

## EXCLUSION OR DEBARMENT: INITIAL REPORT

NATIONAL PRACTITIONER DATA BANK

NPDB

Privacy Policy | OMB Number: 0915-0126 Expiration Date: mm/dd/yyyy

Public Burden Statement ✕

OMB Number: 0915-0126 Expiration Date: XX/XX/20XX

**Public Burden Statement:** The NPDB is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers. Established by Congress in 1986, it is a workforce tool that prevents practitioners from moving state-to-state without disclosure or discovery of previous damaging performance. The statutes and regulations that govern and maintain NPDB operations include: [Title IV of Public Law 99-660, Health Care Quality Improvement Act \(HCQIA\) of 1986](#), [Section 1921 of the Social Security Act](#), [Section 1128E of the Social Security Act](#), and [Section 6403 of the Patient Protection and Affordable Care Act of 2010](#). The NPDB regulations implementing these laws are codified at [45 CFR Part 60](#). 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 information collection is 0915-0126 and it is valid until XX/XX/202X. This information collection is mandatory ([45 CFR Part 60](#)). [45 CFR Section 60.20](#) provides information on the confidentiality of the NPDB. Information reported to the NPDB is considered confidential and shall not be disclosed outside of HHS, except as specified in [Sections 60.17, 60.18, and 60.21](#). Public reporting burden for this collection of information is estimated to average .75 hours per response, 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 14N136B, Rockville, Maryland, 20857 or [paperwork@hrsa.gov](mailto:paperwork@hrsa.gov).

Close

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## 1. Subject Information

Please fill out as much information as possible to help entities find your report when they query.

Need Help ?

## Personal Information

Last Name First Name Middle Name Suffix (Jr, III)

   [+ Additional name \(e.g., maiden name\)](#)

## Gender

 Male  Female  Unknown

## Birthdate

MM / DD / YYYY

## Is this person deceased?

 No  Yes  Unknown

## Date of Death

MM / DD / YYYY

## Practitioner's Address

## Type of Address

If the home address is not known, enter a work address.

## Home Address/Address of Record

## Country

United States

Address  Entering a military address?

## Address Line 2

## City

## State

CHOOSE ONE FROM LIST

## ZIP

## Work Information

 Use our information as the practitioner's work information.

## Organization Name

## Organization Type

## Work Address

## Country

United States

Address  Entering a military address?

## Address Line 2

## City

## State

CHOOSE ONE FROM LIST

## ZIP

## Profession and Licensure

## Against which license or certification was the action taken?

## Profession or Field of Licensure

## Description (Optional)

## Does the subject have a license for the selected profession or field of licensure?

 Yes  No/Not sure

## State

CHOOSE ONE FROM LIST

## License Number

## Professional Schools Attended

Enter the schools or institutions the practitioner attended for their professional degree, training or certification (e.g., medical school, certification program).

What if the practitioner has not graduated?

## Name of School or Institution

## Completion Year

[+ Additional school or institution](#)

## Identification Numbers

## SSN or ITIN (Social Security Number or Individual Taxpayer Identification Number)

[+ Additional SSN or ITIN](#)

## NPI (National Provider Identifier)

To help queriers find your report, add the practitioner's NPI number if you know it.

[+ Additional NPI](#)

## DEA (Drug Enforcement Administration) Number

[+ Additional DEA](#) Does the subject have a FEIN or UPIN identification number?

## FEIN (Federal Employer Identification Number)

[+ Additional FEIN](#)

## UPIN (Unique Physician Identification Number)

[+ Additional UPIN](#)

## Health Care Entity Affiliation

 Is the practitioner affiliated with a health care entity?

## Type of Affiliation

CHOOSE ONE FROM LIST

## Entity Name

## Country

United States

Address  Entering a military address?

## Address Line 2

## City

## State

CHOOSE ONE FROM LIST

## ZIP

[+ Additional Affiliate](#) Add this subject to my subject database[What is a subject database?](#)

Save and finish later

Continue to next step

## 2. Action Information

## 3. Certifier Information

Return to Options



## What type of license are you reporting?

Search

### Recently Used

Occupational Therapist ✖

### Behavioral Health Occupations

Other Behavioral Health Occupation - Not Classified, Specify - BEHAVIOR ANALYST

### Psychologist/Psychological Assistant

Psychologist

Psychologist - CERTIFIED

### Rehabilitative, Respiratory and Restorative Service Practitioner

Occupational Therapist

Occupational Therapy Assistant

Physical Therapist

Physical Therapy Assistant

### Health Care Facility Administrator

Health Care Facility Administrator

---

[Report a different license](#)

# EXCLUSION OR DEBARMENT: INITIAL REPORT

## 1. Subject Information

[Edit](#)

## 2. Action Information

### Adverse Action(s) Taken

Select up to 3 actions

Find an Action

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

Selected Action(s): 0

[Clear All](#)

### Basis for Action(s)

### Description

[+ Additional basis for action](#)

### Adverse Action Information

What is the name of the agency or program that took the action?

### Date the action was taken

The date the decision for the action was issued, filed or signed.

### Date the action went into effect

The starting date for the action. This may be the same as the action was taken or it may be different.

### How long will it remain in effect?

A specific period of time  Permanently  Unknown/Indefinite

Years  Months  Days

### Is the action on appeal?

No  Yes  Unknown

### Date of Appeal

### Describe the subject's acts or omissions that caused the action to be taken.

Do not include any personally identifiable information, such as names, for anyone except the subject of this report.

Your [narrative description](#) helps querying organizations understand more about the action and why it was taken.

There are 4000 characters remaining for the description.

[Spell Check](#)

### Optional Reference Numbers

Entity Report Reference is an optional field that allows entities to add their own internal reference number to the report, such as a claim number. The reference number is available to all queriers.

### Entity Report Reference

Customer Use is an optional field for you to create an identification for internal use. Your customer use number is only available to your organization.

### Customer Use

[Save and finish later](#)

[Continue to next step](#)

## 3. Certifier Information

[Return to Options](#)

## Select a Basis for Action



Enter a keyword or phrase to find a matching basis for the action(s). (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

Don't see what you're looking for?

## EXCLUSION OR DEBARMENT: INITIAL REPORT

NPDB

[Privacy Policy](#) | OMB Number: 0915-0126 Expiration Date: mm/dd/yyyy

1. Subject Information

[Edit](#)

2. Action Information

[Edit](#)

3. Certifier Information

**Review your entries to be sure they are correct before you Continue.****Subject Information** [Edit](#)

Subject Name: SMITH, JOHN  
 Other Name(s) Used: None/NA  
 Gender: UNKNOWN  
 Date of Birth: 01/01/1960  
 Organization Name: None/NA  
 Work Address: None/NA  
 City, State, ZIP: None/NA  
 Organization Type: None/NA  
 Home Address: 55 TEST ST  
 City, State, ZIP: TEST CITY, ST 11111  
 Deceased: UNKNOWN  
 Federal Employer Identification Numbers (FEIN): None/NA  
 Social Security Numbers (SSN): \*\*\*-\*\*-6778  
 Individual Taxpayer Identification Numbers (ITIN): None/NA  
 National Provider Identifiers (NPI): None/NA  
 Professional School(s) & Year(s) of Graduation: STATE UNIVERSITY COLLEGE OF MEDICINE (2000)  
 Occupation/Field of Licensure: OCCUPATIONAL THERAPIST  
 State License Number, State of Licensure: 11111, ST  
 Drug Enforcement Administration (DEA) Numbers: None/NA  
 Unique Physician Identification Numbers (UPIN): None/NA  
 Name(s) of Health Care Entity (Entities) With Which Subject Is Affiliated or Associated (Inclusion Does Not Imply Complicity in the Reported Action): None/NA  
 Business Address of Affiliate: None/NA  
 City, State, ZIP: None/NA  
 Nature of Relationship(s): None/NA

**Action Information** [Edit](#)

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: TEST AGENCY  
 Adverse Action Classification Code(s): DEBARMENT FROM FEDERAL PROGRAMS (1500)  
 Date Action Was Taken: 02/01/2020  
 Date Action Became Effective: 02/01/2020  
 Length of Action: INDEFINITE  
 Is the subject automatically reinstated after the adverse action period is completed?: None/NA  
 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 description  
 Is the action on appeal?: UNKNOWN

## 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**

TEST

**Authorized Submitter's Title**

TEST

**Authorized Submitter's Phone**

7777777777

**Ext.****WARNING:**

Any person who knowingly makes a false statement or misrepresentation to the National Practitioner Data Bank (NPDB) may be subject to a fine and imprisonment under federal statute.

[Save and finish later](#)[Submit to the NPDB](#)[Return to Options](#)

## EXCLUSION OR DEBARMENT: INITIAL REPORT

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Public Burden Statement ✕

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Close

United States

Address [Entering a military address?](#)

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## 1. Subject Information

Please fill out as much information as possible to help entities find your report when they query.

[Need Help ?](#)

## Organization Information

**Organization Name**

- Include a store number or other identifier for a location in the organization name (e.g., XYZ Pharmacy #123).  
 - Add any previous names or other names used by the organization, such as a Doing Business As name (DBA).

TEST ORG

[+ Additional name](#)**Organization Type**

999 Other Type - Not Classified, Specify

**Organization Description**

## Location Address

Enter the physical address for this location.

**Country**

United States

**Address** [Entering a military address?](#)**Address Line 2****City****State**

CHOOSE ONE FROM LIST

**ZIP**

## Principal Officers and Owners

**Title****Last Name****First Name****Middle Name****Suffix (Jr, III)**[+ Additional principal officer or owner](#)

## Identification Numbers

**NPI (National Provider Identifier)**

To help queriers find your report, add the organization's NPI number if you know it.

[+ Additional NPI](#)**FEIN (Federal Employer Identification Number)**[+ Additional FEIN](#)**SSN or ITIN (Social Security Number or Individual Taxpayer Identification Number)**[+ Additional SSN or ITIN](#)**DEA (Drug Enforcement Administration) Number**[+ Additional DEA](#)**MPN/MSN (Medicare Provider/Supplier Number)**[+ Additional MPN/MSN](#) Does the subject have a FDA or CLIA identification number?**FDA (Federal Food and Drug Administration)**[+ Additional FDA](#)**CLIA (Clinical Laboratory Improvement Act)**[+ Additional CLIA](#)

## Organization State Licensure Information

## License 1

**Does the organization have a license?** Yes  No/Not sure**License Number****State**

CHOOSE ONE FROM LIST

[+ Additional license](#)

## Health Care Entity Affiliation

 Is the organization affiliated with a health care entity?**Type of Affiliation**

CHOOSE ONE FROM LIST

**Entity Name****Country**

United States

**Address** [Entering a military address?](#)**Address Line 2****City****State**

CHOOSE ONE FROM LIST

**ZIP**[+ Additional Affiliate](#) Add this subject to my subject database[What is a subject database?](#)

Save and finish later

Continue to next step

## 2. Action Information

## 3. Certifier Information

[Return to Options](#)



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## 1. Subject Information

Edit

## 2. Action Information

## Adverse Action(s) Taken

Select up to 3 actions

Find an Action

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

Selected Action(s): 1

Clear All

- Debarment From Federal Programs (3500)

## Basis for Action(s)

Other - Not Classified, Specify

## Description

[+ Additional basis for action](#)

## Adverse Action Information

What is the name of the agency or program that took the action?

## Date the action was taken

The date the decision for the action was issued, filed or signed.

MM / DD / YYYY

## Date the action went into effect

The starting date for the action. This may be the same as the action was taken or it may be different.

MM / DD / YYYY

## How long will it remain in effect?

 A specific period of time
  Permanently
  Unknown/Indefinite

Years Months Days




Is reinstatement automatic after this period of time?

 No
  Yes
  Yes, with conditions (requires a Revision to Action report when status changes)

Is the action on appeal?

 No
  Yes
  Unknown

Date of Appeal

MM / DD / YYYY

Describe the subject's acts or omissions that caused the action to be taken.

Do not include any personally identifiable information, such as names.

Your [narrative description](#) helps querying organizations understand more about the action and why it was taken.There are **4000** characters remaining for the description.

Spell Check

## Optional Reference Numbers

Entity Report Reference is an optional field that allows entities to add their own internal reference number to the report, such as a claim number. The reference number is available to all queriers.

Entity Report Reference

Customer Use is an optional field for you to create an identification for internal use. Your customer use number is only available to your organization.

Customer Use

Save and finish later

Continue to next step

## 3. Certifier Information

Return to Options

## Select a Basis for Action



Enter a keyword or phrase to find a matching basis for the action(s). (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

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Felony Conviction Relating to Health Care Fraud

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### Other

Conflict of Interest

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1. Subject Information

Edit

2. Action Information

Edit

3. Certifier Information

Review your entries to be sure they are correct before you Continue.

Subject Information [Edit](#)

Organization Name: TEST ORG

Other Organization Name(s) Used: None/NA

Business Address: 55 TEST ST

City, State, ZIP: TEST CITY, ST 11111

Organization Type: HOME HEALTH AGENCY/ORGANIZATION (393)

Names and Titles of Principal Officers and Owners

(POO): TEST, TEST (TEST)

Federal Employer Identification Numbers (FEIN): None/NA

Social Security Numbers (SSN): \*\*\*-\*\*-6666

Individual Taxpayer Identification Numbers (ITIN): None/NA

State License Number, State of Licensure: 11111, IL

Drug Enforcement Administration (DEA) Numbers: None/NA

Clinical Laboratory Act (CLIA) Numbers: None/NA

Food and Drug Administration (FDA) Numbers: None/NA

National Provider Identifiers (NPI): None/NA

Medicare Provider/Supplier Numbers: None/NA

Name(s) of Health Care Entity (Entities) With Which  
Subject Is Affiliated or Associated (Inclusion Does  
Not Imply Complicity in the Reported Action):

None/NA

Business Address of Affiliate: None/NA

City, State, ZIP: None/NA

Nature of Relationship(s): None/NA

Action Information [Edit](#)

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:

TEST AGENCY

Adverse Action Classification Code(s): DEBARMENT FROM FEDERAL PROGRAMS (3500)

Date Action Was Taken: 02/01/2020

Date Action Became Effective: 02/01/2020

Length of Action: INDEFINITE

Is the subject automatically reinstated after the  
adverse action period is completed?:

None/NA

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 description

Is the action on appeal?: UNKNOWN

## 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

TEST

## Authorized Submitter's Title

TEST

## Authorized Submitter's Phone

7777777777

## Ext.

## WARNING:

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Save and finish later

Submit to the NPDB

Return to Options

## Non-visible Questions

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
Date of Death	Exclusion or Debarment(1)	Below "Is this person deceased?"	Text Entry	The field is displayed if the user selects the "Yes" radio button for "Is this person deceased?"	
Organization Description	Exclusion or Debarment(1)	Below Organization Type	Text Entry	The field is displayed if the user selects an organization type that requires a description.	
Specialty	Exclusion or Debarment(1)	Beside Profession or Field of Licensure	Text entry	The field is displayed if the user selects a profession or field of licensure that requires a description.	"Specialty" is displayed in place of "Description" if the selected profession or field of licensure requires specialty information.
Description	Exclusion or Debarment(1)	Beside Profession or Field of Licensure	Drop List	The field is displayed if the user selects a profession or field of licensure that requires information for specialty.	"Description" is displayed in place of "Specialty" if the selected profession or field of licensure does not require information for a specialty.

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
FEIN (Federal Employer Identification Number)	Exclusion or Debarment(1)	Below checkbox "Does the subject have an FEIN, or UPIN identification number?"	Text Entry	The field is displayed in the individual form if the user selects the checkbox for "Does the subject have an FEIN, or UPIN identification number?"	Selecting the checkbox displays FEIN and UPIN text entry fields.
UPIN (Unique Physician Identification Numbers)	Exclusion or Debarment(1)	Below FEIN text entry	Text Entry	The field is displayed in the individual form if the user selects the checkbox for "Does the subject have an FEIN, or UPIN identification number?"	Selecting the checkbox displays FEIN and UPIN text entry fields.
FDA (Federal Food and Drug Administration)	Exclusion or Debarment(1)	Below checkbox "Does the subject have a FDA or CLIA identification number?"	Text Entry	The field is displayed in the organization report form if the user selects the checkbox for "Does the subject have a FDA or CLIA identification number?"	Selecting the checkbox displays FDA and CLIA, and text entry fields.

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
CLIA (Clinical Laboratory Improvement Act)	Exclusion or Debarment(1)	Below text entry FDA (Federal Food and Drug Administration)	Text Entry	The field is displayed in the organization report form if the user selects the checkbox for "Does the subject have a FDA or CLIA identification number?"	Selecting the checkbox displays FDA and CLIA, and text entry fields.
Type of Affiliation	Exclusion or Debarment(1)	Below "Is the practitioner affiliated with a health care entity?" checkbox	Drop List	The field is displayed if the user selects the "Is the practitioner affiliated with a health care entity?" checkbox	Selecting the checkbox displays Type of Affiliation, Entity Name, Country, Address, Address Line 2, City, State and ZIP entries.
Entity Name	Exclusion or Debarment(1)	Below Type of Affiliation	Text Entry	The field is displayed if the user selects the "Is the practitioner affiliated with a health care entity?" checkbox	Selecting the checkbox displays Type of Affiliation, Entity Name, Country, Address, Address Line 2, City, State and ZIP entries.
Country	Exclusion or Debarment(1)	Below "Is the practitioner affiliated with a health care entity?" checkbox	Drop List	The field is displayed if the user selects the "Is the practitioner affiliated with a health care entity?" checkbox	Selecting the checkbox displays Type of Affiliation, Entity Name, Country, Address, Address Line 2, City, State and ZIP entries. United States is the default selection.

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
Address	Exclusion or Debarment(1)	Below Country	Text Entry	The field is displayed if the user selects the "Is the practitioner affiliated with a health care entity?" checkbox	Selecting the checkbox displays Type of Affiliation, Entity Name, Country, Address, Address Line 2, City, State and ZIP entries.
Address Line 2	Exclusion or Debarment(1)	Below Address	Text Entry	The field is displayed if the user selects the "Is the practitioner affiliated with a health care entity?" checkbox	Selecting the checkbox displays Type of Affiliation, Entity Name, Country, Address, Address Line 2, City, State and ZIP entries.
City	Exclusion or Debarment(1)	Below Address Line 2	Text Entry	The field is displayed if the user selects the "Is the practitioner affiliated with a health care entity?" checkbox	Selecting the checkbox displays Type of Affiliation, Entity Name, Country, Address, Address Line 2, City, State and ZIP entries.
State	Exclusion or Debarment(1)	Below City	Drop List	The field is displayed if the user selects the "Is the practitioner affiliated with a health care entity?" checkbox	Selecting the checkbox displays Type of Affiliation, Entity Name, Country, Address, Address Line 2, City, State and ZIP entries. .

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
ZIP	Exclusion or Debarment(1)	Below State	Text Entry	The field is displayed if the user selects the "Is the practitioner affiliated with a health care entity?" checkbox	Selecting the checkbox displays Type of Affiliation, Entity Name, Country, Address, Address Line 2, City, State and ZIP entries.
Description	Exclusion or Debarment (2)	Below an action that requires a description	Text Entry	The field is displayed if the user selects an action that requires a description.	
Description	Exclusion or Debarment (2)	Below Basis of Action(s)	Text Entry	The field is displayed if the user selects a basis of action that requires a description.	
Period of time number	Exclusion or Debarment (2)	Below "How long will it remain in effect?"	Text Entry	The field is displayed if the user selects "A specific period of time" option for "How long will it remain in effect?"	Selecting the radio button displays the number text entry and type of time period drop list.
Period of time type	Exclusion or Debarment (2)	Below "How long will it remain in effect?"	Drop List	The field is displayed if the user selects "A specific period of time" option for "How long will it remain in effect?"	Selecting the radio button displays the number text entry and type of time period drop list.



Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
Date of Appeal	Exclusion or Debarment (2)	Below Is the action on appeal?	Text Entry	The field is displayed if the user selects Yes option for "Is the action on appeal?"	

## State Changes

Label	PDF Name	Item Type	Trigger
OMB Number: 0915-0126 Expiration Date: mm/dd/yyyy	Exclusion or Debarment	Modal	When the user selects the link the modal is displayed with the public burden statement content.
Select a Profession or Field of Licensure	Exclusion or Debarment	Modal	When the user sets focus on the Profession or Field of Licensure text entry, the modal to select a profession is displayed and focus is set on the Search text entry. The user can enter text in the Search text box to find a specific profession or select a profession from the list without searching. The modal is hidden once the user selects a profession from the list. The user's selection populates the Profession or Field of Licensure text entry.
Name of Occupation	Exclusion or Debarment	Text Entry	Text entry is disabled if the user does not select a profession or field of licensure requiring a description.
License Number	Exclusion or Debarment	Text Entry	Text entry is disabled if the user selects the "No/ Not sure" option for "Does the subject have a license for the selected profession or field of licensure?"
Select a Basis for Action	Exclusion or Debarment	Modal	When the user sets focus on the Basis for Action(s) text entry, the modal to select an act is displayed and focus is set on the Search text entry. The user can enter text in the Search text box to find a specific basis or select a basis from the list without searching. The modal is hidden once the user selects a basis from the list. The user's selection populates the Basis for Action(s) text entry.