

EXCLUSION/DEBARMENT

Individual Subject: Initial Report

Please provide as much of the following information as possible. Failure to provide sufficient information to permit identification of a single subject will result in the report being rejected, necessitating resubmission.

Do not print this page. A printable copy of your report submission will be provided after submission.

OMB # 0915-0239 expiration date 05/31/14

OMB # 0915-0126 expiration date 12/31/13

OMB # 0915-0331 expiration date 12/31/13

<u>Public Burden Statement:</u> 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 numbers for this project are 0915-0239 (HIPDB), 0915-0126 (NPDB) and 0915-0331 (NPDB). 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 14-22, Rockville, Maryland, 20857.

PRACTITIONER INFORMATION



We have pre-populated the practitioner information from the most recent report. Please review all pre-populated information for accuracy.

<u>ed</u> ⊙ Unknown		
○ Unknown		
○ Unknown		
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Υ)		
•	Ύ)	

Home Address/Addr	ess of Record
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	-
Country: (if U.S., leave blan	k)
Work Information ☐ Check here if the pra	actitioner's work information is the same as your organization.
Organization	
Name:	GENERAL HOSPITAL
Type:	301 General/Acute Care Hospital
Click Help ? for Address	information on filling out non-U.S. and military addresses.
Street Address:	123 FAKE STREET
Address Line 2:	
City:	FAIRFAX
State:	VA Virginia
ZIP Code:	22030 -
Country: (if U.S., leave blan	k)
Social Security Num *****2333 Add another SSN	bers (SSN) <u>Edit</u>
Individual Taxpayer Add another ITIN	Identification Numbers (ITIN)

Federal Employer Identification Numbers (FEIN)
Add another FEIN
National Provider Identifiers (NPI)
Add another NPI
Drug Enforcement Administration (DEA) Numbers
Add another DEA Number
Unique Physician Identification Numbers (UPIN)
Add another UPIN
Professional Schools Attended
The form will suggest schools as you type. Please choose the matching school or enter the
complete school name.
School Name: Year of Graduation (YYYY)
Add another Professional School
Add another Processional Concerns
Occupation And State Licensure Information (Provide at least one license. Check 'No License' if the subject does not have a State License Number. Use the Add Additional License/Occupation button to provide more than one license. Up to 60 licenses may be provided.)
 State License Number: OR □ No License
State of Licensure: AL Alabama
Occupation/Field of Licensure: Physician (MD)
Specialty: Aerospace Medicine
Add Additional License/Occupation

addresses.	on. Click Help ? for information on filling out non-U.S. and militar
Name of	
Affiliated/Associ	ated
Health Care Ent	
Address	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	-
Country:	
(if U.S., leave bl	ank)
Nature of Subje	at's
Relationship to	CHOOSE ONE FROM LIST
Affiliate:	
Add another Aff	<u>iate</u>

Select a category and then choose a basis for action code that best describes the reason for the action. Click **Add Additional Basis For Action** to provide up to 5 basis for action selections. View a complete <u>basis for action list</u>.

- 1. © Criminal Conviction
 - Other

Clear

Adverse Action Information Name of Agency or Program that Took	
the Adverse Action Specified in This Report:	
Date Action Was Taken:	

(MMDDYYYY)	Date Action Became Effective: (MMDDYYYY)
Length of Action:	
© Permanent	
© Indefinite/Unspecified	
© Specific Period	et Consulation of Advance Action Desired
© Yes	at Completion of Adverse Action Period?
Yes, with conditions (rNo	requires a Revision to Action Report when status changes)
Is the Action on Appeal?	
○ Yes	
○ No	
O Unknown	
other than the subject of this enable a knowledgeable review	personal identification information (e.g., names) of anyone report. The description must include sufficient specificity to ewer to determine clearly the circumstances of the action(s) or g, Submitting a Factually-Sufficient Narrative, for detailed
There are 4000 characters re	emaining for the description.
This entional field allows your	
information to help you identi	r entity to include an internal file number or other reference fy this report in your files. This information is not used by the ided on copies of the report sent to queriers.
Entity Internal Report Reference:	

(e.g., claim number)

Customer Use This optional field may be used				
returned without modification as Customer Use:	nd only appears	on the respo	nse returned to you	ur organization.
Certification				
I certify that I am authorized to correct to the best of my knowle		saction and th	at all information is	s true and
Authorized Submitter's Name:	DEVELOPER			
Authorized Submitter's Title:	DEVELOPER			
Authorized Submitter's Phone:	7035551212		Ext.	
Date:	01/31/2013			
Send e-mail notification when this ar	nd any future res	sponses are a	vailable.	
Check this box if you wish to add/up use in future queries and/or reports. result in duplicate queries. You will be completing this subject entry.	Duplicate entrie	s in your subj	ect database may	Help ?
Submit to Data Bank Validate With	hout Submitting	Store as a Draf	t	

Return to Options



EXCLUSION/DEBARMENT

Report Correction

To submit a **correction** to previously submitted report DCN 7930000076905924, complete all necessary modifications in the form below, and press **Submit to Data Bank**.

The report entered here will replace the original report, so please ensure that all known data is entered in its entirety. Failure to provide sufficient information to permit identification of a single subject may result in the report being rejected, necessitating resubmission.

Do not print this page. A printable copy of your report submission will be provided after submission.

OMB # 0915-0239 expiration date 05/31/14

OMB # 0915-0126 expiration date 12/31/13

OMB # 0915-0331 expiration date 12/31/13

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PRACTITIONER INFORMATION



Dar	canal Information				
Per	sonal Information	1			
Pr	ractitioner Name				
	Last Name	First Name	Middle Name	Suffix (Jr, III)	
	SMITH	JOHN			
	Add another name	used			
G	ender • Male	e C Unknown			
l ,	irth Date (MMDDY 05051950	YYY)			
ls	Subject Decease	d?			
	No ○ Unknow				

— Ctroot Address.		
Street Address:		
Address Line 2:		
City:		
State:	CHOOSE ONE FROM LIST	
ZIP Code:	_	
Country: (if U.S., leave blan	nk)	
·	ractitioner's work information is the same as your organization.	
Organization		
Name:	GENERAL HOSPITAL	
Type:	301 General/Acute Care Hospital	
Address Street Address: Address Line 2: City: State: ZIP Code: Country: (if U.S., leave blan	123 FAKE STREET FAIRFAX VA Virginia 22030	
Social Security Num ****2333 Add another SSN	nbers (SSN) <u>Edit</u>	
Individual Taxpayer Add another ITIN	Identification Numbers (ITIN)	

Federal Employer Identification Numbers (FEIN)

Add another FEIN
National Provider Identifiers (NPI)
Add another NPI
Drug Enforcement Administration (DEA) Numbers
Add another DEA Number
Add another DEA Number
Unique Physician Identification Numbers (UPIN)
Add another UPIN
Add another OF IN
Professional Schools Attended The form will suggest schools as you type. Please choose the matching school or enter the complete school name. Year of Graduation (YYYY) Add another Professional School
Occupation And State Licensure Information (Provide at least one license. Check 'No License' if the subject does not have a State License Number. Use the Add Additional License/Occupation button to provide more than one license. Up to 60 licenses may be provided.)
 State License
State of Licensure: AL Alabama
Occupation/Field of Licensure: Physician (MD)
Specialty: Aerospace Medicine
Add Additional License/Occupation

Health Care Entities With Which the Subject is Affiliated or Associated Inclusion of an affiliated/associated health care entity in this report does not imply complicity in

the reported action addresses. Name of Affiliated/Associate Health Care Entity:	ed
Address	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	-
Country: (if U.S., leave blank	(x)
Nature of Subject's Relationship to Affiliate: Add another Affiliat	CHOOSE ONE FROM LIST

ADVERSE ACTION INFORMATION



Basis for Action

Select a category and then choose a basis for action code that best describes the reason for the action. Click **Add Additional Basis For Action** to provide up to 5 basis for action selections. View a complete basis for action list.

1.

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

Clear

AGENCY 01012013 01022013
01012013
01022013
ion of Adverse Action Period? Revision to Action Report when status changes)
sion(s) or Other Reasons for Action(s) Taken Reporting Entity dentification information (e.g., names) of anyone le description must include sufficient specificity to termine clearly the circumstances of the action(s) or ng a Factually-Sufficient Narrative, for detailed
F

to include an internal file number or other reference report in your files. This information is not used by the copies of the report sent to queriers.
ne submitter to identify this transaction. This information is
nly appears on the response returned to your organization.
nit this transaction and that all information is true and
VELOPER
VELOPER
5551212 Ext.



EXCLUSION/DEBARMENT

Organization Subject: Initial Report

Please provide as much of the following information as possible. Failure to provide sufficient information to permit identification of a single subject will result in the report being rejected, necessitating resubmission.

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SUBJECT INFORMATION



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

Clinical Laboratory Improvement Act (CLIA) Numbers
Add another CLIA Number
Federal Food and Drug Administration (FDA) Numbers
Add another FDA Number
National Provider Identifiers (NPI)
Add another NPI
<u>, ad another m.</u>
Medicare Provider/Supplier Numbers
Add another Medicare Provider/Supplier Number
Organization State Licensure Information————————————————————————————————————
(If no State License, check the 'No License' box.)
State License OR No License Number:
State of Licensure: CHOOSE ONE FROM LIST
Add another License
7 dd driothol Elochoo
Principal Officers and Owners—
Last Name First Name Middle Name Suffix Title
Last Ivalite I list Ivalite Ivalite Sulfix Title
Add another Principal Officer or Owner

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ADVERSE ACTION INFORMATION



Basis for Action-

Select a category and then choose a basis for action code that best describes the reason for the action. Click **Add Additional Basis For Action** to provide up to 5 basis for action selections. View a complete <u>basis for action list</u>.

- 1. Criminal Conviction
 - Other

Clear

Yes, with conditions (requires a Revision to Action Report when status changes) No Is the Action on Appeal? Yes No Unknown Description of Subject's Act(s) or Omission(s) or Other Reasons for Action(s) Taken and Description of Action(s) Taken by Reporting Entity Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report. The description must include sufficient specificity to enable a knowledgeable reviewer to determine clearly the circumstances of the action(s) surrender. Refer to Reporting, Submitting a Factually-Sufficient Narrative, for detailed information.	Name of Agency or Program that Took Adverse Action Specified in This Repo	
(MMDDYYYY) Length of Action: Permanent Indefinite/Unspecified Specific Period Is Reinstatement Automatic at Completion of Adverse Action Period? Yes Yes, with conditions (requires a Revision to Action Report when status changes) No Is the Action on Appeal? Yes No Unknown Description of Subject's Act(s) or Omission(s) or Other Reasons for Action(s) Taken and Description of Action(s) Taken by Reporting Entity Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report. The description must include sufficient specificity to enable a knowledgeable reviewer to determine clearly the circumstances of the action(s) surrender. Refer to Reporting, Submitting a Factually-Sufficient Narrative, for detailed information.		
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Data Bank, but it will be provid	this report in your files. This information is not used by the ed on copies of the report sent to queriers.
Entity Internal Report Reference:	
(e.g., claim number)	
Customer Use	
	d by the submitter to identify this transaction. This information and only appears on the response returned to your
Customer Use:	
correct to the best of my knowl Authorized Submitter's Name:	submit this transaction and that all information is true and ledge.
Authorized Submitter's Title:	
Authorized Submitter's Title: Authorized Submitter's Phone:	Ext.
	02/01/2013

Return to Options



EXCLUSION/DEBARMENT

Report Correction

To submit a **correction** to previously submitted report DCN 7930000076906052, complete all necessary modifications in the form below, and press Submit to Data Bank.

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OMB # 0915-0126 expiration date 12/31/13

OMB # 0915-0331 expiration date 12/31/13

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SUBJECT INFORMATION



ABC	
dd another name	<u>e used</u>
Click Help ?	for information on filling out non-U.S. and military addresses.
Street Address:	1 MAIN ST
Address Line 2:	
City:	FAIRFAX
State:	VA Virginia
ZIP Code:	22033
Country: (if U.S., leave olank)	
eral Employer Id	entification Numbers (FEIN)
leral Employer Ide	· ·
Add another FEIN	<u> </u>
	<u> </u>
Add another FEIN	bers (SSN)
Add another FEIN cial Security Num Add another SSN	bers (SSN)
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Clinical Laboratory Improvement Act (CLIA) Numbers
Add another CLIA Number
Federal Food and Drug Administration (FDA) Numbers
Add another FDA Number
National Provider Identifiers (NPI)
Add another NPI
<u>, ad another m.</u>
Medicare Provider/Supplier Numbers
Add another Medicare Provider/Supplier Number
Organization State Licensure Information————————————————————————————————————
(If no State License, check the 'No License' box.)
State License OR No License Number:
State of Licensure: CHOOSE ONE FROM LIST
Add another License
7 dd driothol Elochoo
Principal Officers and Owners—
Last Name First Name Middle Name Suffix Title
Last Ivalite I list Ivalite Ivalite Sulfix Title
Add another Principal Officer or Owner

Health Care Entities W	ith Which the Subject is Affiliated or Associated
Inclusion of an affiliation in the reported action	ated/associated health care entity in this report does not imply complicity on. Click Help ? for information on filling out non-U.S. and military
addresses.	
Name of Affiliated/Associated Health Care Entity:	
Address	
Street Address:	
Address Line 2:	
City:	
State:	CHOOSE ONE FROM LIST
ZIP Code:	-
Country: (if U.S., leave blank)	
Nature of Subject's Relationship to Affiliate:	CHOOSE ONE FROM LIST
Add another Affiliate	

ADVERSE ACTION INFORMATION



Basis for Action-

Select a category and then choose a basis for action code that best describes the reason for the action. Click **Add Additional Basis For Action** to provide up to 5 basis for action selections. View a complete <u>basis for action list</u>.

1. • 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
- C Felony Conviction Relating to Health Care Fraud
- O Program-Related Conviction
- Other

Clear

Adverse Action Specified in This Repor	t: DDD
Date Action Was Taken: (MMDDYYYY)	01012010
Date Action Became Effective: (MMDDYYYY)	01012010
Length of Action:	
Permanent	
C Indefinite/Unspecified	
○ Specific Period	
s Reinstatement Automatic at Complet O Yes	tion of Adverse Action Period?
○ Yes, with conditions (requires a ○ No	Revision to Action Report when status changes)
s the Action on Appeal?	
○ Yes	
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