

## STATE LICENSURE OR CERTIFICATION: INITIAL REPORT

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

## STATE LICENSURE OR CERTIFICATION: INITIAL REPORT

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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)
SMITH	JOHN		

[+ 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?

 Add a related license, certification, registration, permit or other authorization (e.g., controlled substance, prescriptive authority, sedation permit). [See instructions](#)

## 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 [How to report an unlicensed individual](#)

## 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

YYYY

[+ 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](#)

## Do you need to add a regulated profession?

Your board may only report on a license it regulates. To report on a license that is not on the list, you must add it to your regulated professions.

Select Yes to save a draft of this report and go to the Regulated Profession page and add a new profession. You can then return to the draft report to complete it.

No

Yes

## STATE LICENSURE OR CERTIFICATION: INITIAL REPORT

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## 1. Subject Information

Edit

## 2. Action Information

## Adverse Action(s) Taken

## Was the action taken against a multi-state license?

 No  Yes

## Select up to 5 actions

Find an Action

- 
- 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)
- 
- Withdrawal of Renewal Application While Under Investigation (1155)
- 
- Publicly Available Negative Action or Finding, Specify (1189)
- 
- Other Licensure Action - Not Classified, Specify (1199)

## Selected Action(s): 1

Clear All

- Publicly Available Negative Action or Finding, Specify (1189)

## 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)

## Total monetary penalty, assessment, restitution or fine

\$ 00000.00

## Is the adverse action specified in this report based on the subject's professional competence or conduct, which adversely affected, or could have adversely affected, the health or welfare of patient(s)?

 Yes  No

## 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, 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 basis. (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

Don't see what you're looking for?

## STATE LICENSURE OR CERTIFICATION: INITIAL REPORT

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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](#)

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: UNIVERSITY (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: STATE LICENSURE  
 Basis for Action: FAILURE TO COMPLY WITH HEALTH AND SAFETY REQUIREMENTS (31)  
 Name of Agency or Program That Took the Adverse Action Specified in This Report: TEST ENTITY  
 Adverse Action Classification Code(s): SUSPENSION OF LICENSE (1135)  
 Date Action Was Taken: 02/01/2020  
 Date Action Became Effective: 02/01/2020  
 Length of Action: INDEFINITE  
 Total Amount of Monetary Penalty, Assessment and/or Restitution: None/NA  
 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 narrative  
 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](#)

## STATE LICENSURE OR CERTIFICATION: 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](#)

## STATE LICENSURE OR CERTIFICATION: INITIAL REPORT

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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).

[+ 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

## 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

## 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](#)



## STATE LICENSURE OR CERTIFICATION: INITIAL REPORT

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### 1. Subject Information

[Edit](#)

### 2. Action Information

#### Adverse Action(s) Taken

Select up to 5 actions

Find an Action

- Appointment or temporary management (3200)
- 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)

Selected Action(s): 1

[Clear All](#)

- Other Licensure Action - Not Classified, Specify (3239)

#### 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 reinstatement automatic after this period of time?

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

#### Total monetary penalty, assessment, restitution or fine

\$

#### 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.

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 basis. (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

Don't see what you're looking for?

## STATE LICENSURE OR CERTIFICATION: INITIAL REPORT

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](#)

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): 444556677  
 Social Security Numbers (SSN): None/NA  
 Individual Taxpayer Identification Numbers (ITIN): None/NA  
 State License Number, State of Licensure: 11111, TX

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: 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: STATE LICENSURE  
 Basis for Action: FAILURE TO COMPLY WITH HEALTH AND SAFETY REQUIREMENTS (31)

Name of Agency or Program That Took the Adverse Action Specified in This Report: TEST AGENCY  
 Adverse Action Classification Code(s): SUSPENSION OF LICENSE OR CERTIFICATE (3136)  
 Date Action Was Taken: 02/01/2020  
 Date Action Became Effective: 02/01/2020  
 Length of Action: INDEFINITE  
 Total Amount of Monetary Penalty, Assessment and/or Restitution: None/NA

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

## Non-visible Questions

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
Date of Death	State Licensure (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	State Licensure (1)	Below Organization Type	Text Entry	The field is displayed if the user selects an organization type that requires a description.	
Description of Other Type of License, Registration, Certification, Permit or Other Authorization	State Licensure (1)	Below the "Add a related license..." checkbox	Text Entry	If the checkbox is selected the Description of Other Type of License is displayed	This information is only collected if the action involved a license or certification that is not the professional license to practice.
State	State Licensure (1)	Below Description of Other Type of License text entry	Drop List	If the checkbox is selected the State is displayed	This information is only collected if the action involved a license or certification that is not the professional license to practice.
ID Number	State Licensure (1)	Below Description of Other Type of License text entry	Text Entry	If the checkbox is selected the ID Number is displayed	This information is only collected if the action involved a license or certification that is not the professional license to practice.

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
Specialty	State Licensure (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 profession or field of licensure requires specialty information.
Description	State Licensure (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 profession or field of licensure does not require information for specialty.
FEIN (Federal Employer Identification Number)	State Licensure (1)	Below checkbox "Does the subject have an FEIN, or UPIN identification number?"	Text Entry	The field is displayed in the individual report 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)	State Licensure (1)	Below FEIN text entry	Text Entry	The field is displayed in the individual report 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.

<b>Label</b>	<b>PDF Name (step)</b>	<b>Location</b>	<b>Response Input Item</b>	<b>Visibility Trigger</b>	<b>Other</b>
FDA (Federal Food and Drug Administration)	State Licensure (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.
CLIA (Clinical Laboratory Improvement Act)	State Licensure (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	State Licensure (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	State Licensure (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.

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
Country	State Licensure (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.
Address	State Licensure (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	State Licensure (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	State Licensure (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.

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
State	State Licensure (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.
ZIP	State Licensure (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.
Describe the type of registration, certification, permit or other authorization affected by the action.	State Licensure(1)	Below Other license or certification action	Text Entry	The field is displayed if the user selects the " Other license or certification action " option	Selecting the option displays Describe the type of registration, State and ID Number fields.
State	State Licensure(1)	Below Other license or certification action	Drop List	The field is displayed if the user selects the " Other license or certification action " option	Selecting the option displays Describe the type of registration, State and ID Number fields.
ID Number	State Licensure(1)	Below Other license or certification action	Text Entry	The field is displayed if the user selects the " Other license or certification action " option	Selecting the option displays Describe the type of registration, State and ID Number fields.



Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
Was the action taken against a multi-state license?	State Licensure (2)	Below Adverse Action(s) Taken	Radio buttons	The fields are displayed if the user selects a type of professional license that has a multi-state license. Options are "Yes" and "No"	If the selected profession does not have a multi-state license then this option is not displayed.
Select up to 5 actions	State Licensure (2)	Below "Was the action taken against a multi-state license?"	Check Boxes	The appropriate fields are displayed when the user selects a radio button for "Was the action taken against a multi-state license?"	If the selected profession does not have a multi-state license then the fields are not hidden.
Description	State Licensure (2)	Below an action requiring a description	Text Entry	The field is displayed if the user selects an action that requires a description.	
Description	State Licensure (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	State Licensure (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	State Licensure (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
Is reinstatement automatic after this period of time?	State Licensure (2)	Below "How long will it remain in effect?"	Radio Buttons	The fields are displayed if the user selects "A specific period of time" for "Is reinstatement automatic after this period of time?"	Available options are "No," "Yes" and "Yes with conditions (Requires a Revision to Action report when status changes)
Is the adverse action specified in this report based on the subject's professional competence or conduct, which adversely affected, or could have adversely affected, the health or welfare of patient(s)?	State Licensure (2)	Below "Is reinstatement automatic after this period of time?"	Radio Buttons	The fields are displayed if the user selects a license profession of Physician (MD), Physician (DO) or Dentist for the practitioner in Subject Information	Available options are "Yes" and "No"
Date of Appeal	State Licensure (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	State Licensure	Modal	When the user selects the link the modal is displayed with the public burden statement content.
Select a Profession or Field of Licensure	State Licensure	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.
License Number	State Licensure	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	State Licensure	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.