

REPORT INPUT FORM

EXCLUSION/DEBARMENT: 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

REPORT INPUT FORM

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



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](#)

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)
<input type="text" value="Podiatrist"/>	<input type="text"/>
State	License Number
<input type="text" value="MD Maryland"/>	<input type="text" value="SL56"/>
<input type="checkbox"/> 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)
<input type="text"/>	<input type="text"/>

[Add another Professional School](#)

REPORT INPUT FORM



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

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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.

[Help ?](#)

[Continue to Action Information →](#)

[Store as a Draft →](#)

REPORT INPUT FORM



EXCLUSION/DEBARMENT: 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 three adverse action classification codes from one of the action categories and click **Continue**.

Note: Any existing selections can be changed.

- Debarment From Federal Programs (1500)
- Exclusion From a Federal Health Care Program (1505)
- Exclusion From a State Health Care Program (1507)

Basis for Action

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

Basis for Action 1

Basis for Action

Conviction Relating to Controlled Substances

[Add](#) basis for action

REPORT INPUT FORM



Select a Basis for Action

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

Search

Criminal Conviction

Conviction Relating to Controlled Substances
Conviction Relating to Fraud
Conviction Relating to Obstruction of an Investigation
Conviction Relating to Patient Abuse or Neglect
Criminal Conviction - Not Classified
Felony Conviction Relating to Controlled Substance Violations
Felony Conviction Relating to Health Care Fraud
Program-Related Conviction

Other

Conflict of Interest
Corporate Integrity Agreement Breach
Default on Health Education Loan or Scholarship Obligations
Entities Owned or Controlled by a Sanctioned Individual
Exclusion or Suspension From a Federal or State Health Care Program
Failure to Grant Immediate Access

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REPORT INPUT FORM



Adverse Action Information

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

Program Integrity Initiative

Date action was taken:

10 / 10 / 2014

Date action became effective:

10 / 10 / 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

Is the Action on Appeal?

- Yes
- No
- Unknown

Date of Appeal:

12 / 12 / 2014

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.

REPORT INPUT FORM



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:

[Continue to Certification →](#)

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REPORT INPUT FORM



EXCLUSION/DEBARMENT: Initial Report

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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 →](#)

[Store as a Draft →](#)

MANN, ANITTA

LICENSING BOARD

EXCLUSION/DEBARMENT ACTION

Date of Action: 10/10/2014

Initial Action

Basis for Initial Action

- EXCLUSION FROM A FEDERAL HEALTH CARE PROGRAM

- CONVICTION RELATING TO CONTROLLED SUBSTANCES

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 (INDIVIDUAL)

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:
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.):

Business Address of Affiliate:
City, State, ZIP:

Nature of Relationship(s):

C. INFORMATION REPORTED

Type of Adverse Action: EXCLUSION/DEBARMENT
Basis for Action: CONVICTION RELATING TO CONTROLLED SUBSTANCES (66)
Name of Agency or Program That Took the Adverse Action Specified in This Report: PROGRAM INTEGRITY INITIATIVE
Adverse Action Classification Code(s): EXCLUSION FROM A FEDERAL HEALTH CARE PROGRAM (1505)
Date Action Was Taken: 10/10/2014
Date Action Became Effective: 10/10/2014
Length of Action: SPECIFIC PERIOD
Years: 2
Months:
Days:
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: PRACTITIONER DIVERTED DRUGS FOR PERSONAL USE.

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: 12/05/2014

Date of Most Recent Change: 12/05/2014

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.

DCN: 5950000090960775
Process Date: 12/05/2014
Page: 3 of 3
MANN, ANITTA
For authorized use by:
LICENSING BOARD

END OF REPORT

REPORT INPUT FORM



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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 ?](#)

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: 361 Chiropractic 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](#)

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 ?](#)

REPORT INPUT FORM



EXCLUSION/DEBARMENT: Initial Report

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1. Subject Information

2. Action Information

3. Certification

ADVERSE ACTION INFORMATION

[Help ?](#)

Adverse Action Classification Codes

Select up to three adverse action classification codes from one of the action categories and click **Continue**.

Note: Any existing selections can be changed.

- Debarment From Federal Programs (3500)
- Exclusion From a Federal Health Care Program (3505)
- Exclusion From a State Health Care Program (3507)

Basis for Action

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

Basis for Action 1

Basis for Action

Conviction Relating to Patient Abuse or Neglect

[Add](#) basis for action

REPORT INPUT FORM



EXCLUSION/DEBARMENT: Initial Report

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✖

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

Search

Criminal Conviction

Conviction Relating to Controlled Substances
Conviction Relating to Fraud
Conviction Relating to Obstruction of an Investigation
Conviction Relating to Patient Abuse or Neglect
Criminal Conviction - Not Classified
Felony Conviction Relating to Controlled Substance Violations
Felony Conviction Relating to Health Care Fraud
Program-Related Conviction

Other

Conflict of Interest
Corporate Integrity Agreement Breach
Default on Health Education Loan or Scholarship Obligations
Entities Owned or Controlled by a Sanctioned Individual
Exclusion or Suspension From a Federal or State Health Care Program
Failure to Grant Immediate Access

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REPORT INPUT FORM

Adverse Action Information

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

Program Integrity

Date action was taken:

02 / 20 / 2014

Date action became effective:

02 / 20 / 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

Is the Action on Appeal?

- Yes
- No
- Unknown

Date of Appeal:

11 / 11 / 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.

Practitioner neglected patient and did not meet standard of care.

There are **3935** 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



EXCLUSION/DEBARMENT: 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 →](#)

[Store as a Draft →](#)

FOOTCAREINC.

LICENSING BOARD

EXCLUSION/DEBARMENT ACTION

Date of Action: 02/20/2014

Initial Action

Basis for Initial Action

- EXCLUSION FROM A FEDERAL HEALTH CARE PROGRAM

- CONVICTION RELATING TO PATIENT ABUSE OR NEGLECT

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
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: EXCLUSION/DEBARMENT
Basis for Action: CONVICTION RELATING TO PATIENT ABUSE OR NEGLECT (63)
Name of Agency or Program That Took the Adverse Action Specified in This Report: PROGRAM INTEGRITY
Adverse Action Classification Code(s): EXCLUSION FROM A FEDERAL HEALTH CARE PROGRAM (3505)
Date Action Was Taken: 02/20/2014
Date Action Became Effective: 02/20/2014
Length of Action: SPECIFIC PERIOD

Years: 1

Months: 6

Days:

Is Subject Automatically Reinstated After
Adverse Action Period Is Completed?: YES

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 NEGLECTED PATIENT AND DID NOT MEET STANDARD
OF CARE.

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

Date of Appeal: 11/11/2014

**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: 12/05/2014

Date of Most Recent Change: 12/05/2014

This report is maintained under the provisions of: Section 1921

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END OF REPORT