REPORT INPUT FORM

the DataBank NATIONAL PRACTITIONER

Medical Malpractice Payment Report: 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)	
BLAH				
				Remove

Add another name used

Is Subject Deceased?

○ No ○ Unknown ○ Yes

Gender

○ Male ○ Female ○ Unknown

Birth Date

MM / DD / YYYY

REPORT INPUT FORM

Home Address/Address of Record

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

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:

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

Address

Street Address:

Address Line 2:

City:

State: CHOOSE ONE FROM LIST

ZIP Code: -

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

REPORT INPUT FORM

Social Security Numbers (SSN)

Remove

Add another SSN

Drug Enforcement Administration (DEA) Numbers

Remove

Add another DEA Number

Occupation And State Licensure Information

Add information for at least one state license.

License 1

Occupation/Field of Licensure

Other Name for Occupation (Optional)

State

CHOOSE ONE FROM LIST

License Number

Unlicensed / No license number for this occupation

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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: CHOOSE ONE FROM LIST

License Number:

☐ Unlicensed / No license number for this occupation

Add occupation/field of licensure

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

Don't see what you're looking for?

REPORT INPUT FORM

the DataBank
NATIONAL PRACTITIONER

Professional Schools Attended

The form will suggest schools as you type. Please choose the matching school or enter the complete school name.

School Name: Year of Graduation (YYYY)

Remove

Add another Professional School

Hospital Affiliation(s)

Name City State

CHOOSE ONE FROM LIST

CHOOSE ONE FROM LIST Remove

Add another Hospital 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 →

Return to Options

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

REPORT INPUT FORM

the DataBank NATIONAL PRACTITIONER

Medical Malpractice Payment Report: Initial Report

Show Public Burden Statement

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

Payments by This Payer for This Practitioner

Amount of This Payment for This Practitioner: (Format NNNNN.NN) $ 1

Date of This Payment: 11 / 25 / 2014

This Payment Represents:
- A Single Final Payment
- One of Multiple Payments

Total Amount Paid or to Be Paid by This Payer for This Practitioner: (Format NNNNN.NN) $ 1

Payment Result of:
- Judgment
- Settlement (selected)
- Payment Prior to Settlement

Date of Judgment or Settlement: If any 11 / 25 / 2014

Adjudicative Body Case Number: (If applicable)

Adjudicative Body Name: (If applicable)

Court File Number: (If applicable)

Description of Judgment or Settlement and Any Conditions, Including Terms of Payment
Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Did not properly care for foot.

There are 3969 characters remaining for the description.

Spell Check

REPORT INPUT FORM

the DataBank
NATIONAL PRACTITIONER

Payments by This Payer for Other Practitioners in This Case

Total Amount Paid or to Be Paid by This Payer for All Practitioners in This Case: (Format NNNNN.NN) $ ______

(Including the Amount Specified Above for This Practitioner)

Number of Practitioners for Whom This Payer Has Paid or Will Pay in This Case: ______

Payment Information

Relationship of Entity to This Practitioner: Insurance Company - Primary Insurer

Payments by Others for This Practitioner

Complete if your entity is an Insurance Company or a Self-Insured Organization. Has a State Guaranty Fund or State Excess Judgment Fund Made a Payment for This Practitioner in This Case, or Is Such a Payment Expected to Be Made?:

- ○ Yes
- ○ No
- ○ Unknown

Complete if your entity is an Insurance Company, an Insurance Guaranty Fund or a State Medical Malpractice Payment Fund. Has a Self-Insured Organization and/or Other Insurance Company/Companies Made Payment(s) for This Practitioner in This Case, or Is/Are Such Payment (s) Expected to Be Made?:

- ○ Yes
- ○ No
- ○ Unknown

Classification of Act(s) or Omission(s)

Patient Information

Patient's Age at Time of Initial Event:

- ○ Days (if less than 1 month)
- ○ Months (if less than 1 year)
- ○ Years
- ● Unknown

Patient's Gender:

- ○ Male
- ○ Female
- ● Unknown

Patient Type:

- ○ Inpatient
- ○ Outpatient
- ○ Both
- ● Unknown

Description of the Medical Condition With Which the Patient Presented for Treatment (Prior to the Event That Led to the Malpractice Allegation)
Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Did not have a good foot.

There are **3975** characters remaining for the description.

Spell Check

Description of the Procedure Performed
Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Looked at foot.

There are **3985** characters remaining for the description.

Spell Check

Allegation

Nature of Allegation: 100 Behavioral Health Related

Specific Allegation:

Date of Event Associated With Allegation or Incident: MM / DD / YYYY

Add another Allegation

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

REPORT INPUT FORM

the DataBank NATIONAL PRACTITIONER

the subject of this report.

Select a Specific Allegation
Enter a keyword or phrase to find matching specific allegations. (Example: "failure")

Search

Failure to Take Appropriate Action

- Failure To Use Aseptic Technique
- Failure To Diagnose
- Failure To Delay A Case When Indicated
- Failure To Identify Fetal Distress
- Failure To Treat Fetal Distress
- Failure To Medicate
- Failure To Monitor
- Failure To Order Appropriate Medication
- Failure To Order Appropriate Test
- Failure To Perform Preoperative Evaluation
- Failure To Perform Procedure
- Failure To Perform Resuscitation
- Failure To Recognize A Complication
- Failure To Treat

Don't see what you're looking for?

There are **3985** characters remaining for the description.

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Outcome

Outcome:

01 Emotional injury only

Description of the Allegations and Injuries or Illnesses Upon Which the Action or Claim Was Based
Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

Patient was really upset.

There are **3975** 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 →

Return to Options

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

Sign Out

REPORT INPUT FORM

the DataBank
NATIONAL PRACTITIONER

Medical Malpractice Payment Report: Initial Report

Show Public Burden Statement

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

Send to State Board

Federal law (42 USC §11134(c)(1)) requires that you send a copy of your report to the appropriate state licensing board in the state in which the medical malpractice claim arose.

According to Data Bank records, licenses or certifications for **Podiatrist** in the state of **MARYLAND** are administered by:

BOARD OF PODIATRIC MEDICAL EXAMINERS (BALTIMORE, MD)

To fulfill my organization's legal requirement to report this action to the state board:

- ( ) I agree to allow the Data Bank to send an electronic report notice to **BOARD OF PODIATRIC MEDICAL EXAMINERS**. I attest that this is the correct state board to notify based on where the medical malpractice claim arose.
- (•) I attest that I will provide a copy of this report to the appropriate state board.

Note:

- If you choose to send an electronic report notice to the state board, you should receive an email as well as a Data Bank correspondence within 7 days verifying that the state board has or has not viewed the electronic notice.
- If the appropriate state board is not listed here you must mail a printed copy of the official report (the Report Verification Document) to the appropriate state licensing board(s) to fulfill this requirement. If the practitioner was not licensed in the state in which the medical malpractice claim arose (which may be the case with payments for federally-employed practitioners) or if the claim arose for care provided at overseas military locations, you must send a copy of the report to the licensing board in at least one state in which the practitioner is licensed.

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: BOARD OFFICIAL

Authorized Submitter's Phone: 5555555555 Ext.

Date: 11/25/2014

Submit to Data Bank → | Store as a Draft →

Return to Options

the DataBank

P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb.hrsa.gov

MANN, ANITTA

LICENSING BOARD

MEDICAL MALPRACTICE PAYMENT REPORT — Date of Action: 11/25/2014

Initial Action	Basis for Initial Action
- SETTLEMENT	- FAILURE TO USE ASEPTIC TECHNIQUE - FAILURE TO DIAGNOSE

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:	LICENSING BOARD
Work Address:	123 CEDAR LANE
City, State, ZIP:	ROCKVILLE, MD 20857-0001
Home Address:	5600 FISHERS LN
City, State, ZIP:	ROCKVILLE, MD 20852-1750
Deceased:	NO
Social Security Numbers (SSN):	***-**-1111
Professional School(s) & Year(s) of Graduation:	UNIVERSITY OF THE FOOT (2006)
Occupation/Field of Licensure (Code):	PODIATRIST
State License Number, State of Licensure:	SL56, MD
Drug Enforcement Administration (DEA) Numbers:	AM111111111
Hospital Affiliation(s):	

C. INFORMATION REPORTED

Date of Report:	11/25/2014
Relationship of Entity to This Practitioner:	INSURANCE COMPANY - PRIMARY INSURER

PAYMENTS BY THIS PAYER FOR THIS PRACTITIONER

Amount of This Payment for This Practitioner:	$ 1.00
Date of This Payment:	11/25/2014
This Payment Represents:	A SINGLE FINAL PAYMENT
Total Amount Paid or to Be Paid by This Payer for This Practitioner:	$ 1.00
Payment Result of:	SETTLEMENT
Date of Judgment or Settlement, if Any:	11/25/2014
Adjudicative Body Case Number:	
Adjudicative Body Name:	

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

Court File Number:

Description of Judgment or Settlement and Any Conditions, Including Terms of Payment: DID NOT PROPERLY CARE FOR FOOT.

PAYMENTS BY THIS PAYER FOR OTHER PRACTITIONERS IN THIS CASE

Total Amount Paid or to Be Paid by This Payer for All Practitioners in This Case:

Number of Practitioners for Whom This Payer Has Paid or Will Pay in This Case:

PAYMENTS BY OTHERS FOR THIS PRACTITIONER

Has a State Guaranty Fund or State Excess Judgment Fund Made a Payment for This Practitioner in This Case, or Is Such a Payment Expected to Be Made?:

Amount Paid or Expected to Be Paid by the State Fund:

Has a Self-Insured Organization and/or Other Insurance Company/Companies Made Payment(s) for This Practitioner in This Case, or Is/Are Such Payment(s) Expected to Be Made?:

Amount Paid or Expected to Be Paid by Self-Insured Organization(s) and/or Other Insurance Company/Companies:

CLASSIFICATION OF ACT(S) OR OMISSION(S)

Patient's Age at Time of Initial Event: UNKNOWN

Patient's Gender: UNKNOWN

Patient Type: UNKNOWN

Description of the Medical Condition With Which the Patient Presented for Treatment: DID NOT HAVE A GOOD FOOT.

Description of the Procedure Performed: LOOKED AT FOOT.

Nature of Allegation: BEHAVIORAL HEALTH RELATED (100)

Specific Allegation: FAILURE TO USE ASEPTIC TECHNIQUE (100)

Date of Event Associated With Allegation or Incident: 11/24/2014

Specific Allegation: FAILURE TO DIAGNOSE (101)

Date of Event Associated With Allegation or Incident: 11/24/2014

Outcome: EMOTIONAL INJURY ONLY (01)

Description of the Allegations and Injuries or Illnesses Upon Which the Action or Claim Was Based: PATIENT WAS REALLY UPSET.

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: 11/25/2014
Date of Most Recent Change: 11/25/2014

This report is maintained under the provisions of: Title IV

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Title IV of Public Law 99-660, as amended, 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