

REPORT INPUT FORM

DEA/FEDERAL 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.

Personal Information

Practitioner Name

Last Name	First Name	Middle Name	Suffix (Jr, III)
<input type="text" value="MANN"/>	<input type="text" value="ANITA"/>	<input type="text"/>	<input type="text"/>

[Add another name used](#)

Gender

 Male Female Unknown

Birth Date

Is Subject Deceased?

 No Unknown Yes

REPORT INPUT FORM

Home Address/Address of Record

Street Address:
Address Line 2:
City:
State:
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:
Type:

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)

REPORT INPUT FORM



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

Organization

Name: LICENSING BOARD

Type:

- CHOOSE ONE FROM LIST
- CHOOSE ONE FROM LIST
- **GROUP OR PRACTICE (choose one from below)
- 361 Chiropractic Group/Practice
- 362 Dental Group/Practice
- 365 Medical Group/Practice
- 366 Mental Health/Substance Abuse Group/Practice
- 363 Optician/Optomeric Group/Practice
- 367 Physical/Occupational Therapy Group/Practice
- 364 Podiatric Group/Practice
- 393 Home Health Agency/Organization
- 382 Hospice/Hospice Care Provider
- **HOSPITAL (choose one from below)
- 301 General/Acute Care Hospital
- 302 Psychiatric Hospital
- 303 Rehabilitation Hospital
- 304 Federal Hospital

Click [Help ?](#) for int

Address

Street Address: 393 Home Health Agency/Organization

Address Line 2: 382 Hospice/Hospice Care Provider

City: **HOSPITAL (choose one from below)

State: 301 General/Acute Care Hospital

ZIP Code: 302 Psychiatric Hospital

Country: 303 Rehabilitation Hospital

(if U.S., leave blank) 304 Federal Hospital

REPORT INPUT FORM

Social Security Numbers (SSN)

111111111

[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

AM123456789

[Add another DEA Number](#)

Unique Physician Identification Numbers (UPIN)

[Add another UPIN](#)

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

REPORT INPUT FORM



Occupation And State Licensure Information

Add information for at least one state license.

License 1

Occupation/Field of Licensure

Other Name for Occupation (Optional)

Select an Occupation or Field of Licensure

Enter a keyword or phrase to find matching occupations. (Example: "counselor")

Search

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

Nurse Aide/Nursing Assistant
Home Health Aide (Homemaker)

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

REPORT INPUT FORM



[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)
<input type="text" value="NEW YORK COLLEGE OF PODIATRIC MEDICINE"/>	<input type="text" value="2006"/>

[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:

Address

Street Address:

Address Line 2:

City:

State:

ZIP Code: -

Country:

(if U.S., leave blank)

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

The subject is a

[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](#) →

REPORT INPUT FORM



DEA/FEDERAL 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.

- Revocation of License (1110)
- Probation of License (1125)
- Suspension of License (1135)
- 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)
- Publicly Available Fine/Monetary Penalty (1173)
- Publicly Available Negative Action or Finding, Specify (1189)
- Other Licensure Action - Not Classified, Specify (1199)

Basis for Action

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

Basis for Action 1

Basis for Action

License Revocation, Suspension or Other Disciplinary Action Taken by a Federal, State or Local Licens

[Add](#) basis for action

REPORT INPUT FORM

Basis for Action

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

Basis for Action 1

Basis for Action

License Revocation, Suspension or Other Disciplinary Action Taken by a Federal, State or Local License

[Add](#) basis for action

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

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REPORT INPUT FORM



Basis for Action 1

Basis for Action

License Revocation, Suspension or Other Disciplinary Action Taken by a Federal, State or Local License

[Add](#) basis for action

Adverse Action Information

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

ABC Integrity Program

Date action was taken:

11 / 15 / 2014

Date action became effective:

11 / 15 / 2014

Length of Action:

- Permanent
- Indefinite/Unspecified
- Specific Period

Years: 2

Months:

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:

\$1,000.00

(Format NNNNN.NN)

Note: If no amount, leave this field blank.

Is the Action on Appeal?

- Yes
- No
- Unknown

Date of Appeal:

12 / 22 / 2014

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.

Federal licensure action related to Drug Enforcement Administration registration.

There are **3919** 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 →](#)

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REPORT INPUT FORM



DEA/FEDERAL 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:

Authorized Submitter's Title:

Authorized Submitter's Phone: Ext.

Date:

[Submit to Data Bank →](#)

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MANN, ANITTA

MERGE13 STAT16 TESTING

DEA/FEDERAL LICENSURE ACTION

Date of Action: 11/15/2014

Initial Action

Basis for Initial Action

- REVOCATION OF LICENSE
- SUSPENSION OF LICENSE

- LICENSE REVOCATION, SUSPENSION OR OTHER
DISCIPLINARY ACTION TAKEN BY A FEDERAL, STATE OR
LOCAL LICENSING AUTHORITY

**A. REPORTING
ENTITY**

Entity Name: MERGE13 STAT16 TESTING
Address: 109 GERNANY WAY
City, State, Zip: BANBURG, VA 20175
Country:
Name or Office: MERGE13 STATRULE16 TESTING
Title or Department: DEPT
Telephone: (703) 803-1500
Entity Internal Report Reference:
Type of Report: INITIAL

**B. SUBJECT
IDENTIFICATION
INFORMATION
(INDIVIDUAL)**

Subject Name: MANN, ANITTA
Other Name(s) Used:
Gender: FEMALE
Date of Birth: 01/01/1982
Organization Name: LICENSING BOARD
Work Address: 1234 FEDERAL LN
City, State, ZIP: ANNAPOLIS, MD 21401
Organization Type: FEDERAL HOSPITAL (304)
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: NEW YORK COLLEGE OF PODIATRIC MEDICINE (2006)
Occupation/Field of Licensure (Code): PODIATRIST
State License Number, State of Licensure: SL56, MD
Drug Enforcement Administration (DEA) Numbers: AM123456789
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.): FOOTCAREINC
Business Address of Affiliate:
City, State, ZIP:
Nature of Relationship(s):

C. INFORMATION REPORTED

Type of Adverse Action: DEA/FEDERAL LICENSURE
Basis for Action: LICENSE REVOCATION, SUSPENSION OR OTHER DISCIPLINARY ACTION TAKEN BY A FEDERAL, STATE OR LOCAL LICENSING AUTHORITY (39)

Name of Agency or Program That Took the Adverse Action Specified in This Report: ABC INTEGRITY PROGRAM

Adverse Action Classification Code(s): REVOCATION OF LICENSE (1110)
SUSPENSION OF LICENSE (1135)

Date Action Was Taken: 11/15/2014
Date Action Became Effective: 11/15/2014
Length of Action: SPECIFIC PERIOD
Years: 2
Months:
Days:

Total Amount of Monetary Penalty, Assessment and/or Restitution: \$ 1,000.00
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: FEDERAL LICENSURE ACTION RELATED TO DRUG ENFORCEMENT ADMINISTRATION REGISTRATION.

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

Date of Appeal: 12/22/2014

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: 12/08/2014
Date of Most Recent Change: 12/08/2014

This report is maintained under the provisions of: Section 1128E

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Section 1128E 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

REPORT INPUT FORM

DEA/FEDERAL LICENSURE: Initial Report

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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 ?

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: 364 Podiatric Group/Practice ▼

REPORT INPUT FORM



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](#)

REPORT INPUT FORM



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](#)

Principal Officers and Owners

Last Name	First Name	Middle Name	Suffix	Title
<input type="text" value="MANN"/>	<input type="text" value="ANITTA"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

[Add another Principal Officer or Owner](#)

REPORT INPUT FORM



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:
ZIP Code: -
Country:
(if U.S., leave blank)

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

The subject is a

[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.



[Continue to Action Information →](#)

[Store as a Draft →](#)

REPORT INPUT FORM

DEA/FEDERAL 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.

- Revocation of License or Certificate (3111)
- Suspension of License or Certificate (3136)
- 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)
- Other Licensure Action - Not Classified, Specify (3239)

Basis for Action

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

Basis for Action 1

Basis for Action

[Add](#) basis for action

REPORT INPUT FORM

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

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

Adverse Action Information

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

Date action was taken:

Date action became effective:

Length of Action:

- Permanent
 Indefinite/Unspecified
 Specific Period

Years:

Months:

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)

Note: If no amount, leave this field blank.

Is the Action on Appeal?

- Yes
 No
 Unknown

Date of Appeal:

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.

Federal licensure action related to Drug Enforcement Administration registration.

There are 3919 characters remaining for the description.

[Spell Check](#)

REPORT INPUT FORM

There are **3919** 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 →](#)

REPORT INPUT FORM



DEA/FEDERAL 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:

Authorized Submitter's Title:

Authorized Submitter's Phone: Ext.

Date:

[Submit to Data Bank →](#)

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FOOTCAREINC.

MERGE13 STAT16 TESTING

DEA/FEDERAL LICENSURE ACTION

Date of Action: 11/11/2014

Initial Action

Basis for Initial Action

- REVOCATION OF LICENSE OR CERTIFICATE
- SUSPENSION OF LICENSE OR CERTIFICATE

- EXCLUSION OR SUSPENSION FROM A FEDERAL OR
STATE HEALTH CARE PROGRAM

A. REPORTING ENTITY

Entity Name: MERGE13 STAT16 TESTING
Address: 109 GERNANY WAY
City, State, Zip: BANBURG, VA 20175
Country:
Name or Office: MERGE13 STATRULE16 TESTING
Title or Department: DEPT
Telephone: (703) 803-1500
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: PODIATRIC GROUP/PRACTICE (364)
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
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):

C. INFORMATION REPORTED

Type of Adverse Action: DEA/FEDERAL 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: ABC PROGRAM INTEGRITY
Adverse Action
Classification Code(s): REVOCATION OF LICENSE OR CERTIFICATE (3111)
SUSPENSION OF LICENSE OR CERTIFICATE (3136)
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: \$ 5,000.00
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: FEDERAL LICENSURE ACTION RELATED TO DRUG ENFORCEMENT ADMINISTRATION REGISTRATION.

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

Date of Appeal: 12/12/2014

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: 12/08/2014

Date of Most Recent Change: 12/08/2014

This report is maintained under the provisions of: Section 1128E

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Section 1128E 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