

**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 mail it to the Board. 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](http://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*): 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           | 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      | _____                        |



**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: _____       |

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**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](http://www.mass.gov/massmedboard).**

Basis Code:\_\_\_ \_\_\_ \_\_\_ Basis Code:\_\_\_ \_\_\_ \_\_\_ Basis Code:\_\_\_ \_\_\_ \_\_\_ Basis Code:\_\_\_ \_\_\_ \_\_\_

Description:

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**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: _____       |

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Basis Code:\_\_\_ \_\_\_ \_\_\_    Basis Code:\_\_\_ \_\_\_ \_\_\_    Basis Code:\_\_\_ \_\_\_ \_\_\_    Basis Code:\_\_\_ \_\_\_ \_\_\_

Description:

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**Direct any questions concerning this form to the Board's Data Repository Unit: (781) 876-8200. Mail completed forms to the Data Repository Unit at the Board of Registration in Medicine; 200 Harvard Mill Square, Suite 330; Wakefield, MA 01880. Attach a copy of any Adverse Action Report filed with the Division of Practitioner Data Banks.**