

## REPORT INPUT FORM

## 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

## 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](#)

## 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



[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

### 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](#)

### 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



### 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.

- 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)
- Prescriptive Authority Action, Specify (1179)
- 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

[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

#### 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?](#)



## REPORT INPUT FORM



### Adverse Action Information

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

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

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

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:

## 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 quierers.

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:

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## 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**

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: 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

DCN: 5950000090960809  
Process Date: 12/11/2014  
Page: 2 of 3  
MANN, ANITTA  
For authorized use by:  
LICENSING BOARD

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

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:

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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.

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**END OF REPORT**

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## REPORT INPUT FORM

## 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: 361 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)

[Add another FEIN](#)

### Social Security Numbers (SSN)

[Add another SSN](#)

### Individual Taxpayer Identification Numbers (ITIN)

[Add another ITIN](#)

### Drug Enforcement Administration (DEA) Numbers

[Add another DEA Number](#)

### Clinical Laboratory Improvement Act (CLIA) Numbers

[Add another CLIA Number](#)

### Federal Food and Drug Administration (FDA) Numbers

[Add another FDA Number](#)

### National Provider Identifiers (NPI)

[Add another NPI](#)

### Medicare Provider/Supplier Numbers

[Add another Medicare Provider/Supplier Number](#)

### Organization State Licensure Information

(If no State License, check the 'No License' box.)

State License  
Number:

OR

No License

State of Licensure:

[Add another License](#)



## REPORT INPUT FORM

## 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

[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



### STATE LICENSURE: Initial Report

[Show Public Burden Statement](#)

1. Subject Information	2. Action Information	3. Certification
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#### 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)
- Summary or Emergency Action, Specify (3238)
- 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

### 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:

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](#) →

## 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:

Authorized Submitter's Title:

Authorized Submitter's Phone:  Ext.

Date:

[Submit to Data Bank →](#)

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**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.

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:



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Date of Original Submission: 12/11/2014

Date of Most Recent Change: 12/11/2014

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**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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**END OF REPORT**

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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.