PHYSICIANS APPLYING FOR FEDERAL SERVICE: REQUIREMENTS AND CREDENTIALS VERIFICATION

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This study was conducted to (1) identify the education and licensure requirements for physicians in full-time clinical care positions in Federal agencies; and (2) review the process followed to verify physician credentials.

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EXECUTIVE SUMMARY

PURPOSE: This inspection was conducted at the request of the President's Council on Integrity and Efficiency to review physician credentials requirements of various Federal agencies and to evaluate the methods used to verify physician credentials. The study focused on the qualifications of full-time physicians involved with patient care.

BACKGROUND: Federal and State Governments, as well as the private sector, have become increasingly concerned about physicians' performance and qualifications. The number of malpractice suits filed against Federal and private physicians has increased steadily since 1980. The number of license revocations taken by State boards increased almost 60 percent from 1984 to 1986. The news media has reported cases of unethical or incompetent behavior by private physicians as well as some of the approximately 24,000 physicians that the Office of Personnel Management (OPM) reports were employed in 1985 by the Federal Government. In addition, the Federal Bureau of Investigation has identified a number of "diploma mills" selling bogus medical degrees.

The New England Journal of Medicine in a February 11, 1988 article entitled "Falsification of Clinical Credentials by Physicians Applying for Ambulatory-Staff Privileges" reports on the results of a review of clinical credentials listed by applicant physicians. Of 733 physicians applying for positions, 3.5 percent gave false information about their residency, 1.3 percent falsely reported board certification and .3 percent provided false information about both residency and board certification.

Based on information supplied by OPM, we selected for review 7 Federal agencies with 35 or more full-time physicians on staff as of 1985: (1) the Department of Health and Human Services (the Social Security Administration, the Health Care Financing Administration, the Centers for Disease Control, the Alcohol Drug Abuse and Mental Health Administration, the Food and Drug Administration, the Health Resources and Services Administration [HRSA], and the National Institutes of Health); (2) the Department of Defense (the Army and the Navy); (3) the Department of State; (4) the Department of Transportation (the Coast Guard and the Federal Aviation Administration); (5) the Department of Justice (the Bureau of Prisons); (6) the Veterans Administration (VA); and (7) the National Aeronautics and Space Administration (NASA). For ease in reporting, 3 agencies, (NASA, VA, and the Department of State) plus the 12 components in the remaining 4 agencies will hereafter be referred to as organizations.

Most of the Federal organizations reviewed in this study operate under a combination of two of the following personnel systems: the civil service, the Public Health Service (PHS) Commissioned Corps and the military services. The VA and Department of State have personnel systems uniquely their own. Each personnel system establishes minimum physician qualification standards and uses a uniform application form. However, each individual organization may require additional qualifications or information not solicited on the standard personnel forms.

The military, the PHS Commissioned Corps, and the VA have recently revised their physician qualifications and verification procedures. Many of the best practices identified in this report reflect these changes. The OPM is also currently revising the standards and qualifications required of civil service physicians. We hope this report can further assist these organizations in refining their credentialing processes.

FINDINGS:

- All personnel systems require physician applicants who will provide direct patient care to hold, at a minimum, a medical degree from an accredited school or to demonstrate comparable medical education and training if graduating from a foreign or unaccredited school. In addition, physicians must have completed an approved residency program and possess a current, valid, unrestricted State medical license. Five organizations require board certification in specified medical specialty areas for certain positions.

- Civil service is the only personnel system that does not require clinical care physicians, once employed, to maintain current, valid licenses.

- Disclosure requirements vary widely. There is no uniformity among personnel systems, agencies or within some organizations. Within the 15 organizations studied, none require disclosure of Medicare/Medicaid sanctions, only 2 consistently ask about voluntary surrender of a license(s), and only 3 require information regarding censure or reprimand by a hospital staff. Three consistently request malpractice claims information. In addition, disclosure requirements are frequently limiting or unclear, allowing an applicant to misinterpret or withhold the required information.

- Few organizations, with the notable exception of the Army, Navy, and VA, consistently verify all physician credentials with primary sources such as medical schools, although several organizations consistently verify medical licenses with State boards. Some respondents assumed incorrectly

that the National Agency Check and Inquiry constituted verification of credentials. Some organizations are not utilizing the physician disciplinary data bank maintained by the Federation of State Medical Boards (FSMB) to identify adverse practice history information, nor are they requesting the American Medical Association's (AMA) physician profile. Only PHS, the Army, Navy and VA have established written guidelines on proper verification procedures.

RECOMMENDATIONS:

- Agencies employing civil service, clinical care physicians should require them to maintain current, valid State medical licenses; or, to be consistent with other personnel systems, OPM should require all civil service physicians, once employed, to maintain medical licensure if they are providing direct patient care. Provisions to exempt certain physicians from this requirement (e.g., physicians working in foreign countries) should be considered.

- Physician disclosure requirements within an agency should be uniform across all organizations and personnel systems. Organizations should request more in-depth disclosure of adverse practice history information from applicants. Disclosure questions should be written in a clear and precise manner. To assist the organizations in this endeavor, a suggested disclosure questionnaire has been developed and is contained in Appendix B.

- The current licenses held by a physician applicant should always be verified directly with the appropriate State licensing boards. Organizations should also contact primary sources to verify medical degrees and completion of residency programs.

- Most of the organizations reviewed should strengthen verification procedures by developing written guidelines to be used by personnel involved in verifying physician qualifications. Verification of disclosure information should include accessing national physician data banks such as FSMB's disciplinary data base or the AMA's Physician Masterfile.

- All agencies should screen physician applicants and periodically screen all physician employees against the federally-operated National Practitioner Data Bank, when operational. The bank is mandated by The Health Care Quality Improvement Act of 1986 and The Medicare and Medicaid Patient and Program Protection Act of 1987. This activity should be coordinated with all personnel systems and organizations operating within the agency to ensure all physicians are screened.

COMMENTS:

We received comments regarding the draft report from 13 of the 15 organizations reviewed. In addition, we also received comments from OPM and the Air Force. All respondents agreed with the recommendations contained in the report. Four of the organizations reviewed indicated that they will be taking specific action to strengthen policies and procedures pertaining to physician requirements for clinical positions, disclosure requirements, and verification of physician credentials. The remaining organizations stated that all or part of the recommendations were already being followed within their organizations; however, they would continue to evaluate their policies and procedures. Specific comments regarding agency and organization reactions to the recommendations appear on pages 20-23 of the report.

The OPM indicated in their response that they will be reexamining the Medical Officer qualification standards and one of the key issues that will be addressed is the need to require clinical care physicians to maintain current, valid licenses.

We wish to thank those that commented on our draft report. Many of the suggestions to help clarify and strengthen the text have been incorporated into the final report.

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I. INTRODUCTION

PURPOSE

This inspection was conducted at the request of the President's Council on Integrity and Efficiency to:

- identify Federal personnel requirements for physicians seeking full-time employment;
- identify techniques used by organizations in verifying credentials and other information requested from applicants; and,
- identify best practices that can be shared by the Inspectors General with their respective organizations.

BACKGROUND

In recent years a number of events have occurred that indicate both the governmental and private sectors need to increase their scrutiny of physician credentials. They are as follows:

- identification by the Federal Bureau of Investigation (FBI) of physician "diploma mills," schools selling bogus medical degrees ("Fraudulent Credentials: Federal Employees," hearing before the Subcommittee on Health and Long-Term Care, April 1986);
- concerns about the adequacy and authenticity of the education received by graduates of foreign medical schools ("Medical Licensure and Discipline: An Overview," report by the Department of Health and Human Services (HHS), Office of Inspector General (OIG), June 1986, control number P-01-86-00064);
- an increasing pool of unlicensed physicians practicing medicine ("Strengthening Educational and Licensure Standards for Physicians in New Jersey," report by the New Jersey State Board of Higher Education and the State Board of Medical Examiners, March 1987 and "Medicare and Medicaid Payments for Physician Services Rendered by Practitioners who had Lost Legal Authority to Practice in the State of Florida," report by the HHS, OIG, August 1987, control number A-04-87-02011);
- an increase in the number of malpractice suits filed against medical doctors each year ("Report of the Task Force on Medical Liability and Malpractice," HHS, August 1987);

- a 60 percent increase in physician license revocations taken by State boards since 1984 (study conducted and published by the Federation of State Medical Boards (FSMB) reported in the Chicago Tribune, November 9, 1986); and

- a recent article in the February 11, 1988 edition of The New England Journal of Medicine entitled, "Falsification of Clinical Credentials by Physicians Applying for Ambulatory - Staff Privileges," which reports 5 percent of the 773 physicians reviewed presented false clinical credentials. Three and one half percent gave false information about their residency, 1.3 percent falsely reported board certification and .3 percent provided false information about both residency and board certification.

Congress has focused its attention on protecting the public from impaired, unqualified, and unethical physicians. According to reports by the Congressional Subcommittee on Health and Long-Term Care and by educational agencies regarding fraudulent credentials, 1 in 50 physicians may have used some form of fraudulent credentials in seeking employment. These reports also note that while most United States businesses emphasize educational levels when making employment decisions, most do nothing to verify school credentials.

Congress passed The Health Care Quality Improvement Act of 1986 and The Medicare and Medicaid Patient and Program Protection Act of 1987. These laws will facilitate the verification of physician information presented on resumes and application forms.

Most of the medical officer positions located in the Federal agencies reviewed are filled by physicians in clinical, patient-care settings. The next largest group of physicians are researchers and investigators in nonclinical positions, followed by program administrators and managers who supervise staff physicians or formulate policies and procedures.

Physicians applying for positions in Federal service must meet the minimum requirements established by the personnel systems under which an organization operates. Most of the organizations reviewed in this study operate under a combination of two of the following personnel systems: the civil service, the Commissioned Corps of the Public Health Service (PHS), and the military services. For instance, the Department of Defense (DOD) has commissioned military officers who are physicians and civil service physicians. The Coast Guard has both civil service physicians and officers in the PHS Commissioned Corps. The Veterans Administration (VA) and Department of State have personnel systems uniquely their own. The VA employees receive civil service benefits; however, VA uses its own personnel application forms and establishes its own personnel standards and qualifications. The Department of State is under the foreign

service system, although they use the standard civil service forms and require additional qualifications to those specified by the Office of Personnel Management (OPM). Appendix A indicates the types of personnel systems operating within each agency.

Verification of physician credentials and other related information is a somewhat complicated process because there are layers of review. Typically, a physician's qualifications come under scrutiny by personnel specialists who screen the application to ensure all personnel requirements are met. Next, or perhaps at the same time, security personnel verify information to ensure that the applicant is suitable for employment. Physicians applying for clinical care positions may also need to apply to a credentialing board of a Federal hospital for medical privileges. Again, credentials are scrutinized primarily to determine the medical skill and competency of the applicant. Some organizations also have staff who are responsible for screening the credentials of all physician applicants before they are hired. Hiring officials receive the information accumulated through the preemployment process and make a decision regarding the applicant. However, some organizations have centralized medical appointment boards that must approve all physicians before they are hired.

SCOPE AND METHODOLOGY

The term "physician credentials," when used in this report, refers to information and documents provided by the applicant regarding academic background, residency, licensure and, if necessary, board certification. The term "practice history" information refers to adverse actions taken against a physician while practicing medicine. This information may include disciplinary actions taken by State licensure boards, peer review committees, or sanctions by Federal entities. It includes information regarding malpractice awards resulting from inappropriate care, denial of malpractice insurance, censorship by professional organizations, etc.

This report does not focus on the entire preemployment process because it differs in almost every organization. However, we compared requirements and qualifications, and looked at verification techniques which were used by personnel specialists, security specialists, and hospital credentialing committees. Since most of the full-time Federal physicians are employed in clinical care positions, we focused on the verification of credentials for these physicians.

Based on information supplied by OPM, we selected for review 7 Federal agencies with 35 or more full-time physicians on staff as of 1985: (1) HHS (the Social Security Administration, the Health Care Financing Administration, the Centers for Disease

Control, the Alcohol, Drug Abuse and Mental Health Administration, the Food and Drug Administration, the Health Resources and Services Administration [HRSA], and the National Institutes of Health [NIH]); (2) DOD (the Army and the Navy); (3) Department of State; (4) the Department of Transportation (the Coast Guard and the Federal Aviation Administration); (5) the Department of Justice (the Bureau of Prisons); (6) the VA; and (7) the National Aeronautics and Space Administration (NASA). For ease in reporting, 3 agencies, NASA, VA and the Department of State, plus the 12 components within the remaining 4 agencies will hereafter be referred to as organizations. In all, 15 organizations were contacted.

Field work was conducted primarily at the Headquarters of these organizations with the exceptions of VA and DOD. For decentralized organizations, telephone interviews were also conducted with selected regional or local staff. Because the General Accounting Office was concurrently conducting reviews of VA and DOD, we limited our contacts with these agencies to Army, Navy and VA officials within the Chicago area and selected Headquarters officials. (It should be noted that the Air Force was not interviewed during this study). For the most part, we relied on file information regarding DOD and VA physician requirements and credentialing practices. Because it was not feasible to contact every field office, regional office and/or medical facility operated by the sampled organizations, our analysis may not reflect all local credentialing practices within an organization.

We interviewed personnel directors and staff, security officers, clinical directors, area directors, employee relations specialists, tort specialists, and chief medical officers. Appendix A lists the organizations involved in this study by agency and indicates the approximate number of full-time physicians employed.

We examined application forms, disclosure statements, personnel and employee reference form letters and checklists used to verify physician credentials. In addition, we reviewed written policies and directives regarding physician employment requirements and verification procedures, to the extent they were available.

We analyzed 72 case abstracts of HHS and VA physicians whose licenses were revoked, suspended or restricted before they were hired for Federal service. Information regarding the VA physicians was gathered from a report entitled "Audit of Licensure Status of Veterans Administration Physicians," September 1986, prepared by the VA Inspector General. Information regarding HHS physicians was provided by the Office of Audit within HHS, OIG. (It should be noted that the HHS physicians referred to above were identified as a result of the initial matching program, which is currently ongoing, with FSMB

and the AMA's Physician Masterfile. Corrective action regarding these physicians has been taken.)

The military, the PHS Commissioned Corps, and the VA have recently revised their physician qualifications and verification procedures. Many of the best practices identified in this report reflect these changes. The OPM is also currently revising the standards and qualifications required of civil service physicians. We hope this report can further assist these organizations in refining their credentialing processes.

II. FINDINGS

PHYSICIAN QUALIFICATIONS

Finding: All the personnel systems reviewed require physician applicants to meet the same minimum educational and licensure requirements if they are applying for clinical care positions.

The minimum requirements are as follows: a degree from an accredited medical school, completion of an approved internship and/or residency program, and possession of a current, valid, unrestricted State medical license.

An accredited medical school is defined by all the personnel systems as a United States or Canadian medical school approved by the Liaison Committee of Medical Education during the year the applicant graduated.

Applicants graduating from foreign or unaccredited medical schools must demonstrate to reviewing officials that the medical education and knowledge received is substantially comparable and equivalent to that offered by an accredited medical school as defined above. Comparability may be evidenced by a valid, unrestricted State license; specialty board certification; permanent certification by the Educational Commission for Foreign Medical Graduates (ECFMG); or, 1 year of service as an active duty commissioned medical officer in the medical corps of the military or the PHS Commissioned Corps and performance of unrestricted duties including the treatment of patients.

An approved residency program is defined by the personnel systems as one that was approved by the Accreditation Committee on Graduate Medical Education during the applicant's period of participation. Usually the applicant must have completed no less than 1 year of approved residency training. However, exceptions are occasionally made.

Personnel systems, with the exception of the PHS Commissioned Corps, did not usually require an applicant applying for a research position to possess a current license unless the research would include patient care activities. On the other hand, many organizations required licensure for physicians applying for administrative positions where they would be supervising patient care settings, or rotating between clinical and administrative assignments.

Five organizations have some positions which require applicants to have specialty board certification to meet the minimum requirements. However, this qualification is not required for all positions within these organizations. Others "reward" board-certified physicians by allowing them to enter Federal service at

higher grade levels or pay physicians bonuses for such credentials.

United States citizenship is required by all the personnel systems. Occasionally this requirement is waived by civil service if the physician is otherwise qualified and will be placed in a "hard to fill" position in a medically underserved area.

Finding: Civil service is the only personnel system that does not require physicians, once employed, to maintain current, valid licenses.

The PHS Commissioned Corps requires commissioned officers to maintain current medical licenses regardless of whether they are working in clinical, research or administrative positions, although exceptions, usually for physicians holding research positions, may be made on a case-by-case basis. The military, Department of State and VA, with certain exceptions; e.g., physicians working in foreign countries), require their clinical physicians to maintain current, valid licenses. However, civil service physicians, once appointed to clinical positions, do not need to maintain their medical licenses with the exception of those working in the District of Columbia. On the other hand, if a civil service physician applies for another competitive civil service job which requires licensure, then he or she must possess a current, valid license to be eligible for the position.

It should be noted that the above finding applies to personnel systems in general. Civil Service physicians in clinical care positions employed by PHS, DOD, VA and the State Department are required to maintain medical licenses because it is a uniform policy of these agencies.

DISCLOSURE REQUIREMENTS

Finding: Physician disclosure requirements vary widely. There is no uniformity among personnel systems, agencies or within some organizations.

While all personnel systems serving the organizations reviewed have established uniform minimum requirements for physician applicants, each system requests additional information. Chart 1 on page 8 compares disclosure requirements of the military, civil service, and the PHS Commissioned Corps. As this chart indicates, the military requires the most disclosure by its physician applicants. Of the 13 areas listed, only the following are uniformly required by all personnel systems to be disclosed: (1) felony convictions, (2) courts-martial convictions, (3) misdemeanor convictions, (4) professional references, (5) violations of Title 21, U.S. Controlled Substance Act, and (6) revocations of a State medical license. It should be noted that

disclosure of the first four items are required of all applicants applying for Federal service, and only the fifth and sixth items are specifically addressed to physicians.

CHART 1

DISCLOSURE REQUIREMENTS BY PERSONNEL SYSTEMS*

Information Required	Civil Service	PHS Corps	Military Services
MEDICAL LICENSURE			
Multiple Licenses		X	X
License Application Refused	X		
DEA CONTROLLED SUBSTANCE PERMIT			
Registration	X	X	X
Denial/Surrender/Loss of Permit	X	X	X
PRACTICE HISTORY			
Convictions:			
Felonies/Courts-Martial	X	X	X
Misdemeanors	X	X	X
Substance Abuse Violations	X		X
Torts			X
Licensure Problems:			
Voluntary Surrender			X
Involuntary Actions	X	X	X
Privileges Problems			X
Professional Association/Peer Review Problems			X
Professional References	X	X	X

*Most of the organizations reviewed operate under a combination of two of the three personnel systems on this chart. The personnel systems used by the Department of State and VA were not included because each is unique to its own agency.

We also found no consistency in disclosure requirements among the agencies studied, nor consistency among organizations within an agency. In fact, there was rarely consistency within an organization itself. Only VA and the Department of State have consistent disclosure requirements of all physicians applying for positions. The DOD has uniform directives regarding credentialing; however the Army and the Navy have added their own

specific requirements which pertain only to those applying for military positions. Civil service applicants within military organizations must meet only DOD/civil service requirements. Within HHS organizations, there are similar inconsistencies caused by the requirements of the civil service and PHS Commissioned Corps personnel systems. The NIH has addressed the situation by imposing uniform requirements on all physician applicants regardless of the personnel systems operating within this organization.

Chart 2 compares the disclosure requirements used by the 15 organizations studied. Only six consistently require all physicians to disclose all States where they currently hold or have ever held a State medical license. Only three consistently ask about any malpractice claims or settlements. None asked about Medicare/Medicaid sanctions; however, the Bureau of Prisons indicated they did screen physicians against the Medicare/ Medicaid sanction listing. Only two organizations consistently inquired if a State license had ever been voluntarily surrendered. Three organizations consistently asked if hospital privileges had ever been revoked or suspended, and only seven consistently asked applicants if any State drug laws were ever violated.

CHART 2
ORGANIZATIONS' DISCLOSURE REQUIREMENTS

Information Required		Number of Organizations
MEDICAL LICENSURE	Multiple Licenses	6
	License Application(s) Refused	5
DEA CONTROLLED SUBSTANCE PERMIT	Registration	15
	Denial/Surrender/Loss	15
PRACTICE HISTORY	Convictions:	
	Felonies/Courts-Martial	15
	Misdemeanors	15
	Torts	3
	Substance Abuse Violations	7
	Medicare/Medicaid Sanctions	0
	Licensure Problems:	
	Voluntary Surrender	2
	Involuntary Actions	15
	Privileges Problems	3
	Insurance Problems	2
	Professional Association or Peer Review Problems	3
	Professional References	15

The NIH, VA, the Army and the Navy have more comprehensive disclosure requirements, thus allowing their hiring officials to make a more educated assessment of the potential risks to the agency posed by the applicant.

In examining how physicians with disciplinary histories had slipped through employment screens, the OIG/VA and OIG/HHS found, among other problems, that more extensive disclosure could have prevented certain physicians from entering Government service. For instance, one case involved a physician who had a history of voluntarily surrendering his medical license. In all States where this physician "voluntarily surrendered" his license, he did so after being confronted by the State medical board for indecent assault on a patient. Within 3 years of obtaining a Federal position, this same physician was terminated for sexual harassment. Had this organization properly inquired concerning multiple licenses and their status, the risk associated with this physician could have been avoided.

Finding: All organizations require applicants to sign statements indicating they understand that they will be subject to immediate dismissal or penalty for false disclosure.

Most of our respondents agreed that use of disclosure is a good "screening" technique. One respondent stated his organization used disclosure statements to discourage physicians with histories of disciplinary actions. When confronted with answering the questions truthfully or facing a penalty for false disclosure, they found physicians often withdrew their applications.

All organizations require applicants to permit the release of information from past and present employers, schools, law enforcement agencies and other individuals and organizations. For clinical care applicants, the NIH requires information from administrators and members of medical staffs of other hospitals or institutions, medical associations, malpractice carriers, the AMA, FSMB and other nationally recognized bodies that maintain automated data files on clinical care practitioners.

The NIH's, VA's, and the Army's attestation forms require the physician's agreement to release from liability all entities, and their representatives, from actions performed in good faith and without malice. Such a release clears the way for an employer to verify an applicant's credentials, competence, character and professional ethics.

Finding: Disclosure requests are often open to misinterpretation.

In comparing the various disclosure questionnaires used by the 15 organizations, some allowed the applicant to provide a less than complete and truthful response.

Following are examples of questions regarding professional liability:

> "Have you had any malpractice claims within the last 5 years or is a claim pending?"
>
> "Have you ever had any malpractice actions instituted against you?"

The first example places a 5-year limitation on the disclosure request. Serious violations of professional conduct and instances of medical incompetency could have occurred prior to the time period specified. Neither example requests past and present liability claims/judgments/settlements made against a hospital, corporation, or Government, based on a case directly under the applicant's care.

Some examples of poorly crafted questions concerning multiple licensure are:

> "Do you hold a current, valid, unrestricted license(s) to practice medicine, dentistry, or podiatry in a U.S. State(s) or territory(s)?" and;
>
> "List States granting full/unrestricted professional licenses/certificates."

Many physicians, especially those in the early years of their practice, hold up to three or four State medical licenses. While it is not unusual to find a physician not renewing some medical licenses as his/her practice becomes more established in a given State(s), one must guard against the incompetent and/or unprofessional physician who voluntarily surrenders his license in one State only to set up practice in another State in which he/she holds an unrestricted medical license. By limiting the disclosure to "full/unrestricted" or "current, valid, unrestricted" one has provided a loophole for the physician applicant to avoid divulging past or present restricted, suspended, revoked or voluntarily surrendered medical licenses.

In one situation, the application form itself allows space for listing three State licenses. This allows the physician to avoid divulging the State(s) that have taken disciplinary actions against him/her, by listing only those States where he/she has an untarnished record.

With respect to disciplinary actions taken against a physician's license to practice medicine, one organization requests a physician to disclose if his/her license has ever been lost/revoked. Such disciplinary actions as suspension or restriction of a medical license or denial of such are not requested.

Many of the disclosure requests/questions begin with:

"Has your license ..."
"Has your application ..."
"Is your license ..."

If a physician has more than one license or has filed applications for more than one license, then the physician could respond to the disclosure questions by referring only to those State licenses and applications for licensure where he/she has an untarnished record.

Appendix B contains a suggested disclosure questionnaire with sample language for each inquiry. The model is based on the strong disclosure requirements used by NIH and the military.

VERIFICATION TECHNIQUES

Finding: Verification techniques used by organizations vary widely. Few organizations consistently contact primary sources to verify medical degrees, residency certificates or licensure status.

Any one or combination of the following techniques were used to verify particular information: (1) visual inspection; (2) telephonic confirmation; (3) written requests (vouchers); (4) National Agency Check and Inquiry (NACI); (5) background investigations; (6) accessing third-party data banks; and (7) screening against approved listings.

Most respondents who initially screened the application said they looked at the form to ensure all the necessary information was present for a determination whether the applicant met the necessary qualifications. For some organizations, this was the end of this particular phase of the verification process. For others, if "something didn't look right" further inquiry was made.

All organizations sent letters to physician-supplied references. A few organizations indicated that references were called directly. One organization developed a form to solicit specific information regarding the applicant over the phone. Further information regarding reference follow-up is contained on page 16.

Verification of medical education usually consisted of review of a submitted copy of the diploma and residency certificate. However, recognizing that copies of medical degrees and certificates can be forged or altered, the Joint Commission on Accreditation of Health Care Organizations requires effective January 1, 1988 as a standard of accreditation, that hospitals use primary sources such as medical schools and residency programs to verify the qualifications of doctors seeking clinical privileges.

Several respondents indicated that State licensure boards were contacted to verify the status and validity of the current license(s); however, only the military and VA contacted applicable State boards to determine the status of all current and past licenses held by an applicant. In addition to verification of licensure status, for military physician applicants, the Army and Navy verified, from primary sources, the rest of an applicants credentials, including requesting transcripts from all schools (including foreign schools) and checking with the AMA, ECFMG and specialty boards to verify school accreditation, completion of an approved residency and, if necessary, board certification. A physician is not officially hired until the entire verification process is completed.

An analysis of HHS and VA case abstracts indicates that contacting appropriate third parties to verify medical degrees and licensure could have prevented unqualified physicians from entering Federal service. To illustrate, an investigation of the circumstances which left a surgical patient in a irreversible coma due to brain damage revealed that the Federal physician who administered the anesthetic during surgery was not a physician. Before this physician was employed by the Federal Government, the ECFMG was aware that this physician imposter had a bogus medical degree from a foreign medical school. This same person repeatedly attempted to obtain a medical license in different States but failed to pass licensing exams. Despite failing to obtain an ECFMG certificate and repeated failures to obtain a State medical license in several States, this person presented forged foreign documents and obtained a position with the Government. Had the employing organization not relied on copies provided by the applicant and verified credentials by contacting independent sources, this imposter could have been exposed, denied Federal employment, and not allowed to endanger patients.

Finding: A number of respondents assumed that all or part of a physician's credentials were verified through suitability checks or background investigations.

All Federal employees must undergo a security check or some form of background investigation. Most of the physicians employed by the organizations reviewed were classified in nonsensitive

positions which do not require extensive background investigations.

Physicians occupying nonsensitive positions receive a basic security check referred to as a NACI. The OPM has the responsibility for conducting NACIs, although certain Federal organizations have made arrangements with OPM to conduct their own NACIs. The NACI consists of:

A. a written request (called voucher) for verification of highest educational level or degree achieved;

B. vouchers to all schools (if any) in the last 5 years;

C. vouchers to all employers (if any) in the last 5 years;

D. name check of OPM records for results of investigations conducted by other Federal components; and,

E. name and fingerprint search of FBI files.

An NACI suitability check is not designed to determine whether a physician is properly licensed. Those physicians who have graduated from foreign schools and whose employment references are outside the United States may have none of their professional qualifications verified because the NACI does not verify foreign education or foreign employment. Some components incorrectly assume that the NACI constituted verification of credentials. If components want credentials information verified they may request OPM to include it in the NACI or seek verification through other primary sources.

The Department of State, the Bureau of Prisons, and Coast Guard have classified all medical officer positions as sensitive or higher and thus perform full background investigations on each physician. However, this sensitivity level is required of other professionals in these organizations, and does not reflect special scrutiny of physicians.

Raising the sensitivity level of positions occupied by physicians may reduce the risk of unethical, unqualified, or impaired physicians entering Government service, but will increase the cost of the investigation. The NACI for physicians occupying a nonsensitive position costs about $15 to conduct. Raising the sensitivity designation to the next higher level would add a credit check, increasing the cost to about $100 per physician. More in-depth background investigations can cost up to $2,000 or more depending on the scope and depth of the investigation desired by the organization. While OPM does not charge organizations for conducting NACIs, the cost of any "check" or investigation above the level of a NACI must be assumed by the

organization. As detailed in the next finding, there are other verification techniques available.

Finding: Some organizations access independent data banks to verify physician credentials and adverse practice history information.

The three agencies employing the most physicians, VA, HHS, and DOD, screen all physician applicants against a disciplinary data bank operated by the FSMB. This bank serves as the primary center for collection, maintenance, and reporting of disciplinary actions taken against physicians resulting from formal charges by FSMB member boards and other governmental authorities. (See Appendix C for more information regarding this data bank.)

The FSMB's data pertains only to disciplinary actions taken against licensed physicians or physicians applying for a license. It cannot identify whether a physician holds a license at all or is licensed in a given jurisdiction if no disciplinary actions have occurred. Direct confirmation with the licensure board is the best method of verifying licensure status.

Many organizations who employ fewer physicians were not aware of this disciplinary data base. Others which did not use it expressed dissatisfaction with the accuracy and the relevance of the information available. Those organizations who use it as a screening tool were generally satisfied but did express some concern about the uniformity of the data reported.

One organization reported difficulty in following up with the State licensure boards on a potential "hit" from the data bank. The hit resulted from information supplied by the licensure board regarding a physician who voluntarily surrendered his license. Many State licensure boards will not release information concerning their investigations when the physician in question voluntarily surrenders a license to practice medicine before the board completes its investigation. Similarly, many Federal organizations will not release information when physicians voluntarily terminate their employment rather than face disciplinary action and possible involuntary removal from Federal service.

Another data base used by many of the organizations is the AMA Physician Masterfile, which profiles a physician's education, training, board certification, memberships, and biographical information. It also contains limited licensure information, and indicates whether the physician died in the last 15 years.

Specialty board certification can also be verified by purchasing a compendium of board certified physicians prepared by the American Board of Medical Specialties located in Evanston, Illinois. However, the most current and accurate information

regarding board certification can be obtained directly from the appropriate specialty board.

Finding: Form letters (vouchers) used by most organizations to contact references do not obtain all the needed information.

The letter the Coast Guard sends to professional references specifically queries for: (1) confirmation of staff privileges and any restrictions/limitations; (2) clinical/professional knowledge; (3) professional reputation; (4) professional/personal ethics; (5) ability to work with colleagues and staff; and, (6) the ability to communicate with the patients. The Department of State letter specifically asks about any disciplinary actions. On the other hand, a standard form that is used by many organizations has a checklist with items like "capacity for development," and "attendance." The sections for written comments do not focus on professional ability, reputation, or any disciplinary actions.

Finding: Personnel manuals, handbooks and directives are, for the most part, silent regarding how to verify physician credentials.

Most of the organizations reviewed in this study operate a number of health care facilities located across the country. Generally, the preemployment process for physicians starts in local personnel offices. From there, the process becomes somewhat fragmented in that certain tasks in verifying a physician's credentials are done by local staff and others by Headquarters staff. The number of physicians hired may vary from facility to facility. Many of the local personnel offices may process only a few physician applications a year. Therefore, personnel specialists may have limited familiarity with the complexities of physician credentialing.

Personnel manuals, handbooks and directives do not often stipulate how to verify a physician's credentials. Only PHS, VA, the Army and the Navy have developed written guidelines to be used by employee specialists in screening and verifying physician credentials. These guidelines stress the importance of verifying all information obtained from applicants with primary sources, or third-party sources such as the data banks previously described.

The PHS guide lists verification sources, indicates how to access them, and contains examples of the type of information available. The guide also provides a list of comments and questions that personnel specialists should use in assessing the information collected to determine if the applicant is qualified and suitable for employment.

Finding: Recent legislation has expanded the independent sources available for credentials verification.

The Health Care Quality Improvement Act of 1986 requires that paid medical malpractice actions and claims be reported to the Secretary of HHS. This Act also requires health care entities with formalized peer review mechanisms to report to the Secretary, through the State licensing boards, disciplinary actions they take against physicians. The State licensing boards must review these health care entities' referrals and, if warranted, take disciplinary action. Any disciplinary action taken by State medical boards must, in turn, be reported. The Secretary will maintain and make this information available to hospitals and certain other health care providers.

Federal agencies submitting data or accessing this data bank must:

> "(1) use due process in a professional review activity or its equivalent for its actions to be accepted by the bank; and
>
> (2) have an approved Privacy Act system of records for (a) submitting data to the bank if it is to do so one for (b) obtaining data from the bank if it is to do so."

The HRSA will oversee the operation of the National Practitioner Data Bank and organizations will be subject to user fees before they may access the bank.

The Medicare and Medicaid Patient and Program Protection Act of 1987 expands the provision of The Health Care Quality Improvement Act of 1986 regarding disciplinary information by permitting the Secretary to gather information concerning:

> "(A) Any adverse actions taken by such licensing authority as a result of the proceeding, including any revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation.
>
> (B) Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction.
>
> (C) Any other loss of the license of the practitioner or entity, whether by operation of law, voluntary surrender, or otherwise."

The law also allows for the dissemination of such information:

> "(1) to agencies administering Federal health care programs, including private entities administering such programs under contract,
>
> (2) to licensing authorities described in subsection (a)(1),
>
> (3) to State agencies administering or supervising the administration of State health care programs (as defined in section 1128(h)),
>
> (4) to utilization and quality control peer review organizations described in Part B of Title XI to appropriate entities with contracts under section 1154 (a)(4)(C) with respect to eligible organizations reviewed under the contracts,
>
> (5) to State medicaid fraud control units (as defined in section 1903(q)),
>
> (6) to hospitals and other health care entities (as defined in section 431 of the Health Care Quality Improvement Act of 1986), with respect to physicians or other licensed health care practitioners that have entered (or may be entering) into an employment of affiliation relationship with, or have applied for clinical privileges or appointments to the medical staff of, such hospitals or other health care entities (and such information shall be deemed to be disclosed pursuant to section 427 of, and be subject to the provisions of, that Act),
>
> (7) to the Attorney General and such other law enforcement officials as the Secretary deems appropriate, and
>
> (8) upon request, to the Comptroller General, in order for such authorities to determine the fitness of individuals to provide health care services, to protect the health and safety of individuals receiving health care through such programs, and to protect the fiscal integrity of such programs."

Proposed Federal regulations pertaining to the Health Care Quality Improvement Act of 1986 have recently been released. Federal regulations regarding the Patient and Program Protection Act of 1987 are under development. Therefore, details regarding the type of information that is to be reported have not yet been widely disseminated. However, most of the information currently being reported to FSMB will also have to be reported to the Secretary of HHS. Appendix C describes the types of information contained in FSMB's disciplinary data bank.

Additional information regarding the operation of the Federal bank and the information it will contain can be obtained from:

Office of Quality Assurance
Bureau of Health Professions
Health Resources and Services Administration
Room 8-15 Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-2300

III. RECOMMENDATIONS

Recommendation: **Agencies employing civil service, clinical care physicians should require them to maintain current, valid State medical licenses; or, to be consistent with other personnel systems, OPM should require all clinical civil service physicians, once employed, to maintain a current medical license.**

The military, VA, Department of State and the PHS Commissioned Corps personnel systems (all with certain exceptions) require clinical care physicians to maintain their licensure status while employed. Only civil service does not. It is inequitable that physicians working side by side in an organization, with the same duties and responsibilities, are subject to different licensure requirements because they were hired under different personnel systems.

Physicians in private practice or employed by non-Federal health institutions are all required to have medical licenses and renew them when necessary. These same physicians are subject to renewal requirements, such as continuing education, and disciplinary actions mandated by the State licensure boards. These requirements not only help to reduce the pool of unlicensed physicians in this country, but also enhance quality assurance.

Comments:

All respondents concur with this recommendation. One organization indicates that they will be pursuing the policy of requiring civil service physicians within their organization to maintain valid licenses. This is consistent with requirements for civil service physicians in clinical care positions working for DOD, PHS, VA, and the Department of State.

The OPM indicates they will be reexamining the medical officer qualification standards under civil service. One of the key issues that will be addressed is the need to require clinical care physicians to maintain current, valid licenses.

Recommendation: **Physician disclosure requirements within agencies should be uniform across all organizations and personnel services. Most organizations should request more in-depth disclosure of adverse practice history information from applicants. Disclosure questions should be written in a clear and precise manner.**

The extent to which clinical care physician applicants are required to disclose adverse practice history information varies

greatly even within organizations. Adverse practice history information may not necessarily disqualify the physician from employment. However, in determining a physician's medical practice "track record," it is important to obtain as complete a profile of an applicant as is possible. To assist the organizations in this endeavor, a suggested disclosure questionnaire has been developed and is contained in Appendix B.

Comments:

All respondents agreed with the intent of this recommendation. One organization indicated that they would review their current application package to determine which of the questions on the suggested disclosure questionnaire might be incorporated. However, it appears, based on the comments, that not all agencies are taking steps to ensure uniform disclosure requirements across all organizations within their agency. Differences will still exist in some agencies depending on the personnel system under which the applicant applies.

Recommendation: The most current licenses held by an applicant should always be verified directly with the appropriate State licensing board. Organizations should also contact primary sources to verify medical degrees and completion of residency programs.

Few organizations consistently verify academic and licensure credentials with primary sources such as registrars' offices or licensure boards. The case abstracts we reviewed show that such verification would have helped the employer avoid making an erroneous or dangerous hiring decision.

Comments:

One respondent advised us that, in the future, they will include in the full field background investigation "verification of a physician's license through individual State licensing boards and [verification of] adverse practice history elicited from the applicant."

Another respondent advised us that, effective January 1, 1988, the Joint Commission on Accreditation of Healthcare Organizations changed its standards to require that physician credentials be verified with primary issuing authorities. This standard is in the implementation phase during this first year. Following that, medical facilities which do not comply will jeopardize their accreditation status. Based on this information we have revised the text of our report by changing the word advocates to requires.

Recommendation: Most of the organizations reviewed should strengthen verification procedures by developing written guidelines to be used by personnel involved in verifying physician qualifications. Verification of disclosure information should include accessing national physician data banks such as FSMB's disciplinary data base and the AMA Physician Masterfile.

Physician credentialing is a complicated process. Many personnel specialists process only a few applications each year and may have limited familiarity with the complexities involved or the verification sources available. Some respondents assumed incorrectly that the NACI constituted verification of credentials.

Written guidelines for verification procedures would provide guidance to less experienced personnel specialists and reduce the variability of verification techniques which we encountered.

Comments:

One agency that currently has guidelines that mandate verification of qualifications with outside authorities will consider contacting primary sources for future verification of physicians' credentials.

Another respondent, in commenting on physician credentials verification in general, felt that OPM "should issue governmentwide regulations on credentialing physicians, rather than each agency issuing its own." The OPM, in their response to us, indicates they consider DOD policies and procedures regarding physician credentialing exemplary. They plan to make these procedures known to all agencies employing civil service physicians and recommend that they follow these guidelines as appropriate.

The Army, in their comments, indicate that they will gladly provide details regarding medical quality assurance and verification of professional qualifications to any agency or organization desiring assistance in this area. The PHS guidelines entitled "Manual for Preemployment Screening of Physicians' Credentials" is also available upon request.

A number of respondents felt that the use of physician data banks such as the AMA's Physician Masterfile or FSMB's disciplinary data base should not supersede verification of a physician's credentials with primary or issuing sources, i.e., medical schools and State licensure boards. We agree that information regarding physician credentials provided by the applicant during the application process should be verified directly with the primary sources. As indicated in the report, FSMB's data base

cannot identify whether a physician holds a license at all or is licensed in a given jurisdiction if no disciplinary actions have occurred. However, use of nationally operated data banks can provide information that will confirm a physician's disclosure of adverse practice history information or indicate whether the physician withheld any pertinent information.

Use of the AMA's Physician Masterfile provides additional biographical information and of more importance, if known, will indicate whether the physician has died in the last 15 years. This may indicate that the applicant is an imposter. Based on these comments we have clarified the recommendation to stress verification of disclosure information through these types of sources.

Recommendation: **All agencies should screen physician applicants, and periodically screen all physician employees against the federally-operated National Practice Data Bank when operational. This activity should be coordinated with all personnel systems and organizations operating within the agency to ensure all physicians are screened.**

Federal agencies employing large numbers of physicians such as DOD, VA and HHS are already making arrangements to use the data bank. We believe all Federal employers with physicians on staff should avail themselves of this resource.

Comments:

All of the respondents concurred with this recommendation and all but two specifically stated they would be using the federally-operated bank when operational.

IV. APPENDICES

DEPARTMENTAL STATISTICS

Department/Administration	Components Contacted	# Full-time Physicians	Personnel Systems Civil Service : CS Military : M
Veterans Administration (VA)	VA	7,027	VA
National Aeronautics and Space Administration (NASA)	NASA	36	CS
Department of Justice (DOJ)	Bureau of Prisons	55	CS; PHS COMMISSIONED CORPS
Department of Defense (DOD)	Army Navy	11,361	CS; M
Department of State (DOS)	DOS	58	Foreign Service
Department of Transportation (DOT)	Coast Guard	84	M; PHS COMMISSIONED CORPS
	Federal Aviation Administration (FAA)		CS
Department of Health and Human Services (HHS)	Social Security Administration (SSA)		CS
	Health Care Financing Administration (HCFA)		CS; PHS COMMISSIONED CORPS
	Public Health Service (PHS)	5,800	
	- Centers for Disease Control (CDC)		CS; PHS COMMISSIONED CORPS
	- Alcohol, Drug Abuse & Mental Health Administration (ADAMHA)		CS; PHS COMMISSIONED CORPS
	- Food & Drug Administration (FDA)		CS; PHS COMMISSIONED CORPS
	- Health Resources & Services Administration (HRSA) - Indian Health Service (IHS)		CS; PHS COMMISSIONED CORPS
	- National Institutes of Health (NIH)		CS; PHS COMMISSIONED CORPS

*According to OPM survey as of 12/85.

APPENDIX B

MEDICAL OFFICER DISCLOSURE MODEL

If you answer "Yes" to any of the following questions, a full statement of explanation must be attached.

	Yes	No
1. List all jurisdictions in which you currently hold or have held a professional license. _____ _____ _____ _____		
2. Has your professional license to practice in any jurisdiction ever been limited, suspended, revoked, denied, refused renewal, issued on a temporary basis, or voluntarily surrendered?		
3. Have liability claims been filed against you, or against a hospital, corporation, or government based on a case under your care?		
4. Have judgments or settlements been made against you, or against a hospital, corporation, or government based on a case directly under your care?		
5. Have you ever had, or are you about to have, your professional liability insurance declined, cancelled, issued on special terms, or refused renewal?		
6. Provide the names and addresses (past and present) of all of your professional liability insurers and your policy numbers. _____ _____ _____ _____		
7. Have you ever been sanctioned by the Medicare or Medicaid Programs or by any other Federal agency?		
8. Have any or all of your privileges at any health care facility ever been, or are about to be, limited, suspended, revoked, refused renewal, or voluntarily surrendered?		
9. Have you ever been censured or reprimanded by a licensing board, hospital medical board/staff, or any other professional organization?		
10. Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings by any medical or professional organization?		

	Yes	No
11a. List all jurisdictions (past and present) where you are or were registered under Title 21, U.S. Controlled Substance Act and provide your DEA controlled substance registration number for each jurisdiction. (If you have never been registered under this Act, so state.) _____ _____ _____ _____ _____ _____		
b. Has your ~~registration~~ under this Act ever been denied, suspended, revoked, refused renewal, or voluntarily surrendered?		
c. Have you ever been charged with, or are currently facing charges, of a violation of this Act?		
12. "Have you ever been charged with, or are currently facing charges of, a violation of any State, Federal, local, or any foreign government law (e.g., child abuse, sexual assault, fraud, substance abuse (alcohol/drugs), etc.)?"		

Signature, ~~Certification~~, and Release of Information

You Must Sign this Application. Read
The Following Carefully Before You Sign.

A. I fully understand that a false statement to any question in this application, or the misrepresentation of information otherwise provided, may constitute cause for denial/revocation of medical staff appointment and/or clinical privileges and may be punishable by fine or imprisonment (U.S. Code, Title 18, Section 1001).

B. I certify that the statements/documents that I have made/provided in this application are true, complete, and correct to the best of my knowledge and belief and are made in good faith.

C. I hereby authorize investigators, personnel staffing specialists, and other authorized employees of the Federal government to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications.

I fully understand that these Federal representatives may validate my professional credentials by consulting with the American Medical Association, Federation of State Medical Boards, and other nationally recognized bodies that maintain automated data files on clinical care practitioners.

D. I hereby further consent to the inspection by the above mentioned Federal representatives of all records and documents, including medical records at other hospitals, that may be material to an evaluation of my professional qualifications for the position applied for. I hereby release from liability all representatives of the Federal government for their acts performed in good faith and without malice in connection with evaluating my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to these representatives in good faith and without malice concerning my professional competence, ethics, character and other qualifications for the medical officer position and any applicable clinical privileges, and I hereby consent to the release of such information.

_____ _____

Signature **Date**

APPENDIX C

DESCRIPTION OF THE FEDERATION OF STATE MEDICAL BOARDS' DISCIPLINARY DATA BANK

The FSMB was founded in 1912 and is the National Organization of Medical Licensing and Disciplinary Boards. Its membership is comprised of the medical boards of all the States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands and includes 11 of the 16 separate osteopathic boards in the United States. The 10 Canadian provincial medical licensing authorities hold affiliate membership.

The FSMB operates a physician disciplinary data bank (DDB) and collects, maintains, and reports disciplinary actions taken against physicians resulting from formal charges, by its member boards and other governmental authorities.

The types of disciplinary actions collected and subsequently reported by FSMB involve the revocation, probation, suspension, denial, restriction, or voluntary surrender of a medical license and/or narcotic permit, HHS Medicare/Medicaid sanctions, sanctions imposed by DOD, ECFMG sanctions, allegations of cheating on the Federation Licensing Examination, which is now used by all States and a number of other jurisdictions, mail fraud and instances of reprimand or admonishment. (See Exhibit A for a complete list of the types of disciplinary actions maintained by FSMB.)

Access to the information maintained in the DDB falls into two major categories - full access and limited access. All physician licensing and/or disciplinary boards in the U.S. and Canada that are Federation members or that report actions to the Federation for inclusion in the DDB, the AMA, and the American Osteopathic Association (information provided for attributed use) have full access at no charge. Federal and State Departments and agencies with disciplinary, investigative, or law enforcement responsibilities related to medical care also have full access but must pay a negotiated fee. Limited access services are provided, on a negotiated fee basis, to hospitals (individual, group, or multiinstitution systems), health and professional liability insurance carriers, selected physician groups (health maintenance organizations; State, regional and local independent practice associations, etc.), and State and county medical societies.

Exhibit A: Action Codes

100 LICENSE REVOKED
101 ALCOHOLISM
102 INCOMPETENCE/MALPRACTICE/NEGLIGENCE
103 NARCOTIC VIOLATIONS
104 FELONY
105 FRAUD
110 UNPROFESSIONAL CONDUCT
120 MENTAL DISORDER
130 ALLOWING UNLICENSED PERSON TO PRACTICE
140 VOLUNTARY SURRENDER OF LICENSE
150 DISCIPLINARY ACTION TAKEN IN ANOTHER STATE
180 OTHER REASON - NOT CLASSIFIED

200 CODE/PROBATION

200 PROBATION FOR MEDICAL LICENSES (ALONE OR AFTER STAY OF OTHER ACTION)
201 ALCOHOLISM
202 INCOMPETENCE/MALPRACTICE/NEGLIGENCE
203 NARCOTIC VIOLATIONS
204 FELONY
205 FRAUD
210 UNPROFESSIONAL CONDUCT
220 MENTAL DISORDER
230 ALLOWING UNLICENSED PERSON TO PRACTICE
250 DISCIPLINARY ACTION TAKEN IN ANOTHER STATE
260 PROBATION MODIFIED
270 VIOLATED PROBATION
280 OTHER REASON - NOT CLASSIFIED

300 CODE/SUSPENSION

300 LICENSE SUSPENDED
301 ALCOHOLISM
302 INCOMPETENCE/MALPRACTICE/NEGLIGENCE
303 NARCOTIC VIOLATION
304 FELONY
305 FRAUD
310 UNPROFESSIONAL CONDUCT
320 MENTAL DISORDER
330 ALLOWING UNLICENSED PERSON TO PRACTICE
350 DISCIPLINARY ACTION TAKEN IN ANOTHER STATE
380 OTHER REASON - NOT CLASSIFIED

400 CODE/MISCELLANEOUS

400 LICENSE RESTORED OR REINSTATED
401.1 Probation terminated - issued unrestricted license to practice
401.6 Restored or reinstated but still on probation

401.7 Restored or reinstated but must limit practice to certain area(s) or institution(s)
401.8 Other restoration/reinstatement, not listed
402 REINSTATEMENT DENIED
403 LICENSE BY RECIPROCITY DENIED
404 ADMITTANCE TO EXAMINATION DENIED
405 NARCOTIC PERMITS
405.1 Permission given to apply for permit
405.2 Directed not to apply for permit
405.3 Requested to and/or voluntarily surrendered permit
405.4 Permit no longer needed as per agreement with board
405.5 Permit denied
405.6 Permission given to apply for stated schedules
406 REPRIMAND OR ADMONISHMENT
407 DUPLICATE LICENSE ISSUED
407.1 Change of name
407.2 License stolen or lost
408 ACCUSATION DISMISSED
409 DENIED PERMANENT LICENSE - ISSUED TEMPORARY LICENSE
410 OTHER MISCELLANEOUS ACTION - NOT CLASSIFIED (stipulation or consent order)
411 ALLEGATIONS OF CHEATING
411.1 Exam taken but grades not given out
411.2 Ejected from Exam
412 LICENSE DENIED
412.1 Fraudulent Credentials
412.2 Failed to submit acceptable evidence of postgraduate training
412.3 Falsified Application
412.4 Other not listed
414 REQUEST FOR TERMINATION OF PROBATION DENIED
490 ACCUSATION FILED - CONTACT MEDICAL BOARD

500 CODE/MISCELLANEOUS

500 MISCELLANEOUS
513 D.H.H.S. MEDICARE SANCTIONS (SSA: SECS 1128/1862 (d) 1160)
513.1 Exclusion
513.2 Suspension
513.3 Withdrawal
513.4 Reinstatement
514 SANCTIONS OF MILITARY SERVICES
514.1 Intemperate use of alcohol
514.2 Narcotic violations/use
514.3 Health related problems
514.4 Incompetence/negligence
514.5 Other not listed
515 DISMISSED FROM MILITARY SERVICES
515.1 Intemperate use of alcohol
515.2 Narcotic violations/use
515.3 Health related problems

515.4 Incompetence/Negligence
515.5 Other not listed
516 POSTAL INSPECTION SERVICE (MAIL FRAUD-FRAUDULENT CREDENTIALS)
517 E.C.F.M.G. (FRAUDULENT CREDENTIALS)