis for Action

Enter a keyword or phrase to find matching bases. (Example: "failure")

Search

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

Don't see what you're looking for?

REPORT INPUT FORM

theDataBank NATIONAL PRACTITIONER

Adverse Action Information

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

Date action was taken (When was the order issued, filed, or signed by the board?)

11 / 26 / 2014

Date action became effective (When did the action start?)

11 / 26 / 2014

Length of Action:

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

Years: 1

Months: 6

Days:

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) $2,000

Note: If no amount, leave this field blank.

Is the Action on Appeal?

- ◉ Yes
- ○ No
- ○ Unknown

Date of Appeal: 01 / 30 / 2015

REPORT INPUT FORM

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.

Practitioner injured three patients, so license has been revoked. He will be excluded from participating in federal health care programs.

There are **3863** 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:

Continue to Certification → Store as a Draft →

Entity: LICENSING BOARD (ROCKVILLE, MD) | User: boardadmin | Sign Out

REPORT INPUT FORM

STATE LICENSURE: Initial Report

Show Public Burden Statement

1. Subject Information | 2. Action Information | 3. Certification

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:	JANET DOE
Authorized Submitter's Title:	SUBMITTER
Authorized Submitter's Phone:	3013013011 Ext.
Date:	12/11/2014

Submit to Data Bank → | Store as a Draft →

FOOTCAREINC.

LICENSING BOARD

STATE LICENSURE ACTION — **Date of Action:** 11/26/2014

Initial Action	Basis for Initial Action
- REVOCATION OF LICENSE OR CERTIFICATE - SUSPENSION OF LICENSE OR CERTIFICATE - REPRIMAND OR CENSURE - OTHER LICENSURE ACTION, SEE SECTION C. OF THE REPORT FOR DETAILS	- EXCLUSION OR SUSPENSION FROM A FEDERAL OR STATE HEALTH CARE PROGRAM

A. REPORTING ENTITY

Entity Name:	LICENSING BOARD
Address:	123 CEDAR LANE
City, State, Zip:	ROCKVILLE, MD 20857-0001
Country:	
Name or Office:	JANET DOE
Title or Department:	BOARD OFFICIAL
Telephone:	(555) 555-5555
Entity Internal Report Reference:	
Type of Report:	INITIAL

B. SUBJECT IDENTIFICATION INFORMATION (ORGANIZATION)

Organization Name:	FOOTCAREINC.
Other Organization Name(s) Used:	
Business Address:	5600 FISHERS LN
City, State, ZIP:	ROCKVILLE, MD 20852-1750
Organization Type:	CHIROPRACTIC GROUP/PRACTICE (361)
Names and Titles of Principal Officers and Owners (POO):	MANN, ANITTA
Federal Employer Identification Numbers (FEIN):	111111111
Social Security Numbers (SSN):	
Individual Taxpayer Identification Numbers (ITIN):	
State License Number, State of Licensure:	SL89, MD
Is the Subject a health care entity that provides health care services and engages in a formal peer review process for the purpose of furthering quality health care?:	YES
Drug Enforcement Administration (DEA) Numbers:	
Clinical Laboratory Act (CLIA) Numbers:	
Food and Drug Administration (FDA) Numbers:	
National Provider Identifiers (NPI):	
Medicare Provider/Supplier Numbers:	
Name(s) of Health Care Entity (Entities) With Which Subject Is Affiliated or Associated (Inclusion Does Not Imply Complicity in the Reported Action.):	FOOTCAREINC2
Business Address of Affiliate:	
City, State, ZIP:	
Nature of Relationship(s):	SUBJECT IS SUBSIDIARY OF AFFILIATE OR ASSOCIATE (600)

C. INFORMATION REPORTED

Type of Adverse Action: STATE LICENSURE
Basis for Action: EXCLUSION OR SUSPENSION FROM A FEDERAL OR STATE HEALTH CARE PROGRAM (40)
Name of Agency or Program That Took the Adverse Action Specified in This Report: INTEGRITY PROGRAM
Adverse Action Classification Code(s): REVOCATION OF LICENSE OR CERTIFICATE (3111)
SUSPENSION OF LICENSE OR CERTIFICATE (3136)
REPRIMAND OR CENSURE (3138)
OTHER LICENSURE ACTION - NOT CLASSIFIED, SPECIFY (3239)
Other, as Specified: TEST
Date Action Was Taken: 11/26/2014
Date Action Became Effective: 11/26/2014
Length of Action: SPECIFIC PERIOD
Years: 1
Months: 6
Days:
Total Amount of Monetary Penalty, Assessment and/or Restitution: $ 2,000.00
Is Subject Automatically Reinstated After Adverse Action Period Is Completed?: NO
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: PRACTITIONER INJURED THREE PATIENTS, SO LICENSE HAS BEEN REVOKED. HE WILL BE EXCLUDED FROM PARTICIPATING IN FEDERAL HEALTH CARE PROGRAMS.

[X] Subject identified in Section B has appealed the reported adverse action.

Date of Appeal: 01/30/2015

D. SUBJECT STATEMENT

If the subject identified in Section B of this report has submitted a statement, it appears in this section.

E. REPORT STATUS

Unless a box below is checked, the subject of this report identified in Section B has not contested this report.

[ ] This report has been disputed by the subject identified in Section B.

[ ] At the request of the subject identified in Section B, this report is being reviewed by the Secretary of the U.S. Department of Health and Human Services to determine its accuracy and/or whether it complies with reporting requirements. No decision has been reached.

[ ] At the request of the subject identified in Section B, this report was reviewed by the Secretary of the U.S. Department of Health and Human Services and a decision was reached. The subject has requested that the Secretary reconsider the original decision.

[ ] At the request of the subject identified in Section B, this report was reviewed by the Secretary of the U.S. Department of Health and Human Services. The Secretary's decision is shown below:

Date of Original Submission: 12/11/2014
Date of Most Recent Change: 12/11/2014

This report is maintained under the provisions of: Section 1921

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END OF REPORT

Non-visible Questions

Label	PDF Name (page/section header)	Location	Response Input Item	Visibility Trigger	Other
Why does the subject not have a license?	SL New (1/Occupation and State Licensure Information)	Below "Unlicensed/No license number for this occupation"	Radio buttons	If user checks "Unlicensed/No license number for this occupation	Possible answers: State license expired Never had a valid state license Licensed in another state Don't know
The action(s) reported relate primarily to this occupation/license	SL New (1/Occupation and State Licensure Information)	Below each "State"	Radio button	If user enters more than one License/Profession	

State Changes

Label	PDF Name	Item Type	Visibility Trigger
Occupation/Field of Licensure Modal	SL SubjectInfo Occupation	Modal	When the "Occupation/Field of Licensure" text box is selected the Occupation or Field of Licensure modal shown in the SL SubjectInfo Occupation PDF appears.
Basis for Action Modal	SL ActionInfo Basis	Modal	When the "Basis for Action" text box is selected the Basis for Action modal shown in the SL ActionInfo Basis PDF appears.