

Entity: BLACKSTONE VALLEY COMMUNITY HEALTH CARE (PAWTUCKET, RI) | User: 1000Broad [Help Center](#) | [Sign Out](#)

MEDICAL MALPRACTICE PAYMENT: INITIAL REPORT

NATIONAL PRACTITIONER DATA BANK
NPDB

[Privacy Policy](#) | OMB Number: 0906-0081 Expiration Date:mm/dd/yyyy

1. Subject Information

Please fill in this information when the practitioner is new to the system.

Personal Information

Last Name

TEST

[+ Additional Information](#)

Sex

☐ Male

Birthdate

MM / DD / YYYY

Is this person a practitioner?

☐ No ☐ Yes

Practitioner Information

Public Burden Statement ×

OMB Number: 0906-0081 Expiration Date: mm/dd/yyyy

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](#), [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 0906-0081 and it is valid until mm/dd/yyyy. 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 45 minutes 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 Information Collection Clearance Officer, 5600 Fishers Lane, Room 13N82, Rockville, Maryland, 20857.

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

TEST

First Name

TEST

Middle Name

Suffix (Jr, III)

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

Sex

☐ 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 organization's information.

Organization Name

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 type of professional license was the action primarily 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

Add any other health care licenses the individual holds

[+ Additional license](#)

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 (Social Security Number)

[+ Additional SSN](#)

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](#)

Hospital Affiliation

Hospital Name

City

State

CHOOSE ONE FROM LIST

[+ Additional hospital](#)

☐ Add this subject to my subject database.

[What is a subject database?](#)

Save and finish later

Continue

2. Action Information

3. Review

4. Certifier Information

Return to Options



Select an Occupation or Field of Licensure

Enter a keyword or phrase to find matching occupations. (Example: "counselor")

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](#)



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?](#)

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Help Center | Sign Out

NATIONAL PRACTITIONER DATA BANK

NPDB

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1. Subject Information

2. Action Information

3. Review

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

Subject Information

Edit

Subject Name:TEST, TEST

Other Name(s) Used:None/NA

Sex:FEMALE

Date of Birth:11/11/2001

Organization Name:None/NA

Work Address:None/NA

City, State, ZIP:None/NA

Home Address:1111 JACKSON CT

City, State, ZIP:FALLS CHURCH, VA 22046-3834

Deceased:YES

Social Security Numbers (SSN):None/NA

National Provider Identifiers (NPI):None/NA

Professional School(s) & Year(s) of Graduation:TEST (2026)

Occupation/Field of Licensure:REGISTERED NURSE

State License Number, State of Licensure:7777, VA

Description:XXXX

Drug Enforcement Administration (DEA) Numbers:None/NA

Hospital Affiliation(s):None/NA

None/NA

Action Information

Edit

Relationship of Entity to This Practitioner:INSURANCE COMPANY - PRIMARY INSURER

Payments By This Payer For This Practitioner

Amount of This Payment for This Practitioner:\$ 7,777.00

Date of This Payment:11/11/2011

This Payment Represents:A SINGLE FINAL PAYMENT

Total Amount Paid or to Be Paid by This Payer for This Practitioner:\$ 7,777.00

Payment Result of:OTHER

Description:xxxx

Date of Settlement, if Any:None/NA

Adjudicative Body Case Number:None/NA

Adjudicative Body Name:None/NA

Court File Number:None/NA

Description of Settlement and Any Conditions, Including Terms of Payment:xxxx

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:None/NA

Number of Practitioners for Whom This Payer Has Paid or Will Pay in This Case:None/NA

Payments By Others For This Practitioner

Did (or will) a State Guaranty or Excess Fund Make a Payment for This Practitioner in This Case?:None/NA

Amount Paid or Expected to Be Paid by the State Fund:None/NA

Did (or will) a Self-Insured Organization and/or Other Insurance Company Make a Payment for This Practitioner in This Case?:None/NA

Amount Paid or Expected to Be Paid by Self-Insured Organization(s) and/or Other Insurance Company/Companies:None/NA

Classification Of Act(s) Or Omission(s)

Patient's Age at Time of Initial Event:7 DAYS

Patient's Sex:FEMALE

Patient's Type:INPATIENT

Description of the Medical Condition With Which the Patient Presented for Treatment:xxxx

Description of the Procedure Performed:xxxx

Nature of Allegation:OTHER MISCELLANEOUS (090)

Specific Allegation:ALLEGATION - NOT OTHERWISE CLASSIFIED, SPECIFY (999)

Other Specific Allegations:XXXX

Date of Event Associated With Allegation or Incident:11/11/2001

Outcome:CANNOT BE DETERMINED FROM AVAILABLE RECORDS (10)

Description of the Allegations and Injuries or Illnesses Upon Which the Action or Claim Was Based:xxxx

Save and finish later

Continue

4. Certifier Information

Return to Options

MEDICAL MALPRACTICE PAYMENT: INITIAL REPORT



1. Subject Information

Edit

2. Action Information

Edit

3. Review

Edit

4. Certifier Information

Send this report to a 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 the NPDB records, licenses or certifications for Registered Nurse in the state of VIRGINIA are administered by:

STATE BOARD NAME (CITY, VA)

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

- ☐ I agree to allow the NPDB to send an electronic report notice to STATE BOARD NAME. 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 an NPDB 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 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

TEST

Authorized Submitter's Title

TEST

Authorized Submitter's Phone

Ext.

7777777777

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

Non-visible Questions

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
Date of Death	Medical Malpractice Payment (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	Medical Malpractice Payment (1)	Below Organization Type	Text Entry	The field is displayed if the user selects an organization type that requires a description.	
Description	Medical Malpractice Payment (1)	Beside Profession or Field of Licensure	Text Entry	The field is displayed if the user selects a profession or field of licensure that does not have a specialty.	"Description is displayed in place of "Specialty" if the profession or field of licensure does not have a specialty. The label is "Description" if the selected profession or field of licensure requires a description. Otherwise, the label is "Description (Optional)"
Specialty	Medical Malpractice Payment (1)	Beside Profession or Field of Licensure	Drop List	The field is displayed if the user selects a profession or field of licensure that has a specialty.	"Specialty" is displayed in place of "Description" if the selected profession or field of licensure has a specialty.

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
Description	Medical Malpractice Payment (2)	Below the “This payment was a result of” drop list	Text Entry	The field is displayed if the user selects “Other” from the “This payment was a result of” drop list.	The field is hidden if the user makes a selection from the “This payment was a result of” drop list that is not “Other.”
This is a Global Settlement for Multiple Claimants	Medical Malpractice Payment (2)	Below Date of Settlement	Checkbox	The field is displayed if the user selects “Settlement” from the “This payment was a result of” drop list.	The checkbox is unselected by default. If the user selects it, then “Total Number of Claimants Included in The Settlement” is displayed. If the user makes a different selection for “This payment was a result of”, then “This is a Global Settlement for Multiple Claimants” and “Total Number of Claimants Included in The Settlement” are hidden.

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
Total Number of Claimants Included in The Settlement	Medical Malpractice Payment (2)	Below “This is a Global Settlement for Multiple Claimants” checkbox	Text Entry	The field is displayed if the user selects “This is a Global Settlement for Multiple Claimants” checkbox.	This field is hidden if the user deselects the “This is a Global Settlement for Multiple Claimants” checkbox or makes a different drop list selection other than “Settlement” for “This payment was a result of”
Number of practitioner for whom this payer has paid or will pay in this case	Medical Malpractice Payment (2)	Below “Are other practitioners included in this case?”	Text Entry	This field is displayed if the user selects the “Yes” radio button for “Are other practitioners included in this case?”	This field is hidden if the user selects the “No” radio button for “Are other practitioners included in this case?”
Total amount paid (to be paid) by this payer for all practitioners	Medical Malpractice Payment (2)	Below “Number of practitioner for whom this payer has paid or will pay in this case”	Text Entry	This field is displayed if the user selects the “Yes” radio button for “Are other practitioners included in this case?”	This field is hidden if the user selects the “No” radio button for “Are other practitioners included in this case?”

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
Did (or will) a state guaranty or excess fund make a payment for this practitioner in this case?	Medical Malpractice Payment (2)	Below "Your organization's relationship with this practitioner"	Radio Buttons	The field is displayed if the user selects an applicable option for "Your organization's relationship with this practitioner"	Selections are "Yes," "No" and "Unknown." On selection of "Yes," the text box entry for "Total amount paid (or to be paid)" is displayed. On selection of "No" or "Unknown," the text box entry for "Total amount paid (or to be paid)" is hidden.
Did (or will) a self-insured organization and/or other insurance company make a payment for this practitioner in this case?	Medical Malpractice Payment (2)	Below "Your organization's relationship with this practitioner"	Radio Buttons	The field is displayed if the user selects an applicable option for "Your organization's relationship with this practitioner"	Selections are "Yes," "No" and "Unknown." On selection of "Yes," the text box entry for "Total amount paid (or to be paid)" is displayed. On selection of "No" or "Unknown," the text box entry for "Total amount paid (or to be paid)" is hidden.

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
Total amount paid (or to be paid)	Medical Malpractice Payment (2)	Below the radio buttons displayed if the user selects an applicable option for “Your organization’s relationship with this practitioner”	Text Entry	This field is displayed if the user selects “Yes” for the radio buttons displayed if the user selects an applicable option for “Your organization’s relationship with this practitioner”	On selection of “No” or “Unknown,” the text box entry for “Total amount paid (or to be paid)” is hidden.
Description	Medical Malpractice Payment (2)	Below “Specific Allegation”	Text Entry	The field is displayed if the user selects an allegation that requires a description.	

State Changes

Label	PDF Name	Item Type	Trigger
OMB Number: 0906-0081 Expiration Date: mm/dd/yyyy	Medical Malpractice Payment	Modal	When the user selects the link the modal is displayed with the public burden statement content.
Select a Profession or Field of Licensure	Medical Malpractice Payment	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.
Description (Optional)	Medical Malpractice Payment	Text Entry	Text entry is disabled until the user selects a profession or field of licensure that allows or requires a description.
License Number	Medical Malpractice Payment	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?"
Name of School or Institution	Medical Malpractice Payment	Text Entry	Names of School or Institution and Completion Year text entries are disabled by default. When the user selects a health care-related Profession or Field of Licensure, the Name of School or Institution and Completion Year are enabled. If the user selects a profession that is not related to health care, entries for the Name of School or Institution and Completion Year are not allowed, so Name of School or Institution and Completion Year are cleared and hidden. Subsequent selection of a health care-related profession redisplay both fields.

Label	PDF Name	Item Type	Trigger
Completion Year	Medical Malpractice Payment	Text Entry	Names of School or Institution and Completion Year text entries are disabled by default. When the user selects a health care-related Profession or Field of Licensure, the Name of School or Institution and Completion Year are enabled. If the user selects a profession that is not related to health care, entries for the Name of School or Institution and Completion Year are not allowed, so Name of School or Institution and Completion Year are cleared and hidden. Subsequent selection of a health care-related profession redisplay both fields.
Date of the Settlement	Medical Malpractice Payment	Text Entry	This field is dynamic, depending on the selection in the drop list "The payment was a result of" If the user selects "Judgment", the label is changed to "Date of the Judgment." Otherwise, the label is "Date of the Settlement."
Describe the settlement including any conditions or terms of payment	Medical Malpractice Payment	Text Entry	This field is dynamic, depending on the selection in the drop list "The payment was a result of" If the user selects Judgment, then the label is "Describe the judgement including any conditions or terms of payment." Otherwise, the label is "Describe the settlement including any conditions or terms of payment."
Select a Specific Allegation	Medical Malpractice Payment	Modal	When the user sets focus on the Specific Allegation 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 act or select an act from the list without searching. The modal is hidden once the user selects an act from the list. The user's selection populates the Specific Allegation text entry.

Label	PDF Name	Item Type	Trigger
I agree to allow the NPDB to send an electronic report notice to (STATE BOARD NAME). I attest that this is the correct state board to notify based on where the medical malpractice claim arose.	Medical Malpractice Payment	Radio button	This radio button is displayed if the user selected a profession or field of licensure and state for which a state licensing or certification authority is registered with the NPDB, regulates the profession for the state and has enabled report forwarding. The registered entity name is displayed as the STATE BOARD NAME. The radio button is displayed above the radio button "I attest that I will provide a copy of this report to the appropriate state board." This is above the final Certification section of the form.