

PRACTITIONER REQUEST FOR INFORMATION DISCLOSURE (SELF-QUERY)

Please print or type clearly all information

INSTRUCTIONS FOR SECTION A

- 1). **PRACTITIONER NAME:** Enter your **Last, First and Middle Names** and any **Suffix** (e.g., Jr., Sr., III). Do NOT enter M.D., D.O., D.D.S., R.N., etc.
- 2). **OTHER NAME USED:** Enter **Last, First and Middle Names** and any **Suffix** of other names used (e.g., Maiden Name).
- 3). **DATE OF BIRTH:** Use numerals to represent date -- Month (two digits), Day (two digits), and Year (four digits). Example -- February 24, 1946 = **02-24-1946**.
- 4). **SOCIAL SECURITY NUMBER:** Enter your nine-digit U.S. Social Security Number. Disclosure of your Social Security Number for the purposes of this program is voluntary. A Social Security Number is extremely useful to the NPDB for the purpose of assuring the accuracy of your response.
- 5). **GENDER:** Check the appropriate box.
- 6). **CREDIT CARD NUMBER:** Enter your MasterCard, Discover, or VISA card number and expiration date.
- 7). **LICENSE NUMBER:** Enter each U.S. license number (up to five) that you currently hold. Provide the two-letter abbreviation for the State in which the license is held (*see State codes on back of Instructions*). Enter the three-digit code for field of licensure for the license(s) you hold. (*see Field of Licensure Codes on back of Instructions*).
- 8). **FEDERAL DEA (DRUG ENFORCEMENT AGENCY) NUMBER:** Enter each DEA Registration Number that you currently hold (up to five).
- 9). **PROFESSIONAL SCHOOL AND YEAR OF GRADUATION:** Enter the name of each health care professional school you attended (up to two schools) and the last two digits of the year in which you graduated. If you did not graduate, provide the name of the school and the last two-digits of the last year of attendance.
- 10a). **CURRENT WORK ADDRESS:** Enter your complete current work address. This field may be used for matching on reports. If you want the query response sent to this address, check Work in Item 11.

10b). **CURRENT HOME ADDRESS:** Enter your complete current home address. This field may be used for matching on reports. If you want the query response sent to this address, check Home in Item 11.

11). Check the **ADDRESS TO WHICH YOU WANT RESPONSE SENT** (Home or Work). If no instruction is given for mailing, the response will be sent to the Home address.

INSTRUCTIONS FOR SECTION B

- 12). **TELEPHONE NUMBER:** Enter a number where you can be reached during weekday business hours. Our staff may contact you if there is a problem with your request that can be resolved by phone. We will attempt to resolve these problems as quickly as possible.
- 13). **Enter the DATE:** in numerals on which you signed the request. See Item 3 for example.
- 14). **Enter Practitioner SIGNATURE:** By signing the form, you certify that you are the individual named in Section A and that are eligible to receive the information. (Print your full name and sign in ink.) **NOTE:** You must sign your request in the presence of a Notary Public.

SELF-QUERY NOTARIZATION

ALL SELF-QUERIES MUST BE NOTARIZED in order to be accepted by the NPDB. Any Self-Query received without notarization will be rejected. *All fields in this section must be completed or the request will be rejected.*

The Notary must: (1) print his/her name, (2) provide the date his/her commission expires, (3) sign the form, (4) fill in the date on which the practitioner appeared, (5) provide a daytime telephone number, (6) affix his/her seal.

MAILING INSTRUCTIONS -- Return *Original* (white copy)

Mail to: National Practitioner Data Bank
P.O. Box 10832
Chantilly, VA 20151

Public Reporting Burden

Request for Information Disclosure (Self-Query)

The estimate of public reporting burden for this collection of information is 15 minutes. This estimate includes the time for reviewing instructions, gathering the information, completing the information request, and sending the information. It does not include the time required to have the request notarized. Send comments regarding this burden estimate or any aspect of this collection of information, including suggestions for reducing the burden, to DHHS Reports Clearance Officer, Paperwork Reduction Project (0915-0126), Hubert H. Humphrey Building, Room 531-H, 200 Independence Avenue, S.W., Washington, D.C. 20201.

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 number for this project is 0915-0126.

Request for Information (Self-Query) Legal Notices

The National Practitioner Data Bank was established to carry out the information collection and disclosure requirements of the *Health Care Quality Improvement Act of 1986*, (Title IV of Public Law 99-660 as amended). Final regulations governing the NPDB, published in the *Federal Register* on October 17, 1989, are codified at 45, CFR, Part 60, *National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners*. The U.S. Department of Health and Human Services (HHS) is responsible for administration of the NPDB.

What the Law Requires

Hospitals are the only health care entities with mandatory requirements to request information from the NPDB. Each hospital, or its authorized agent, must request information from the NPDB as follows:

1. At the time a physician, dentist, or other health care practitioner applies for a position on its medical staff (courtesy or otherwise) or for clinical privileges at the
2. Every 2 years on any physician, dentist, or other health care practitioner who is on the medical staff or who has clinical privileges. This biennial query may be done in accordance with regular medical staff reappointment and clinical privilege redelineation. A hospital is not required to query more than once every 2 years on a practitioner who is continuously on its staff. Hospitals with annual reappointments are not required to query annually. Hospitals may query at any other time.

Hospitals are also required to query the NPDB when a physician, dentist, or other health care practitioner wishes to add to or expand existing privileges or submits an application for temporary privileges. A hospital is required to query the NPDB each time a *locum tenens* practitioner makes an application for temporary privileges -- not each time the practitioner comes to the facility.

Hospitals are required to query the NPDB on courtesy staff considered to be part of the medical staff, even if afforded only nonclinical professional courtesies, such as use of the medical library and continuing education facilities. Therefore, if a hospital extends nonclinical practice courtesies without first appointing practitioners to a medical staff category, querying is not required on these individuals.

Any hospital that does not request information on a specific practitioner as required in the regulations is presumed to have knowledge of any information reported to the NPDB concerning that individual.

**PRACTITIONER REQUEST FOR INFORMATION DISCLOSURE
(SELF-QUERY)**

Please type or CLEARLY print all information

MAIL TO: National Practitioner Data Bank
P.O. Box 10832
Chantilly, VA 20151

NPDB Help Line: 1-800-767-6732
(703) 802-9380
TDD: (703) 802-9395

SECTION A - PRACTITIONER INFORMATION

1. PRACTITIONER NAME - Last	First	Middle	Suffix (e.g., Jr., III)
2. OTHER NAME USED - Last	First	Middle	Suffix (e.g., Jr., III)
3. DATE OF BIRTH MM-DD-YYYY ___/___/19___	4. SOCIAL SECURITY NUMBER ___-___-____	5. GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male	
6. CREDIT CARD (Check one) <input type="checkbox"/> Discover <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA		EXPIRATION DATE:	
Card No. _____		MM-YYYY ___-____	

7. LICENSE NUMBERS

License Number (If no U.S. License, enter NO LICENSE) a. _____	State of Licensure (SEE CODES ON BACK OF INSTRUCTIONS) ___ ___	Field of Licensure Code (SEE CODES ON BACK OF INSTRUCTIONS) ___ ___ ___
License Number (If no U.S. License, enter NO LICENSE) b. _____	State of Licensure (SEE CODES ON BACK OF INSTRUCTIONS) ___ ___	Field of Licensure Code (SEE CODES ON BACK OF INSTRUCTIONS) ___ ___ ___
License Number (If no U.S. License, enter NO LICENSE) c. _____	State of Licensure (SEE CODES ON BACK OF INSTRUCTIONS) ___ ___	Field of Licensure Code (SEE CODES ON BACK OF INSTRUCTIONS) ___ ___ ___
License Number (If no U.S. License, enter NO LICENSE) d. _____	State of Licensure (SEE CODES ON BACK OF INSTRUCTIONS) ___ ___	Field of Licensure Code (SEE CODES ON BACK OF INSTRUCTIONS) ___ ___ ___
License Number (If no U.S. License, enter NO LICENSE) e. _____	State of Licensure (SEE CODES ON BACK OF INSTRUCTIONS) ___ ___	Field of Licensure Code (SEE CODES ON BACK OF INSTRUCTIONS) ___ ___ ___

8. FEDERAL DEA NUMBERS

a. Federal DEA Number _____	b. Federal DEA Number _____	c. Federal DEA Number _____	d. Federal DEA Number _____
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9. PROFESSIONAL HEALTH CARE SCHOOLS

a. Professional Health Care School _____	Year of Graduation 19___
b. Professional Health Care School _____	Year of Graduation 19___

10. ADDRESSES

a. Work Address: Organization Name: _____ Street _____ City _____ Country _____ State ___ _ ZIP ___ ___ ___-___ ___ ___	b. Home Address: Street _____ City _____ Country _____ State ___ _ ZIP ___ ___ ___-___ ___ ___
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11. ADDRESS TO WHICH YOU WANT RESPONSE SENT: Work Home

SECTION B - CERTIFICATION

I certify that I am authorized to request this information and that I am the practitioner described in Section A of this form. I further certify that the information provided on this form is true and complete.
WARNING: Any person who knowingly makes a false statement or misrepresentation to the National Practitioner Data Bank is subject to a fine and imprisonment under Federal statute.

12. TELEPHONE NUMBER () - Ext. _____	13. SIGNATURE DATE (MM-DD-YYYY) ___/___/____	14. ORIGINAL SIGNATURE OF PRACTITIONER (Print name and sign in ink in presence of notary.)
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SELF-QUERY NOTARIZATION

The individual named in Section A of this form has appeared before me in person and acknowledged the due execution of this request for information disclosure.

15. PRINTED NAME OF NOTARY PUBLIC _____	16. DATE COMMISSION EXPIRES (MM-DD-YYYY) ___/___/____	
17. ORIGINAL SIGNATURE OF NOTARY PUBLIC _____	18. DATE OF APPEARANCE ___/___/____	19. NOTARY PHONE NUMBER ()

NOTARY SEAL

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Please type or CLEARLY print all information

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Chantilly, VA 20151

NPDB Help Line: 1-800-767-6732
(703) 802-9380
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1. PRACTITIONER NAME - Last	First	Middle	Suffix (e.g., Jr., III)
2. OTHER NAME USED - Last	First	Middle	Suffix (e.g., Jr., III)
3. DATE OF BIRTH MM-DD-YYYY ___/___/19___	4. SOCIAL SECURITY NUMBER ___-___-____	5. GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male	
6. CREDIT CARD (Check one) <input type="checkbox"/> Discover <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA		EXPIRATION DATE:	
Card No. _____		MM-YYYY ____-____	

7. LICENSE NUMBERS

License Number (If no U.S. License, enter NO LICENSE) a. _____	State of Licensure (SEE CODES ON BACK OF INSTRUCTIONS) ____ __	Field of Licensure Code (SEE CODES ON BACK OF INSTRUCTIONS) ____ __ __
License Number (If no U.S. License, enter NO LICENSE) b. _____	State of Licensure (SEE CODES ON BACK OF INSTRUCTIONS) ____ __	Field of Licensure Code (SEE CODES ON BACK OF INSTRUCTIONS) ____ __ __
License Number (If no U.S. License, enter NO LICENSE) c. _____	State of Licensure (SEE CODES ON BACK OF INSTRUCTIONS) ____ __	Field of Licensure Code (SEE CODES ON BACK OF INSTRUCTIONS) ____ __ __
License Number (If no U.S. License, enter NO LICENSE) d. _____	State of Licensure (SEE CODES ON BACK OF INSTRUCTIONS) ____ __	Field of Licensure Code (SEE CODES ON BACK OF INSTRUCTIONS) ____ __ __
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8. FEDERAL DEA NUMBERS

a. Federal DEA Number _____	b. Federal DEA Number _____	c. Federal DEA Number _____	d. Federal DEA Number _____
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9. PROFESSIONAL HEALTH CARE SCHOOLS

a. Professional Health Care School _____	Year of Graduation 19____
b. Professional Health Care School _____	Year of Graduation 19____

10. ADDRESSES

a. Work Address: Organization Name: _____ Street _____ City _____ Country _____ State ___ __ ZIP ___ ___ ___ ___-___ ___ ___	b. Home Address: Street _____ City _____ Country _____ State ___ __ ZIP ___ ___ ___ ___-___ ___ ___
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I certify that I am authorized to request this information and that I am the practitioner described in Section A of this form. I further certify that the information provided on this form is true and complete.
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SELF-QUERY NOTARIZATION

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15. PRINTED NAME OF NOTARY PUBLIC _____	16. DATE COMMISSION EXPIRES (MM-DD-YYYY) ___/___/____	
17. ORIGINAL SIGNATURE OF NOTARY PUBLIC _____	18. DATE OF APPEARANCE ___/___/____	19. NOTARY PHONE NUMBER ()

NOTARY SEAL