

### **EXCLUSION/DEBARMENT: Initial Report**

### Hide Public Burden Statement

OMB # 0915-0126 expiration date 05/31/16

<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 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

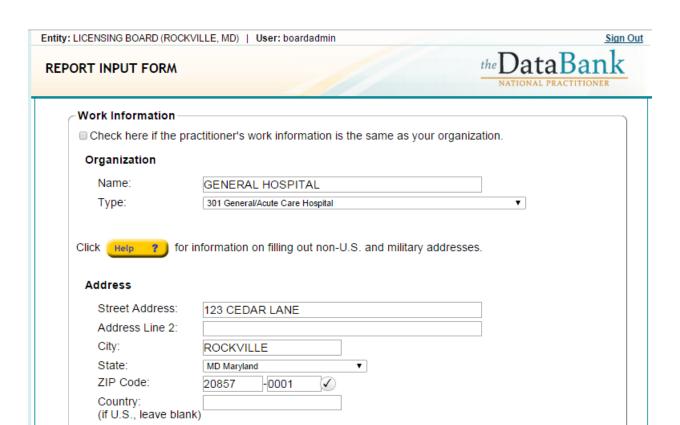
### PRACTITIONER INFORMATION



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	n			
Practitioner Name				
Last Name MANN	First Name ANITTA	Middle Name	Suffix (Jr, III)	
Add another name	e used			
Gender	e O Unknown			
Birth Date				
01 / 01 / 1982				
ls Subject Decease	d?			
No □ Unknow	wn Yes			

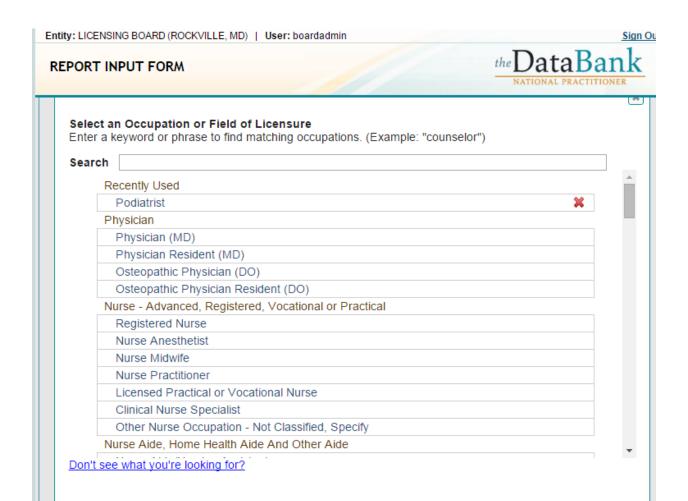


Entity: LICENSING BOARD (ROCKVILLE, MD)   User: boardadmin	Sign Out
REPORT INPUT FORM	the DataBank NATIONAL PRACTITIONER
Social Security Numbers (SSN)	

	NATIONAL PRACTITIONER
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	
AM11111111 Add another DEA Number	
Unique Physician Identification Numbers (UPIN)	
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Entity: LICENSING BOARD (ROCKVILLE, MD)   User: boardadmin	Sign Out
REPORT INPUT FORM	the DataBank

Occupation And State Licensure Information—	
Add information for at least one state license.	
License 1	
Occupation/Field of Licensure	Other Name for Occupation (Optional)
Podiatrist	( )
State License Numbe	unlicensed / No license number for
MD Maryland ▼ SL56	this occupation
Add occupation/field of licensure	
Add occupation/field of ficeristic	
Professional Schools Attended	
The form will suggest schools as you type. Please c school name.	hoose the matching school or enter the complete
	Year of
School Name:	Graduation (YYYY)





reported action.	ffiliated/associated health care entity in this report does not imply complicity in the Click Help ? for information on filling out non-U.S. and military addresses.
Name of	
Affiliated/Associa Health Care Ent	
Address	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST ▼
ZIP Code:	- 7
Country: (if U.S., leave blank)	
-	ect of this report related to the affiliated entity?
The subject is a	CHOOSE ONE FROM LIST ▼
Add another Affi	<u>liate</u>
ise in future queries:	wish to add/update this subject in your subject database for and/or reports. Duplicate entries in your subject database may eries. You will be notified of potential duplicate entries prior to ct entry.

# EXCLUSION/DEBARMENT: Initial Report

Show Public Burden Statement

1. Subject Information

2. Action Information

3. Certification

### ADVERSE ACTION INFORMATION



### 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

Failure to Grant Immediate Access

Don't see what you're looking for?



2
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:
n of Adverse Action Period?
n or Autoroo Action 1 orlow:
evision to Action Report when status changes)
12 / 12 / 2014

PORT INPUT FORM	the DataBank
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Entity Internal Report Reference	
Spell Check	
Entity Internal Report Reference  This optional field allows your entity to include an internal to help you identify this report in your files. This information	

Continue to Certification →

Store as a Draft →

Customer Use:

Subject Information	2. Action	Information	3. Certification	on	
-Certification-					
I certify that I am a the best of my kno		submit this trans	saction and that a	all information is	true and correct to
Authorized Subm	itter's Name:	JANET DOE			
Authorized Subm	itter's Title:	BOARD OFFIC	CIAL		
Authorized Subm	itter's Phone:	555555555	E	Ext.	
Date:		12/05/2014			_
Date:		12/05/2014			



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**DCN:** 5950000090960775 **Process Date:** 12/05/2014

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MANN, ANITTA
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LICENSING BOARD

# MANN, ANITTA

# LICENSING BOARD

# EXCLUSION/DEBARMENT ACTION

Basis for Initial Action

**Date of Action:** 10/10/2014

**Initial Action** 

Busis 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):

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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:  $\ensuremath{\,^{\mathrm{PROGRAM}}}$  <code>INTEGRITY INITIATIVE</code>

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.

X 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.

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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.

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MANN, ANITTA
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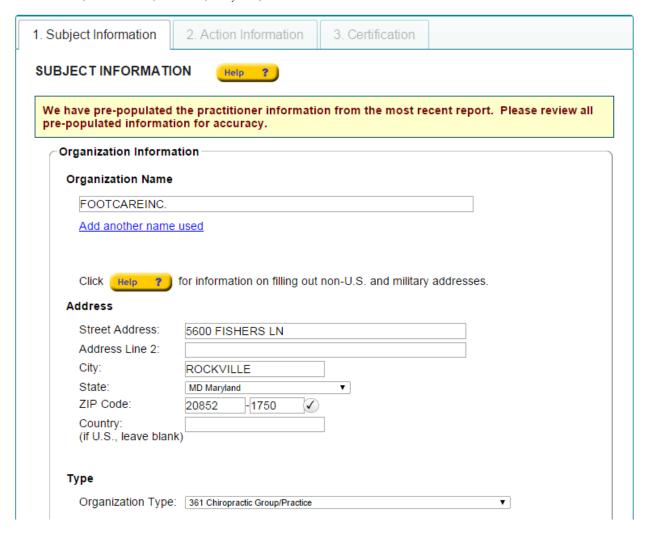
END OF REPORT —



#### Hide Public Burden Statement

OMB # 0915-0126 expiration date 05/31/16

<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 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.





Federal Employer Identification Numbers (FEIN)	
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Add another FEIN	
Social Security Numbers (SSN)	
Add another SSN	
Add another 55N	
Individual Taxpayer Identification Numbers (ITIN)	
Add another ITIN	
Drug Enforcement Administration (DEA) Numbers	
Add and the SEA Name	
Add another DEA Number	
Clinical Laboratory Improvement Act (CLIA) Numbers	
Add another CLIA Number	
Federal Food and Drug Administration (FDA) Numbers	
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State License Number: State of Licensur	SL89 OR No License  Te: MD Maryland   T
Add another Lice	<u>ense</u>
Principal Officers a	nd Owners
Last Name MANN	First Name Middle Name Suffix Title ANITTA
Add another Prin	ncipal Officer or Owner
Address	
Street Address:	
Street Address: Address Line 2: City:	
Address Line 2: City: State:	CHOOSE ONE FROM LIST ▼
Address Line 2: City:	CHOOSE ONE FROM LIST ▼
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Address Line 2: City: State: ZIP Code: Country: (if U.S., leave blank)	ct of this report related to the affiliated entity?
Address Line 2: City: State: ZIP Code: Country: (if U.S., leave blank)  How is the subje	ct of this report related to the affiliated entity?



### **EXCLUSION/DEBARMENT: Initial Report**

Show Public Burden Statement

2. Action Information 1. Subject 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

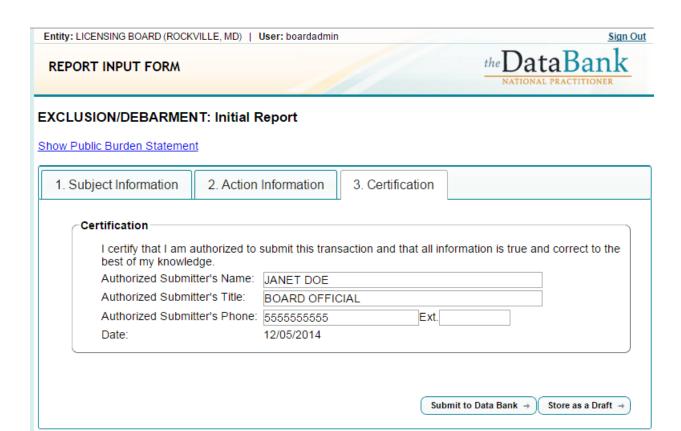




verse Action Information	
Name of Agency or Program that Took the Adverse Action Specified in This Report:	Program Integrity
Date action was taken:	
02 / 20 / 2014	
Date action became effective:	
02 / 20 / 2014	
Length of Action:	
<ul> <li>Permanent</li> </ul>	
<ul> <li>Indefinite/Unspecified</li> </ul>	
<ul><li>Specific Period</li></ul>	
Year	rs: <mark>1</mark>
Month	ns: <sub>6</sub>
Day	vs:
Is Reinstatement Automatic at Completio  • Yes	on of Adverse Action Period?
<ul><li>Yes, with conditions (requires a R</li><li>No</li></ul>	evision to Action Report when status changes)
Is the Action on Appeal?	
Yes	
○ No	
Unknown	
Date of Appeal:	11 / 11 / 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.
	Practitioner neglected patient and did not meet standard of care.
	There are 3935 characters remaining for the description.
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E	ntity Internal Report Reference
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Eı	ntity 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
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	ntity 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)  ustomer 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.
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DCN: 5950000090960776 Process Date: 12/05/2014

Page: 1 of 2 FOOTCAREINC. For authorized use by: LICENSING BOARD

# FOOTCAREINC.

# LICENSING BOARD

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**Basis for Initial Action** 

Date of Action: 02/20/2014

**Initial Action** 

- CONVICTION RELATING TO PATIENT ABUSE OR

- EXCLUSION FROM A FEDERAL HEALTH CARE

**PROGRAM** 

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** 

Organization Name: FOOTCAREINC.

**IDENTIFICATION INFORMATION** (ORGANIZATION) 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

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FOOTCAREINC.
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Description of S	Years: Months: Days: Subject Automatically Reinstated After Adverse Action Period Is Completed?: ubject's Act(s) or Omission(s) or Other ten and Description of Action(s) Taken by Reporting Entity:  X Subject identified in Section B ha	6
D. SUBJECT STATEMENT	If the subject identified in Section B o	f this report has submitted a statement, it appears in this section.
E. REPORT STATUS	This report has been disputed by At the request of the subject ide U.S. Department of Health and reporting requirements. No dec	entified in Section B, this report was reviewed by the Secretary of the U.S. an Services and a decision was reached. The subject has requested that
The information contained provisions of Section 192 the purpose for which it w	d under the provisions of: Section d in this report is maintained by the 1 of the Social Security Act, and 45	n 1921  National Practitioner Data Bank for restricted use under the  CFR Part 60. All information is confidential and may be used only for confidential information for other purposes is a violation of federal law.

END OF REPORT —