



**MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE
HEALTH CARE FACILITY DISCIPLINARY ACTION INITIAL REPORT (HCFD-1)**

Complete all 4 pages of this report, including Part A and/or Part B, and e-mail it to the Board at borim.statutory.reports@mass.gov. Attach additional pages as necessary. For further information, refer to the Instructions and List of Basis Codes, which are available on our website at: www.mass.gov/massmedboard. Please type or print legibly.

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

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): a. Fulfilled b. 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):

a. Less than 30 days

c. 91 - 180 days

e. Permanent

g. Other

b. 30 – 90 days

d. More than 180 days

f. Pending

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

- | | | |
|-----------------------------------|---|------------------------------|
| 01 Revocation of right/privilege | 06 Non-renewal of right/privilege | 11 Leave of absence |
| 02 Suspension of right/privilege | 07 Education/training/counseling/monitoring | 12 Withdrawal of application |
| 03 Censure | 08 Denial of right/privilege | 13 Other (explain below) |
| 04 Written reprimand/admonition | 09 Resignation | |
| 05 Restriction of right/privilege | 10 Termination/non-renewal of contract | _____ |

5. Please answer the following questions and provide a brief narrative description of the action taken. Specify who imposed the action (for example, the Chief of Staff, the Medical Executive Committee, the Board of Trustees, etc.).

A. The action was (*circle one*): i. Voluntary ii. Involuntary

B. If involuntary, date the physician was notified of the action: ____ / ____ / ____

C. If involuntary, please describe what procedural due process was afforded the physician:

i. Was the physician notified of the reason(s) for the action taken and provided with an opportunity to respond in writing? (*circle one*): a. Yes b. No

ii. Was the physician afforded an opportunity to appear before the decision making authority? (*circle one*): a. Yes b. No

iii. Other? Explain:

iv. If procedural due process was not necessary, please explain why:

D. Was the action taken in lieu of or in settlement of a pending disciplinary case? (*circle one*): i. Yes ii. No

E. The physician has appealed the action (*circle one*): i. Yes ii. No

F. Description of disciplinary action:

CONTINUE TO PART A

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 Physician's Office

02 Labor/Delivery

06 Patient Room

10 Clinic

03 Laboratory/X-Ray/Testing

07 ICU

11 Walk-In Center

04 Operating Room

08 Hospital – Other

12 Nursing Home

13 Other: _____

Basis Codes: Please refer to the Board's List of Basis Codes and provide those which best characterize the action taken. You must provide a basis code in order to comply with mandated reporting obligations. The basis codes are on the website at www.mass.gov/massmedboard.

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

Description:

CONTINUE TO PART B

PART B

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 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 Physician's Office |
| 02 Labor/Delivery | 06 Patient Room | 10 Clinic |
| 03 Laboratory/X-Ray/Testing | 07 ICU | 11 Walk-In Center |
| 04 Operating Room | 08 Hospital – Other | 12 Nursing Home |
| | | 13 Other: _____ |

Basis Codes: Please refer to the Board's List of Basis Codes and provide those which best characterize the action taken. You must provide a basis code in order to comply with mandated reporting obligations. The basis codes are on the website at www.mass.gov/massmedboard.

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

Description:

Direct any questions concerning this form to the Board's Data Repository Unit: (781) 876-8200. E-mail a completed form to borim.statutory.reports@mass.gov. Please attach a copy of any Adverse Action Report filed with the National Practitioner Data Bank.