

**MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE
HEALTH CARE FACILITY DISCIPLINARY ACTION INITIAL REPORT**

This HCFD-1 Report must be filed within 30 days of the disciplinary action.

Complete all 4 pages of this report, including Part A and/or Part B. Attach additional pages as necessary. For further information, refer to the attached Instructions and List of Basis Codes. Instructions and Codes can be downloaded from our website: www.massmedboard.org, however HCFD Forms must be mailed to the Board. Please type or print legibly.

Physician Information

Name: _____

License number: _____

Reporting Health Care Facility

Organization name: _____ Telephone: _____

Report completed by: _____ Title: _____

Signature: _____ Date: ____ / ____ / ____

Disciplinary Action Taken

1. Date action imposed: ____ / ____ / ____

2. Terms of action are currently (*circle one*): 1. Fulfilled 2. Continuing

Circle "fulfilled" for a "one-time-only" action or an action intended to be permanent.

3. Expected or actual total duration of action is (*circle one*):

- | | | | |
|----------------------|-----------------------|--------------|----------|
| 1. Less than 30 days | 3. 91 - 180 days | 5. Permanent | 7. Other |
| 2. 30 – 90 days | 4. More than 180 days | 6. Pending | |

4. Nature of action taken (*circle each that applies*):

- | | | |
|-----------------------------------|---|--|
| 01 Revocation of right/privilege | 06 Non-renewal of right/privilege | 12 Leave of absence |
| 02 Suspension of right/privilege | 09 Education/training/counseling/monitoring | 13 Withdrawal of application |
| 03 Censure | 10 Denial of right/privilege | 14 Termination/non-renewal of contract |
| 04 Written reprimand/admonition | 11 Resignation | 98 Other (explain below) |
| 05 Restriction of right/privilege | | |

IMPORTANT – PART A

The Board does not consider this HCFD-1 Report to satisfy statutory and regulatory requirements unless Part A and/or Part B is completed. You must provide the required identifying information and codes, as well as a narrative description of each case or incident.

PART A - Substantiating Information – Specific Incidents

If the action arose from specific cases or incidents, provide the specified codes indicating the location of the incident giving rise to the action taken and the reason(s) for the action taken. Include a narrative description. If applicable, include the patient's sex, date of birth and medical record number, the severity and type of injury, and incident date(s). If more than one incident gave rise to the action, or if more than one patient was involved, attach additional pages as necessary.

Patient Sex (M/F): _____ Date of Birth: _____ / _____ / _____ Medical Record Number: _____

Date of Incident: _____ / _____ / _____ (to _____ / _____ / _____)

Incident Location (*circle one*):

- | | | | |
|-----------------------------|---------------------|-----------------|-----------------------|
| 01 Emergency Room | 05 Outpatient | 09 HMO | 12 Physician's Office |
| 02 Labor/Delivery | 06 Patient Room | 10 Clinic | 13 Walk-In Center |
| 03 Laboratory/X-Ray/Testing | 16 ICU | 11 Nursing Home | 14 Other: _____ |
| 04 Operating Room | 07 Hospital – Other | | |

Basis Codes: Please refer to the attached List of Basis Codes and provide those which best characterize the basis(es) for the action taken. These basis codes are also on the website at www.massmedboard.org.

Basis Code:___ ___ ___ Basis Code:___ ___ ___ Basis Code:___ ___ ___ Basis Code:___ ___ ___ Basis Code:___ ___ ___

Description:

CONTINUE TO PART B

IMPORTANT – PART B

The Board does not consider a report to satisfy statutory and regulatory requirements unless Part A and/or Part B is completed. You must provide the required codes as well as a narrative description of the reason(s) for the action.

Part B - Substantiating Information – General Issues

If the action arose from a physician's attitude, conduct or behavior, or general issues unrelated to specific cases or patients, describe the reason(s) for the action and provide appropriate basis code(s). Attach additional pages as necessary.

Date: ____ / ____ / ____ (to ____ / ____ / ____)

Location (*circle one*):

- | | | | |
|-----------------------------|-------------------|-----------------|-----------------------|
| 01 Emergency Room | 05 Outpatient | 09 HMO | 12 Physician's Office |
| 02 Labor/Delivery | 06 Patient Room | 10 Clinic | 13 Walk-In Center |
| 03 Laboratory/X-Ray/Testing | 16 ICU | 11 Nursing Home | 14 Other: _____ |
| 04 Operating Room | 07 Hospital-Other | | |

Basis Codes: Please refer to the attached List of Basis Codes and provide those which best characterize the basis(es) for the action taken. These basis codes are also on the website at www.massmedboard.org.

Basis Code:____ Basis Code:____ Basis Code:____ Basis Code:____ Basis Code:____

Description:

Any questions concerning the proper completion of this form should be directed to the Data Repository Counsel for the Board of Medicine: (781) 876-8200. Completed forms should be mailed to Data Repository Counsel, Board of Registration in Medicine, 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880. If you have also filed an Adverse Action Report with the National Practitioner Data Bank, please enclose a copy of the NPDB report you filed.