EXHIBIT #1

(TOTAL OF 10 pages)

FILED

JAN 26 2007

TIME 3:56 pm

BEVERLY F. [illegible]

CIRCUIT COURT CLERK

FRANCIS J. SAVARIRAYAN, M.D.
(Pronounced as 'Sava Ryan')
169 Radio Lane
Sparta, TN 38583
Telephone: 931-739-1010
Cell: 931-510-3965
Email: savariray@aol.com

Education:

Medical Degree-MBBS (M.D.)
Christian Medical College
Vellore, Tamil Nadu, India

Post Graduate Training:

Residency – Surgery
Westminster Hospital
London, Ontario, Canada

Chief Residency – Urology
Boston University Medical Center
Boston, Massachusetts

Residency – Urology
Lahey-Hitchcock Clinic
Boston, Massachusetts

Residency – General Surgery
Charlton Memorial Hospital, Inc.
Fall River, Massachusetts

Internship (rotating)
Lawrence Memorial Hospital
New London, Connecticut

Professional:

Active Staff (On Leave)
White County Community Hospital
Sparta, Tennessee

Active Staff & Member, Executive Committee
Keweenaw Memorial Hospital

Front Page only of the Exhibit # 1 & # 2. Rest of the pages are same as the White County Court Filing and copies of the are with the attorney of Record / [signature] 8/24/07

EXHIBIT #2

<Total of 4 pages>

FILED
JAN 26 2007
TIME 3:45pm
BEVERLY F. TEMPLETON
CIRCUIT COURT CLERK

Community Health Systems, Inc. (CYH)

On Nov 2: 32.82 ↑

Profile

Get Profile for: GO

Community Health Systems, Inc.
7100 Commerce Way
Suite 100
Brentwood, TN 37027
United States - Map
Phone: 615-465-7000
Web Site: http://www.chs.net/

DETAILS

Index Membership:	S&P 400 MidCap S&P 1500 Super Comp
Sector:	Healthcare
Industry:	Hospitals
Full Time Employees:	21,600

BUSINESS SUMMARY

Community Health Systems, Inc. provides general hospital healthcare services in the United States. It engages in the ownership, lease, and operation of acute care hospitals. As

CORPORATE GOVERNANCE

Community Health Systems, Inc.'s Corporate Governance Quotient (CGQ®) as of 1-Nov-06 is better than 83.9% of S&P 400 companies and 94.9% of Health Care Equipment & Services

RECRUITMENT AGREEMENT EXHIBIT #3

(Total = 12

Date of Agreement: October 11, 2002

Physician Name: Francis Savariraysn, MD

Hospital Name: White County Community Hospital

Specialty: Urology

Hospital Legal Entity: Sparta Hospital Corporation

Telephone Number: 906-483-4020

Address of Hospital:

401 Sewell Road

Sparta, TN 38583

Address of Physician at Date of Agreement:

340 Navy Street, Unit 10

Hancock, MI 49930

Community: Sparta, Tennessee

Social Security Number: 045-38-4748

Practice Commencement Date: February 15, 2003

State(s) of Licensure: MI, ND, NE, IL, WA

Term of the Agreement: Thirty-six (36) Months

Relocation Expense Amount: Up to $10,000.00 upon submission of relocation receipts

Guarantee Period: Twelve (12) Months

CME Amount: $ 2,000.00

Total Guarantee Amount: $ 425,004.00

Marketing Expense Amount: Up to $20,000.00

Monthly Guarantee Amount: $ 35,417.00

Sign-On Bonus: $ 25,000.00 /FS/

The attached Standard Terms and Conditions are incorporated into the Recruiting Agreement.

SIGNATURES AND APPROVALS:
(See paragraph E.2 of the Standard Terms and Conditions)

Physician: Francis Savariraysn, MD

Date: 10/31/2002

Hospital Legal Name:

Sparta Hospital Corporation d/b/a White County Community Hospital

Gary [illegible], President

Date: 11-12-02

Approved as to Form:

In-House Legal Counsel

Date: 11/13/02

Reviewed and Approved:

Mark Cline, Facility Officer

Date: 11/1/02

EXHIBIT #4

Principles of Medical Ethics, June 2001

Preamble

The medical profession has long subscribed to a body of ethical statements developed pr benefit of the patient. As a member of this profession, a physician must recognize respon patients first and foremost, as well as to society, to other health professionals, and to self. Principles adopted by the American Medical Association are not laws, but standards of co define the essentials of honorable behavior for the physician.

Principles of Medical Ethics

I. A physician shall be dedicated to providing competent medical care, with compass respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professi interactions, and strive to report physicians deficient in character or competence, o fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek chang requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health profes shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, main commitment to medical education, make relevant information available to patients, and the public, obtain consultation, and use the talents of other health professional indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencie choose whom to serve, with whom to associate, and the environment in which to p care.

VII. A physician shall recognize a responsibility to participate in activities contributing to improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as p

IX. A physician shall support access to medical care for all people.

Adopted by the AMA's House of Delegates June 17, 2001

EXHIBIT #5

FILED
JAN 2 6 2007
TIME 3:45 p.m.
BEVERLY [illegible]
CIRCUIT COURT CLK

Date	Physician	Patient	Procedure	Infection Yes	Infection No	Hospital Acquired?	Complication ?
9-04-03	Sevarirayan	Grundy, Young	Bilateral Sub capsular orchiectomy		/		0
9-04-03	Sevarirayan	Blakford, Regina	Cystoscopy		/		0
9-04-03	Sevarirayan	Clouse, Truman	Cysto,Four Bladder Bx Retrograde Cath,Bil Ureters & Kidney Washings Bil Ureteroscopy		/		0
9-12-03	Sevarirayan	Clouse, Truman	TURP [illegible]		/		0
9-20-03	Sevarirayan	Cole, Charles	Cysto w/Attempted Stone Removal		/		0
9-21-03	Sevarirayan	Brock, Sammy	Cysto,Manipulation of Stone, Placement of Stent Right		/		0
9-22-03	Sevarirayan	Martin, Shannon	Cysto, Bi Retrograde Pyelogram		/		0

2003 - Total : 7 Cases

Total number of Surgeries performed at White County Hospital in ~~[illegible]~~ 9/02 with one Urologist on the Staff : 0 Cases.

Total number of Surgeries performed with 2 urologists at WC in 9/03 .... : 7 Cases, which is an Astronomical % increase! i.e.: OVER 600% in Urological Surgery at WCH after I arrived From !

EXHIBIT #6
(Total 3 pages)

FILED
JAN 26 2004
3:45 PM

American Hospital Directory - CMS Data

AHA DATAProfile
White Cnty Community Hospitalview
CMS (HCFA) DATA Profile
WHITE COUNTY COMMUNITY HOSPITAL (440192)view

CMS Data
Hospital identification taken from the Medicare Provider of Services Listing
As updated 03/31/03.
WHITE COUNTY COMMUNITY HOSPITAL
401 SEWELL RD
SPARTA, TN 38583
(931) 738-9211
Medicare Provider Number: 440192

Inpatient Utilization Statistics

All information in this report is taken from
The Medicare Provider Analysis and Review (MedPAR) file.
Data are for the federal fiscal year ending 9/30/2002.
This report is consistent with CMS (HCFA) Data Release policies.

Statistics by Medical Service

Number Medicare Inpatients	Average Length of Stay	Average Charges	Medicare Case Mix Index (CMI)
Cardiology	1392.71	$11,319	0.9834
Medicine	3162.44	$8,761	0.8053
Neurology	994.46	$11,820	0.9637
Oncology	122.67	$8,661	1.4167
Orthopedics	413.32	$22,644	1.3278
Psychiatry	18812.03	$23,206	0.7725
Pulmonology	2903.62	$13,665	1.1352
Surgery	313.10	$21,874	0.0561
Urology	612.80	$9,592	0.9215
Total	1,1884.52	$13,827	0.9804

Note 1 - Medicare Case Mix index is based on the Medicare Prospective Payment System for the corresponding federal fiscal year.
Note 2 - Click here for description of Medicare Prospective Payment System, DRGs, and case mix index.

Patient Origin for Top 3 Zip Codes
Data are from the Medicare Hospital Market Service Area File
for the calendar year ending 12/31/2002 versus prior year.

ZIP Code of Residence	Admissions	Days of Care	Charges	Admissions Inc/(Dec)	Market Share
38583	744	2,539	$8,986,546	4.0	44.0%
38581	275	946	$3,815,383	5.0	31.0%

EXHIBIT #7.

furnished to regulatory authorities such as the National Practitioner Data
the Nebraska Board of Medicine and Surgery. This resulted in loss of re
business to the plaintiff, including employment opportunities.

13. In February 1995, Padden, Wallace, Forney, and BBGH, am
placed false information in the National Practitioner Data Bank, statin
plaintiff had resigned staff privileges at BBGH pending investigatio
requests for corrective actions filed by the hospital administrator.

14. In January 1997, Padden and Wallace, among others, prov
information, including information contained in the plaintiff's person
BBGH and the results of the peer review, to Central Alabama Veterans H
System (CAVHCS) in connection with the plaintiff's application for resp
to the staff of CAVHCS. The information was provided only after th
signed a special release form, prepared by or at the direction of Padden,
Forney, and Curtiss, among others, which provided absolute immunity t
its officers, directors, employees, representatives, and staff physicians. B
the false information, the plaintiff was denied staff advancement at CAV
was subsequently terminated, resulting in loss of income for 6 months
employment opportunities elsewhere because of the plaintiff's lack of adv
at CAVHCS.

15. In October 1999, Padden and BBGH, among others, failed t
to a request for information from Genesys Regional Medical Center (G
connection with plaintiff's application for staff privileges at GRMC. Aft
to respond to this request for approximately 3 months, BBGH, through its
Curtiss, stated that no information would be provided unless the plaintiff
special release form which provided absolute immunity to BBGH, its
directors, employees, and staff physicians. Because the information
provided, the plaintiff's application was tabled indefinitely by GRMC and
that had been made to the plaintiff to [illegible]

EXHIBIT #8

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

FRANCIS J. SAVARIRAYAN, M.D., Plaintiff, vs. BOX BUTTE GENERAL HOSPITAL, et al., Defendants.	)	7:97CV3400 **PRELIMINARY PRETRIAL CONFERENCE ORDER**

IT IS ORDERED that pursuant to the court's Memorandum and Order previously filed this date, and pursuant to Fed. R. Civ. P. 16(e), the following statement of the plaintiff's case shall supersede all prior pleadings by the plaintiff:

Statement of the Plaintiff's Case

I. The Parties

A. The Plaintiff

1. The plaintiff alleges that he is a naturalized United States citizen; that he is a native of India and is non-white; that he currently is a resident of the State of Alabama; that from April 1991 until February 1995, he was a resident of the State of Nebraska and an attending urologist at Box Butte General Hospital in Alliance, Nebraska; and that at all time relevant to his complaint, he has been a Board certified urologist.

FILED

JAN 26 2007

TIME 3:45 pm

BEVERLY E. TEMPLETON

CIRCUIT COURT CLERK

EXHIBIT #9

(Total: 3 pages)

PRACTITIONER PROFILE DATA

This information is provided by the licensee as required by law.

BARRETT MD, DANIEL RABON

PRACTICE ADDRESS:	BLUE CROSS BLUE SHIELD OF TN 801 PINE STREET CHATTANOOGA, TN 37402
LANGUAGES: (Other than English)	None Reported DOB: 6/28/1958
SUPERVISING PHYSICIAN:	None Reported

GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAIN

PROGRAM/ INSTITUTION	CITY STATE/ COUNTRY	DATE OF GRADUATION	TYPE (DEGR
EMORY UNIVERSITY	ATLANTA, GA	05/14/1984	MD

OTHER EDUCATION AND TRAINING

PROGRAM/ INSTITUTION	CITY STATE/ COUNTRY	FROM	TO
EMORY UNIV.-GEN. SURG. INTERN	ATLANTA, GA	07/01/1984	06/30/
EMORY UNIV.-INT. MED. RESID.	ATLANTA, GA	01/01/1993	12/31/

SPECIALTY BOARD CERTIFICATION

CERTIFYING BODY/ BOARD/ INSTITUTION	CERTIFICATION/ SPECIALTY/ SUBSPECIALTY
AMERICAN BOARD INTERNAL MEDICINE	BOARD CERTIFIED-INT. MEDICINE

FACULTY APPOINTMENTS

TITLE	INSTITUTION	CITY/S
None Reported		

STAFF PRIVILEGES

This practitioner currently holds staff privileges at the following hospit

HOSPITAL	CITY/STATE
None Reported	

This practitioner currently participates in the following TennCare plan

None Reported

FINAL DISCIPLINARY ACTION

ACTIONS BY STATE REGULATORY BOARD

Tennessee Department of Health - Practitioner Profile

EXHIBIT #10 (Total 3 pgs)

TENNESSEE.GOV

Department of Health
Kenneth S. Robinson, MD, Commissioner

FILED
JAN 26 2007
TIME 2:45 pm
BEVERLY [illegible]
CIRCUIT COURT CLERK

PRACTITIONER PROFILE DATA

This information is provided by the licensee as required by law.

[illegible], FRANCIS JEBARAJAN

PRACTICE ADDRESS:	TENNESSEE UROLOGY CLINIC PC 435 SEWELL RD #A SPARTA, TN 38583
LANGUAGES: (Other than English)	None Reported
SUPERVISING PHYSICIAN:	None Reported

GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINI

PROGRAM/ INSTITUTION	CITY STATE/ COUNTRY	DATE OF GRADUATION	TYPI DEG
CHRISTIAN MEDICAL COLLEGE	MADRAS MADRAS INDIA	04/01/1960	MD

OTHER EDUCATION AND TRAINING

PROGRAM/ INSTITUTION	CITY STATE/ COUNTRY	FROM	TO
LAWRENCE & MEMORIAL HOSPS/INTERNSHIP	NEW LONDON CT	07/01/1963	06/3
TRUESDALE HOSP/SURGICAL RESIDENCY	FALL RIVER MA	07/01/1964	06/3
LAHEY CLINIC/UROLOGY RESIDENCY	BOSTON MA	07/01/1965	06/3
BOSTON UNIV/UROLOGY-CHIEF RESIDENT	BOSTON MA	07/01/1967	06/3

SPECIALTY BOARD CERTIFICATIONS

CERTIFYING BODY/ BOARD/ INSTITUTION	CERTIFICATION SPECIALTY/ SUBSPECIALTY
AM BD OF UROLOGY	UROLOGY

FACULTY APPOINTMENTS

TITLE	INSTITUTION	CITY
None Reported		

STAFF PRIVILEGES

This practitioner currently holds staff privileges at the following hospit

HOSPITAL	CITY/STATE
KEWEENAW MEMORIAL MEDICAL CTR HOSP	LAURIUM, MI

To Err Is Human: Building a Safer Health System (2000)

Institute of Medicine ( )

The knowledgeable health reporter for the *Boston Globe*, Betsy Lehman, died from an overdose during chemotherapy. Willie Ring had the wrong leg amputated. Ben Kolb was eight years old when he died during "minor" surgery due to a drug mix-up.

These horrific cases that make the headlines are just the tip of the iceberg. Two large studies, one conducted in Colorado and Utah and the other in New York, found that adverse events occurred in 2.9 and 3.7 percent of hospitalizations, respectively. In Colorado and Utah hospitals, 6.6 percent of adverse events led to death, as compared with 13.6 percent in New York hospitals. In both of these studies, over half of these adverse events resulted from medical errors and could have been prevented.

When extrapolated to the over 33.6 million admissions to U.S. hospitals in 1997, the results of the study in Colorado and Utah imply that at least 44,000 Americans die each year as a result of medical errors. The results of the New York Study suggest the number may be as high as 98,000. Even when using the lower estimate, deaths due to medical errors exceed the number attributable to the fifth-leading cause of death. More people die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516).

Total *national* costs (lost *income*, lost *household production*, *disability* and health care costs) of preventable adverse events (medical errors result-

EXHIBIT #12

(TOTAL: 6 PAGES)

About.com

Geography

World Life Expectancy Chart

This chart provides the 2000 and 1998 average life expectancies for both sexes in each country of the world. The data comes from the U.S. Census Bureau's International Data Base. The top and bottom three countries are highlighted.

Read my article about life expectancy to learn more about what these numbers mean.

Country	2000 LE	1998 LE
Afghanistan	46.9	46.8
Albania	71.6	72.6
Algeria	69.7	69.9
Andorra	83.5	83.5
Angola	38.3	47.9
Antigua and Barbuda	70.5	71.2
Argentina	75.1	74.1
Armenia	68.4	68.7
Australia	79.8	79.9
Austria	77.7	77.3
Azerbaijan	62.9	63.3
The Bahamas	71.1	74.0
Bahrain	73.0	75.0
Bangladesh	60.2	58.7
Barbados	73.0	74.8
Belarus	68.0	68.3
Belgium	77.6	77.4
Belize	70.9	69.9
Benin	50.2	53.6
Bhutan	52.4	52.3
Bolivia	63.7	60.9
Bosnia and Herzegovina	71.5	63.0
Botswana	39.3	40.1
Brazil	62.9	64.4
Brunei	73.6	71.7
Bulgaria	70.9	72.0

RECRUITMENT AGREEMENT EXHIBIT #13

Date of Agreement: October 11, 2002

Physician Name: Francis Stevenson, MD

Hospital Name: White County Community Hospital

Specialty: Urology

Hospital Legal Entity: Sparta Hospital Corporation

Telephone Number: 606-482-4020

Address of Hospital:

401 Sewell Road

Sparta, TN 38583

Address of Physician at Date of Agreement:

349 Main Street, Unit 10

Hancock, MI 49930

Community: Sparta, Tennessee

Social Security Number: 045-38-4748

Practice Commencement Date: February 15, 2003

State(s) of Licensure: MI, ND, NE, IL, WA

Term of the Agreement: Thirty-six (36) Months

Relocation Expense Amount: Up to $10,000.00 upon submission of relocation receipts

Guarantee Period: Twelve (12) Months

CME Amount: $ 2,000.00

Total Guarantee Amount: $ [illegible]

Recruiting Expense Amount: Up to $20,000.00

Monthly Guarantee Amount: $ 35,417.00

Sign-On Bonus: $ 25,000.00 / 25%

The attached Standard Terms and Conditions are incorporated into the Recruiting Agreement.

SIGNATURES AND APPROVALS:
(See paragraph E.2 of the Standard Terms and Conditions)

Physician: Francis Stevenson, MD

Date: 10/31/2002

Hospital Legal Name:

Sparta Hospital Corporation d/b/a White County Community Hospital

By: [illegible], President

Date: 11-12-02

Approved as to Form:

In-House Legal Counsel

Date: 11/13/02

Reviewed and Approved:

Mark Cole, Facility Officer

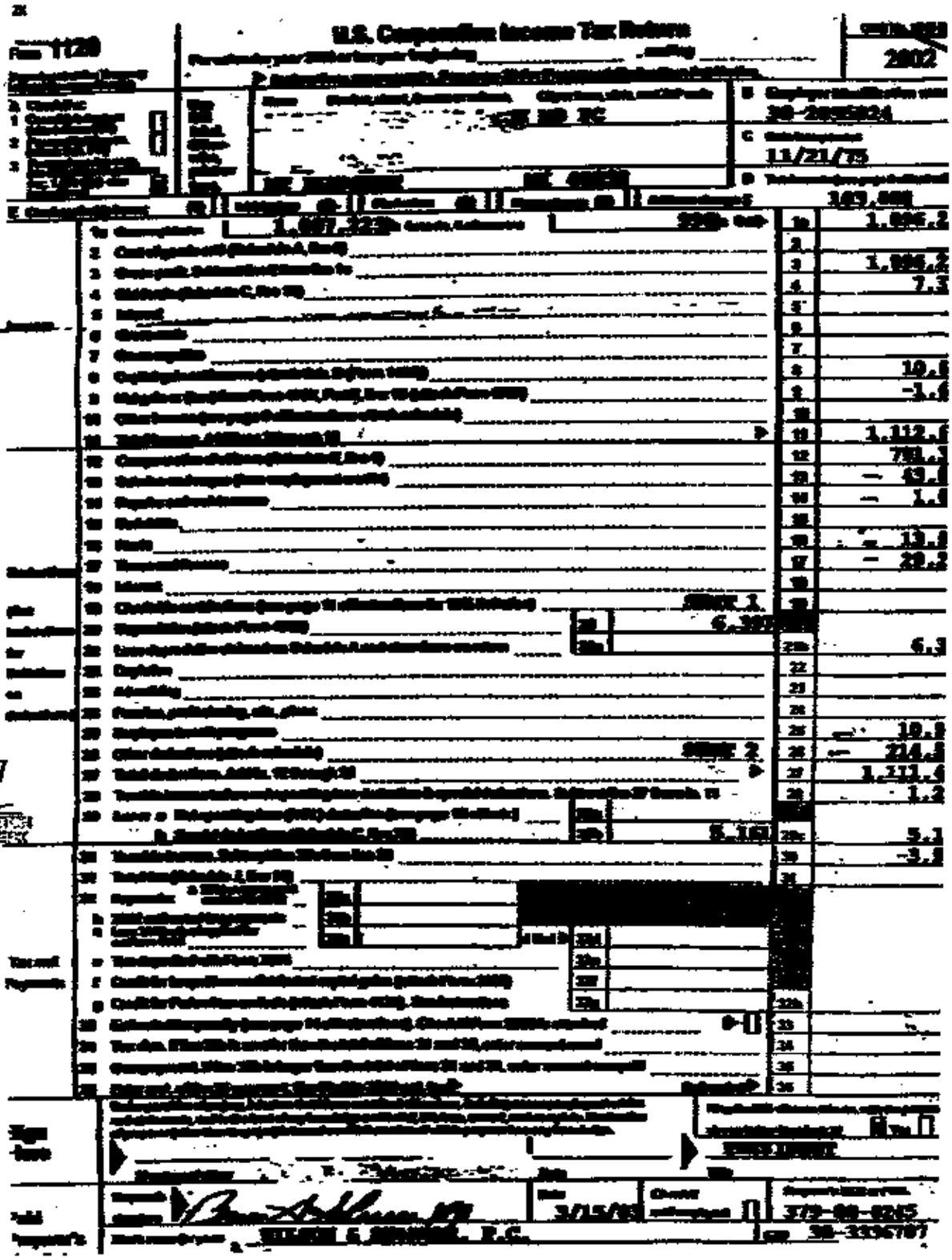
Date: 1-1-02

FILED

JAN 26 2007

TIME 3:45 pm

EXHIBIT #14



Form 1120 U.S. Corporation Income Tax Return 2002

FILED
JAN 26 2007
BEVERLY B. REID O'CONNOR
CLERK OF THE COURT

ATTORNEY CANDIDATE QUESTIONNAIRE

1) Name: Tom Nebel

2) Law Office Address: Tom Nebel, P.C., 2525 West End Ave., Ste. 1490, Nashville, TN 37203

3) Tennessee License #: Atty. Reg. No. 5206

4) Do you have Professional Liability Insurance? Yes: X No:___

5) Do you have any conflict with the CHS (Community Health Systems), its Affiliate Hospitals and physicians? Yes:___ No: X

6) Has your license to practice Law in Tennessee or any other state ever been revoked or temporarily suspended? Yes:___ No: X (If you checked YES, please explain. Use additional space if necessary.)

7) What is the Dollar amount of the largest damage awarded to your client, through settlement or adjudication, in [illegible] death or Medical Malpractice case? $ 7,100,000.00 plus $2,000,000 in attorney's fees.
Dollar amount in words: Seven Million One Hundred Thousand plus Two Million Dollars in attorney's fees.

8) Have you tried cases in the Nashville Federal Court? Yes: X No:___

9) Have you argued cases in Federal Appellate Court? Yes: X No:___

10) Have you argued cases in the Supreme Court? Yes: X No:___

11) Are you eligible to argue cases in the US Supreme Court? Yes: X No:___

12) Have you represented clients on a pro hac vice in a different State? Yes: X No:___

13) Are you willing to represent clients on pro hac vice in a different State? Yes: X No:___

14) Do you intend always to provide legal service to Dr. [illegible] in good faith and without malice? Yes: X No:___

Exhibit 16 b

ATTORNEY/CLIENT CONTRACT (Two Pages)

Francis J. Savarirayan, M.D., hereinafter ("Client") employs J.W.Allen, J.D. (hereinafter "Attorney") to represent him (Client) in the prosecution, recovery, and settlement of claims and potential claims associated with this litigation.

Client agrees to pay Attorney for services rendered pursuant to this Contract of Employment a sum equal to thirty-three and one-third percent (33 1/3%) of any recovery of anything of value, whether the recover is in the form of money, stock, real or personal property or any other recovery.

This is a contingent fee contract and Client will owe attorneys NO FEES until the case is concluded. This contract grants Attorney and Client, liens upon any offer of settlement secured during the course of the attorney's representation of the client. The attorney will transfer Client's portion of the funds recovered by adjudication or settlement within three business days to the designated account of the Client.

Client will advance the costs incident to the case. Attorneys will attempt to keep costs to a minimum and will expend only those monies deemed necessary to properly prepare a client's case.

Typically, Costs consist of and may include some or all of the following: filing fees, medical records costs, expert deposition fees, court reporter charges and the like. All *litigation* expenses listed above are out of office third party expenses and will be documented by invoice and canceled checks.

Client expenses generated within the office such as telephone calls local and long distance charges, postage, fax transmissions, photocopies, computer maintenance and file set up fee, etc., will be considered as legal expenses, and the client will not be charged for these expenses. The Client will pay an advance of $250.00 payable to Attorney, at the time of acceptance of contract, towards court costs and out of office third party expenses, as listed above. At the time of acceptance of the contract, the initial complaint will be ready for client's review , approval and signature. The initial complaint shall also include criminal charges where ever applicable.

At all times the attorney will act in the best financial and professional *interests* of the *Client*, within the framework of the law.

Attorney at all times will act diligently, with good faith and without malice towards the Client.

Attorney warrants he has no conflict of interest with any of the defendants, including the Blue Cross Blue *Shield* of *Tennessee*.

Attorney will file motions including interlocutory appeals, if discovery is blocked by the courts through protective orders, etc., as per timeframes set in the Federal Rules of Civil Procedures.

Attorney also agrees to file an Appeal and provide representation in the appropriate court, if an adverse *judgment* or an award unacceptable to the *Client* is rendered, when requested by the Client.

Attorney will also provide representation to the Client, in the appropriate court, if the defendants appeal the verdict.

Attorney will vigorously prosecute the defendants under the general framework set forth in the initial pleading attached to this contract as exhibit#1.

18-3

Case Number|CC001798 |FRANCIS J. [illegible] | Disposition Date
Case Class |CIV |WHITE CO CHANCERY DIV | 4,18,2007

-[illegible]-

Ref #| Rec Date |Tr| Received From/Payable To |#| Amount | Ck # |Ck/Rf Date

13547| 1.26.2007|R|FRANCIS [illegible] | 220.00| 10150| 1,31,2007
P|[illegible] FEES |CA
13547| 1.26 2007|R|FRANCIS [illegible] | 44.00| 15020| 2,26,2007
P|[illegible] DC SURCHG |CA
13547| 1,26,2007|R|FRANCIS [illegible] | 44.00| 15020| 3,07,2007
P|[illegible] OF WILLIAMSON CNTY|CA

TOTAL RECEIPTS-> 417.50

John Wayne Allen

ATTORNEY AT LAW

Exhibit # 19

441 East Broad Street, Suite I
Cookeville, TN 38501

TEL: 931-260-3588
EMAIL: JWAlaw@charter.net

February 14, 2007

Judge John Maddux
Circuit Judge
Thirteenth Judicial District Court
228 E Broad St
Cookeville, TN 38501

Thursday, February 15, 2007 America Online: Savarirav

Re: FRANCIS J. SAVARIRAYAN, M.D. v. White County Community Hospital, Et al.
Circuit Court for White County, Tennessee
Case No. CC1790

Dear Judge Maddux:

I represent Dr. Savarirayan in the above-styled case. Dr. Savarirayan strenuously objects to Dr. Chad Griffin's efforts to transfer this case outside of your Court. He does, however, have no objection to Dr. Griffin or any of the other defendants entering into an attorney-client relationship with counsel of their choice. If you desire a hearing on the matter, please advise.

We therefore request that you keep this case in your Court. Thank you for your attention to this matter.

Sincerely,

John Wayne Allen

JWA:ll

cc: Dr. Francis Savarirayan
Daniel H. Rader, III, P.O. Box 3347, Cookeville, TN 38502

ATKINS FERGUSON ZIMMERMAN CARNEY

ATTORNEYS AT LAW
A PROFESSIONAL CORPORATION

[illegible]
[illegible] FERGUSON
ZIMMERMAN
M. CARNEY
J. FRANCISCO
[illegible]

[illegible]
P.O. Box [illegible]
Scottsbluff, NE [illegible]

[illegible]
FAX [illegible]

Exhibit #20
(3 pages)

September 22, 1993

'erry J. Curtiss, Esq.
'.O. Box 460
.lliance, Nebraska 69301-0460

arl Maltas, Administrator
ox Butte General Hospital
103 Box Butte
lliance, Nebraska 69301

RE: Dr. Jerry Troy

ear Mr. Curtiss and Mr. Maltas:

This letter is to advise you that I have been retained to epresent Dr. Troy as a result of his being denied full hospital rivileges which, based upon my investigation, is premised on rbitrary and capricious motives, and on totally inadequate and nsupported claims that have been made against him. All claims are remised on prejudice and a conspiracy which I believe exists etween the hospital, the ex-administrator for the hospital, and rs. Koch, Wallace and Elston.

The provisional privileges that were requested by Drs. Forney, hannon and Pierce are not acceptable, and I find it appalling they ould try to place those terms and conditions upon Dr. Troy. Talk bout the pot calling the kettle black! It is obvious the formation they reviewed had either been substantially sanitized their review was less than thorough and was likewise based upon proper motive.

This letter is to advise you that we demand Dr. Troy be anted the right of a hearing before an ad hoc committee. wever, I would suggest that hearing be scheduled to take place ar a two-day period. I intend to subpoena Drs. Forney, Shannon, erce, Wallace, Elston, and Koch, Bill Ferguson, Jean Ferguson, Rolfe, and Elizabeth Peterson. I am quite confident that by time I have finished examining these people and have gone over ir qualifications for medical staff privileges based upon what occurred in their practices over the years, as well as drug and ohol dependency as it would relate to several of these lividuals, and the obvious conspiracy directed to harm Dr. Troy

Exhibit # 22 (Total = 1 page)

I-A-1

federal register

Tuesday
October 17, 1989

Part VIII

Department of Health and Human Services

Public Health Service

45 CFR Part 60

National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners; Final Regulations

T9-(-2)

HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986[1]

(References in brackets [ ] are to title 42, United States Code)

SEC. 401. [11101 note] SHORT TITLE.

This title may be cited as the "Health Care Quality Improvement Act of 1986".

SEC. 402. [11101] FINDINGS.

The Congress finds the following:

(1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.

(2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.

(3) This nationwide problem can be remedied through effective professional peer review.

(4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.

(5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

PART A—PROMOTION OF PROFESSIONAL REVIEW ACTIVITIES

SEC. 411. [11111] PROFESSIONAL REVIEW.

(a) IN GENERAL.—

(1) LIMITATION ON DAMAGES FOR PROFESSIONAL REVIEW ACTIONS.—If a professional review action (as defined in section 431(9)) of a professional review body meets all the standards specified in section 412(a), except as provided in subsection (b)—

(A) the professional review body,

(B) any person acting as a member or staff to the body,

(C) any person under a contract or other formal agreement with the body, and

(D) any person who participates with or assists the body with respect to the action,

shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with re-

[1] Title IV of Public Law 99-660.

spect to the action. The preceding sentence shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964, 42 U.S.C. 2000a, et seq. and the Civil Rights Acts, 42 U.S.C. 1981, et seq. Nothing in this paragraph shall prevent the United States or any Attorney General of a State from bringing an action, including an action under section 4C of the Clayton Act, 15 U.S.C. 15C, where such an action is otherwise authorized.

(2) PROTECTION FOR THOSE PROVIDING INFORMATION TO PROFESSIONAL REVIEW BODIES.—Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any State (or political subdivision thereof) unless such information is false and the person providing it knew that such information was false.

(b) EXCEPTION.—If the Secretary has reason to believe that a health care entity has failed to report information in accordance with section 422(a), the Secretary shall conduct an investigation. If, after providing notice of noncompliance, an opportunity to correct the noncompliance, and an opportunity for a hearing, the Secretary determines that a health care entity has failed substantially to report information in accordance with section 422(a), the Secretary shall publish the name of the entity in the Federal Register. The protections of subsection (a)(1) shall not apply to an entity the name of which is published in the Federal Register under the previous sentence with respect to professional review actions of the entity commenced during the 3-year period beginning 30 days after the date of publication of the name.

(c) TREATMENT UNDER STATE LAWS.—

(1) PROFESSIONAL REVIEW ACTIONS TAKEN ON OR AFTER OCTOBER 14, 1989.—Except as provided in paragraph (2), subsection (a) shall apply to State laws in a State only for professional review actions commenced on or after October 14, 1989.

(2) EXCEPTIONS.—

(A) STATE EARLY OPT-IN.—Subsection (a) shall apply to State laws in a State for actions commenced before October 14, 1989, if the State by legislation elects such treatment.

(B) EFFECTIVE DATE OF ELECTION.—An election under State law is not effective, for purposes of,[1] for actions commenced before the effective date of the State law, which may not be earlier than the date of the enactment of that law.

[1] So in original. Probably should be "for purposes of subparagraph (A)". The provision formerly made a reference to "subparagraphs (A) and (B)". Section 6139(a)(9) of Public Law 101-239 struck out this reference, after having struck former subparagraph (B). (Former subparagraph (C) was redesignated as subparagraph (B).)

SEC. 412. [11112] STANDARDS FOR PROFESSIONAL REVIEW ACTIONS.

(a) IN GENERAL.—For purposes of the protection set forth in section 411(a), a professional review action must be taken—

(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 411(a) unless the presumption is rebutted by a preponderance of the evidence.

(b) ADEQUATE NOTICE AND HEARING.—A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) NOTICE OF PROPOSED ACTION.—The physician has been given notice stating—

(A)(i) that a professional review action has been proposed to be taken against the physician,

(ii) reasons for the proposed action,

(B)(i) that the physician has the right to request a hearing on the proposed action,

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) NOTICE OF HEARING.—If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating—

(A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) CONDUCT OF HEARING AND NOTICE.—If a hearing is requested on a timely basis under paragraph (1)(B)—

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)—

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right—

(i) to representation by an attorney or other person of the physician's choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right—

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.

A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3).

(c) ADEQUATE PROCEDURES IN INVESTIGATIONS OR HEALTH EMERGENCIES.—For purposes of section 411(a), nothing in this section shall be construed as—

(1) requiring the procedures referred to in subsection (a)(3)—

(A) where there is no adverse professional review action taken, or

(B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or

(2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

SEC. 413. [11113] PAYMENT OF REASONABLE ATTORNEYS' FEES AND COSTS IN DEFENSE OF SUIT.

In any suit brought against a defendant, to the extent that a defendant has met the standards set forth under section 412(a) and the defendant substantially prevails, the court shall, at the conclusion of the action, award to a substantially prevailing party defending against any such claim the cost of the suit attributable to such claim, including a reasonable attorney's fee, if the claim, or the claimant's conduct during the litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith. For the purposes of this section, a defendant shall not be considered to have substan-

tially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.

SEC. 414. [11134] GUIDELINES OF THE SECRETARY.

The Secretary may establish, after notice and opportunity for comment, such voluntary guidelines as may assist the professional review bodies in meeting the standards described in section 412(a).

SEC. 415. [11135] CONSTRUCTION.

(a) IN GENERAL.—Except as specifically provided in this part, nothing in this part shall be construed as changing the liabilities or immunities under law or as preempting or overriding any State law which provides incentives, immunities, or protection for those engaged in a professional review action that is in addition to or greater than that provided by this part.

(b) SCOPE OF CLINICAL PRIVILEGES.—Nothing in this part shall be construed as requiring health care entities to provide clinical privileges to any or all classes or types of physicians or other licensed health care practitioners.

(c) TREATMENT OF NURSES AND OTHER PRACTITIONERS.—Nothing in this part shall be construed as affecting, or modifying any provision of Federal or State law, with respect to activities of professional review bodies regarding nurses, other licensed health care practitioners, or other health professionals who are not physicians.

(d) TREATMENT OF PATIENT MALPRACTICE CLAIMS.—Nothing in this title shall be construed as affecting in any manner the rights and remedies afforded patients under any provision of Federal or State law to seek redress for any harm or injury suffered as a result of negligent treatment or care by any physician, health care practitioner, or health care entity, or as limiting any defenses or immunities available to any physician, health care practitioner, or health care entity.

SEC. 416. [11111 note] EFFECTIVE DATE.

This part shall apply to professional review actions commenced on or after the date of the enactment of this Act.

PART B—REPORTING OF INFORMATION

SEC. 421. [11131] REQUIRING REPORTS ON MEDICAL MALPRACTICE PAYMENTS.

(a) IN GENERAL.—Each entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report, in accordance with section 424, information respecting the payment and circumstances thereof.

(b) INFORMATION TO BE REPORTED.—The information to be reported under subsection (a) includes—

(1) the name of any physician or licensed health care practitioner for whom benefit the payment is made,

(2) the amount of the payment,

(3) the name (if known) of any hospital with which the physician or practitioner is affiliated or associated,

(4) a description of the acts or omissions and injuries or illnesses upon which the action or claim was based, and

(5) such other information as the Secretary determines is required for appropriate interpretation of information reported under this section.

(c) SANCTIONS FOR FAILURE TO REPORT.—Any entity that fails to report information on a payment required to be reported under this section shall be subject to a civil money penalty of not more than $10,000 for each such payment involved. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A of the Social Security Act are imposed and collected under that section.

(d) REPORT ON TREATMENT OF SMALL PAYMENTS.—The Secretary shall study and report to Congress, not later than two years after the date of the enactment of this Act, on whether information respecting small payments should continue to be required to be reported under subsection (a) and whether information respecting all claims made concerning a medical malpractice action should be required to be reported under such subsection.

SEC. 422. [11132] REPORTING OF SANCTIONS TAKEN BY BOARDS OF MEDICAL EXAMINERS.

(a) IN GENERAL.—

(1) ACTIONS SUBJECT TO REPORTING.—Each Board of Medical Examiners—

(A) which revokes or suspends (or otherwise restricts) a physician's license or censures, reprimands, or places on probation a physician, for reasons relating to the physician's professional competence or professional conduct, or

(B) to which a physician's license is surrendered,

shall report, in accordance with section 424, the information described in paragraph (2).

(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) is—

(A) the name of the physician involved,

(B) a description of the acts or omissions or other reasons (if known) for the revocation, suspension, or surrender of license, and

(C) such other information respecting the circumstances of the action or surrender as the Secretary deems appropriate.

(b) FAILURE TO REPORT.—If, after notice of noncompliance and providing opportunity to correct noncompliance, the Secretary determines that a Board of Medical Examiners has failed to report information in accordance with subsection (a), the Secretary shall designate another qualified entity for the reporting of information under section 423.

SEC. 423. [11133] REPORTING OF CERTAIN PROFESSIONAL REVIEW ACTIONS TAKEN BY HEALTH CARE ENTITIES.

(a) REPORTING BY HEALTH CARE ENTITIES.—

(1) ON PHYSICIANS.—Each health care entity which—

(A) takes a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days;

(B) accepts the surrender of clinical privileges of a physician—

(i) while the physician is under an investigation by the entity relating to possible incompetence or improper professional conduct, or

(ii) in return for not conducting such an investigation or proceeding; or

(C) in the case of such an entity which is a professional society, takes a professional review action which adversely affects the membership of a physician in the society,

shall report to the Board of Medical Examiners, in accordance with section 424(a), the information described in paragraph (3).

(2) PERMISSIVE REPORTING ON OTHER LICENSED HEALTH CARE PRACTITIONERS.—A health care entity may report to the Board of Medical Examiners, in accordance with section 424(a), the information described in paragraph (3) in the case of a licensed health care practitioner who is not a physician, if the entity would be required to report such information under paragraph (1) with respect to the practitioner if the practitioner were a physician.

(3) INFORMATION TO BE REPORTED.—The information to be reported under this subsection is—

(A) the name of the physician or practitioner involved,

(B) a description of the acts or omissions or other reasons for the action or, if known, for the surrender, and

(C) such other information respecting the circumstances of the action or surrender as the Secretary deems appropriate.

(b) REPORTING BY BOARD OF MEDICAL EXAMINERS.—Each Board of Medical Examiners shall report, in accordance with section 424, the information reported to it under subsection (a) and known instances of a health care entity's failure to report information under subsection (a)(1).

(c) SANCTIONS.—

(1) HEALTH CARE ENTITIES.—A health care entity that fails substantially to meet the requirement of subsection (a)(1) shall lose the protections of section 411(a)(1) if the Secretary publishes the name of the entity under section 411(b).

(2) BOARD OF MEDICAL EXAMINERS.—If, after notice of noncompliance and providing an opportunity to correct noncompliance, the Secretary determines that a Board of Medical Examiners has failed to report information in accordance with subsection (b), the Secretary shall designate another qualified entity for the reporting of information under subsection (b).

(d) REFERENCES TO BOARD OF MEDICAL EXAMINERS.—Any reference in this part to a Board of Medical Examiners includes, in the case of a Board in a State that fails to meet the reporting requirements of section 423(a) or subsection (b), a reference to such other qualified entity as the Secretary designates.

SEC. 424. [11134] FORM OF REPORTING.

(a) TIMING AND FORM.—The information required to be reported under sections 421, 422(a), and 423 shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be re-

quired to be reported on a date (not later than one year after the date of the enactment of this Act) specified by the Secretary.

(b) TO WHOM REPORTED.—The information required to be reported under sections 421, 422(a), and 423(b) shall be reported to the Secretary, or, in the Secretary's discretion, to an appropriate private or public agency which has made suitable arrangements with the Secretary with respect to receipt, storage, protection of confidentiality, and dissemination of the information under this part.

(c) REPORTING TO STATE LICENSING BOARDS.—

(1) MALPRACTICE PAYMENTS.—Information required to be reported under section 421 shall also be reported to the appropriate State licensing board (or boards) in the State in which the medical malpractice claim arose.

(2) REPORTING TO OTHER LICENSING BOARDS.—Information required to be reported under section 422(b) shall also be reported to the appropriate State licensing board in the State in which the health care entity is located if it is not otherwise reported to such board under subsection (b).

SEC. 424. [11136] DUTY OF HOSPITALS TO OBTAIN INFORMATION.

(a) IN GENERAL.—It is the duty of each hospital to request from the Secretary (or the agency designated under section 424(b)), on and after the date information is first required to be reported under section 424(a))—

(1) at the time a physician or licensed health care practitioner applies to be on the medical staff (courtesy or otherwise) of, or for clinical privileges at, the hospital, information reported under this part concerning the physician or practitioner, and

(2) once every 2 years information reported under this part concerning any physician or such practitioner who is on the medical staff (courtesy or otherwise) of, or has been granted clinical privileges at, the hospital.

A hospital may request such information at other times.

(b) FAILURE TO OBTAIN INFORMATION.—With respect to a medical malpractice action, a hospital which does not request information respecting a physician or practitioner as required under subsection (a) is presumed to have knowledge of any information reported under this part to the Secretary with respect to the physician or practitioner.

(c) RELIANCE ON INFORMATION PROVIDED.—Each hospital may rely upon information provided to the hospital under this title and shall not be held liable for such reliance in the absence of the hospital's knowledge that the information provided was false.

SEC. 425. [11137] DISCLOSURE AND CORRECTION OF INFORMATION.

With respect to the information reported to the Secretary (or the agency designated under section 424(b)) under this part respecting a physician or other licensed health care practitioner, the Secretary shall, by regulation, provide for—

(1) disclosure of the information, upon request, to the physician or practitioner, and

(2) procedures in the case of disputed accuracy of the information.

SEC. 427. [11137] MISCELLANEOUS PROVISIONS.

(a) PROVIDING LICENSING BOARDS AND OTHER HEALTH CARE ENTITIES WITH ACCESS TO INFORMATION.—The Secretary (or the agency designated under section 424(b)) shall, upon request, provide information reported under this part with respect to a physician or other licensed health care practitioner to State licensing boards, to hospitals, and to other health care entities (including health maintenance organizations) that have entered (or may be entering) into an employment or affiliation relationship with the physician or practitioner or in which the physician or practitioner has applied for clinical privileges or appointment to the medical staff.

(b) CONFIDENTIALITY OF INFORMATION.—

(1) IN GENERAL.—Information reported under this part is considered confidential and shall not be disclosed (other than to the physician or practitioner involved) except with respect to professional review activity, as necessary to carry out subsections (b) and (c) of section 425 (as specified in regulations by the Secretary), or in accordance with regulations of the Secretary promulgated pursuant to subsection (a). Nothing in this subsection shall prevent the disclosure of such information by a party which is otherwise authorized, under applicable State law, to make such disclosure. Information reported under this part that is in a form that does not permit the identification of any particular health care entity, physician, other health care practitioner, or patient shall not be considered confidential. The Secretary (or the agency designated under section 424(b)), on application by any person, shall prepare such information in such form and shall disclose such information in such form.

(2) PENALTY FOR VIOLATION.—Any person who violates paragraph (1) shall be subject to a civil money penalty of not more than $10,000 for each such violation involved. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A of the Social Security Act are imposed and collected under that section.

(3) USE OF INFORMATION.—Subject to paragraph (1), information provided under section 425 and subsection (a) is intended to be used solely with respect to activities in the furtherance of the quality of health care.

(4) FEES.—The Secretary may establish or approve reasonable fees for the disclosure of information under this section or section 425. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary (or, in the Secretary's discretion, to the agency designated under section 424(b)) to cover such costs.

(c) RELIEF FROM LIABILITY FOR REPORTERS.—No person or entity (including the agency designated under section 424(b)) shall be held liable in any civil action with respect to any report made under this part (including information provided under subsection

(a)[1] without knowledge of the falsity of the information contained in the report.

(d) INTERPRETATION OF INFORMATION.—In interpreting information reported under this part, a payment in settlement of a medical malpractice action or claim shall not be construed as creating a presumption that medical malpractice has occurred.

PART C—DEFINITIONS AND REPORTS

SEC. 431. [11131] DEFINITIONS.

In this title:

(1) The term "adversely affecting" includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity.

(2) The term "Board of Medical Examiners" includes a body comparable to such a Board (as determined by the State) with responsibility for the licensing of physicians and also includes a subdivision of such a Board or body.

(3) The term "clinical privileges" includes privileges, membership on the medical staff, and the other circumstances pertaining to the furnishing of medical care under which a physician or other licensed health care practitioner is permitted to furnish such care by a health care entity.

(4)(A) The term "health care entity" means—

(i) a hospital that is licensed to provide health care services by the State in which it is located,

(ii) an entity (including a health maintenance organization or group medical practice) that provides health care services and that follows a formal peer review process for the purpose of furthering quality health care (as determined under regulations of the Secretary), and

(iii) subject to subparagraph (B), a professional society (or committee thereof) of physicians or other licensed health care practitioners that follows a formal peer review process for the purpose of furthering quality health care (as determined under regulations of the Secretary).

(B) The term "health care entity" does not include a professional society (or committee thereof) if, within the previous 5 years, the society has been found by the Federal Trade Commission or any court to have engaged in any anti-competitive practice which had the effect of restricting the practice of licensed health care practitioners.

(5) The term "hospital" means an entity described in paragraphs (1) and (7) of section 1861(e) of the Social Security Act.

(6) The terms "licensed health care practitioner" and "practitioner" mean, with respect to a State, an individual (other than a physician) who is licensed or otherwise authorized by the State to provide health care services.

(7) The term "medical malpractice action or claim" means a written claim or demand for payment based on a health care provider's furnishing (or failure to furnish) health care services, and includes the filing of a cause of action, based on the

[1] So in original. A closing parenthesis probably should follow "subsection (a)".

law of tort, brought in any court of any State or the United States seeking monetary damages.

(8) The term "physician" means a doctor of medicine or osteopathy or a doctor of dental surgery or medical dentistry legally authorized to practice medicine and surgery or dentistry by a State (or any individual who, without authority holds himself or herself out to be so authorized).

(9) The term "professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action. In this title, an action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on—

(A) the physician's association, or lack of association, with a professional society or association,

(B) the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business,

(C) the physician's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis,

(D) a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional, or

(E) any other matter that does not relate to the competence or professional conduct of a physician.

(10) The term "professional review activity" means an activity of a health care entity with respect to an individual physician—

(A) to determine whether the physician may have clinical privileges with respect to, or membership in, the entity,

(B) to determine the scope or conditions of such privileges or membership, or

(C) to change or modify such privileges or membership.

(11) The term "professional review body" means a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity.

(12) The term "Secretary" means the Secretary of Health and Human Services.

(13) The term "State" means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(14) The term "State licensing board" means, with respect to a physician or health care provider in a State, the agency of the State which is primarily responsible for the licensing of the physician or provider to furnish health care services.

SEC. 432. [11136] REPORTS AND MEMORANDA OF UNDERSTANDING.

(a) ANNUAL REPORTS TO CONGRESS.—The Secretary shall report to Congress, annually during the three years after the date of the enactment of this Act, on the implementation of this title.

(b) MEMORANDA OF UNDERSTANDING.—The Secretary of Health and Human Services shall seek to enter into memoranda of understanding with the Secretary of Defense and the Administrator of Veterans' Affairs to apply the provisions of part B of this title to hospitals and other facilities and health care providers under the jurisdiction of the Secretary or Administrator, respectively. The Secretary shall report to Congress, not later than two years after the date of the enactment of this Act, on any such memoranda and on the cooperation among such officials in establishing such memoranda.

(c) MEMORANDUM OF UNDERSTANDING WITH DRUG ENFORCEMENT ADMINISTRATION.—The Secretary of Health and Human Services shall seek to enter into a memorandum of understanding with the Administrator of Drug Enforcement relating to providing for the reporting by the Administrator to the Secretary of information respecting physicians and other practitioners whose registration to dispense controlled substances has been suspended or revoked under section 304 of the Controlled Substances Act. The Secretary shall report to Congress, not later than two years after the date of the enactment of this Act, on any such memorandum and on the cooperation between the Secretary and the Administrator in establishing such a memorandum.

Exhibit # 22e

ABOUT THE DATA BANKS
- NPDB
- HIPDB

GENERAL INFORMATION
- Registering
- Billing and Fees
- Disputing Reports
- Querying & Reporting

USING THE IQRS
- IQRS Features
- What's New

PUBLICATIONS
- Fact Sheets
- Guidebooks
- Interface Control Docs (ICDs)
- Newsletters

LEGISLATION AND POLICIES
- Federal Register Notices
- Legislation & Regulations

STATISTICAL INFORMATION
- Annual Reports
- Public Data Files
- Data By Profession & State

TITLE IV OF PUBLIC LAW 99-660

The *Health* Care *Quality Improvement* Act of 1986, as *amended* 42 USC Sec. 11101 01/26/98

TITLE 42 - THE PUBLIC HEALTH AND WELFARE CHAPTER 117 - ENCOURAGING GOOD FAITH PROFESSIONAL REVIEW ACTIVITIES

Sec. 11101. *Findings*

The Congress finds the following:

(1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.

(2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.

(3) This nationwide problem can be remedied through effective professional peer review.

(4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.

(5) There is an *overriding national* need to *provide incentive* and *protection* for physicians engaging in effective professional peer review.

(Pub. L. 99-660, title IV, Sec. 402, Nov. 14, 1986, 100 Stat. 3784.)

REFERENCES IN TEXT

The Federal antitrust laws, referred to in par. (4), are classified generally to chapter 1 (Sec. 1 et seq.) of Title 15, Commerce and Trade.

SHORT TITLE

Section 401 of title IV of Pub. L. 99-660 *provided* that: "This title (*enacting* this chapter and *provisions* set out as a *note* under section 11111 of this title) may be cited as the 'Health Care Quality Improvement Act of 1986'."

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42 USC SUBCHAPTER I - PROMOTION OF PROFESSIONAL REVIEW ACTIVITIES 01/26/98

TITLE 42 - THE PUBLIC HEALTH AND WELFARE CHAPTER 117 - ENCOURAGING GOOD FAITH PROFESSIONAL REVIEW ACTIVITIES

those at the national, State, or local level, of physicians, dentists, or other health care practitioners that engages in professional review activity through a formal peer review process, for the purpose of furthering quality health care. For purposes of paragraph (b) of this definition, an entity includes: a health maintenance organization which is licensed by a State or determined to be qualified as such by the Department of Health and Human Services; and any group or prepaid medical or dental practice which meets the criteria of paragraph (b).

Health care practitioner means an individual other than a physician or dentist, who is licensed or otherwise authorized by a State to provide health care services.

Hospital means an entity described in paragraphs (1) and (7) of section 1861(e) of the Social Security Act.

Medical malpractice action or claim means a written complaint or claim demanding payment based on a physician's, dentist's or other health care practitioner's provision of or failure to provide health care services, and includes the filing of a cause of action based on the law of tort, brought in any State or Federal Court or other adjudicative body.

Physician means a doctor of medicine or osteopathy legally authorized to practice medicine or surgery by a State (or who, without authority, holds himself or herself out to be so authorized).

Professional review action means an action or recommendation of a health care entity:

(a) Taken in the course of professional review activity;

(b) Based on the professional competence or professional conduct of an individual physician, dentist or other health care practitioner which affects or could affect adversely the health or welfare of a patient or patients; and

(c) Which adversely affects or may adversely affect the clinical privileges or membership in a professional society of the physician, dentist or other health care practitioner.

(d) This term *excludes actions* which ...re primarily based on:

(1) The physician's, dentist's or other ...lth care practitioner's association, or ...of association, with a professional ... or association;

...e physician's, dentist's or other ...ve practitioner's fees or the ..., dentist's or other health ...ner's advertising or ...her competitive acts ...licit or retain business;

...ian's, dentist's or other ...tioner's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis;

(4) A physician's, dentist's or other health care practitioner's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional; or

(5) Any other matter that does not relate to the competence or professional conduct of a physician, dentist or other health care practitioner.

Professional review activity means an activity of a health care entity with respect to an individual physician, dentist or other health care practitioner:

(a) To determine whether the physician, dentist or other health care practitioner may have clinical privileges with respect to, or membership in, the entity;

(b) To determine the scope or conditions of such privileges or membership; or

(c) To change or modify such privileges or membership.

Secretary means the Secretary of Health and Human Services and any other officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.

State means the fifty States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Subpart B—Reporting of Information

§ 60.4 How information must be reported.

Information must be reported to the Data Bank or to a Board of Medical Examiners as required under §§ 60.7, 60.8, and 60.9 in such form and manner as the Secretary may prescribe.

§ 60.5 When information must be reported.

Information required under §§ 60.7, 60.8, and 60.9 must be submitted to the Data Bank within 30 days following the action to be reported, beginning with actions occurring on or after the effective date of these regulations or the date of the establishment of the Data Bank, whichever is later, as follows:

(a) *Malpractice Payments (§ 60.7).* Persons or entities must submit information to the Data Bank within 30 days from the date that a payment, as described in § 60.7, is made. If required under § 60.7, this information must be submitted simultaneously to the appropriate State licensing board.

(b) *Licensure Actions (§ 60.8).* The Board must submit information within 30 days from the date the licensure action was taken.

(c) *Adverse Actions (§ 60.9).* A health care entity must report an adverse action to the Board within 15 days from the date the adverse action was taken. The Board must submit the information received from a health care entity within 15 days from the date on which it received this information. If required under § 60.9, this information must be submitted by the Board simultaneously to the appropriate State licensing board in the State in which the health care entity is located, if the Board is not such licensing Board.

§ 60.6 Reporting errors, omissions, and revisions.

(a) Persons and entities are responsible for the accuracy of information which they report to the Data Bank. If errors or omissions are found after information has been reported, the person or entity which reported it must send an addition or correction to the Data Bank or, in the case of reports made under § 60.9, to the Board of Medical Examiners, as soon as possible.

(b) An individual or entity which reports information on licensure or clinical privileges under §§ 60.8 or 60.9 must also report any revision of the action originally reported. Revisions include reversal of a professional review action or reinstatement of a license. Revisions are subject to the same time constraints and procedures of §§ 60.5, 60.8, and 60.9, as applicable to the original action which was reported.

(Section 60.6(a) approved by the Office of Management and Budget under control number 0915-0126)

§ 60.7 Reporting medical malpractice payments.

(a) *Who must report.* Each person or entity, including an insurance company, which makes a payment under an insurance policy, self-insurance, or otherwise, for the benefit of a physician, dentist or other health care practitioner in settlement of or in satisfaction in whole or in part of a claim or a judgment against such physician, dentist, or other health care practitioner for medical malpractice, must report information as set forth in paragraph (b) to the Data Bank and to the appropriate State licensing board(s) in the State in which the act or omission upon which the medical malpractice claim was based. For purposes of this section, the waiver of an outstanding debt is not construed

adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

The Department has determined that these regulations do not meet the criteria for a major rule as defined by section 1(b) of Executive Order 12291. This final regulation establishes procedures for the reporting and releasing of information from the Data Bank. As such, the regulations would have little direct effect on the economy or on Federal or State expenditures. Consequently, the Department has concluded that an initial regulatory impact analysis is not required.

Paperwork Reduction Act of 1980

Section 60.4 of this regulation requires that information to be reported under §§ 60.7, 60.8 and 60.9 shall be provided in the form and manner prescribed by the Secretary. Section 60.11(b) provides that requests for information from the Data Bank, including those required under § 60.10, shall be made in the form and manner prescribed by the Secretary. The actual forms to be used for reporting information to or requesting information from the Data Bank will be submitted to the Office of Management and Budget for review and public comment in accordance with the Paperwork Reduction Act of 1980 as soon as they are available.

Sections 60.8(a), 60.7, 60.8, 60.9, 60.10, and 60.14 contain information collection requirements which have been approved by the Office of Management and Budget (OMB) under section 3504(h) of the Paperwork Reduction Act of 1980 and assigned control number 0915-0126.

Section 60.8(b) contains information collection requirements which are subject to OMB review. We have submitted an information request to OMB for approval under section 3504(h) of the Paperwork Reduction Act of 1980. These requirements will not be effective until the Department obtains OMB approval, at which time a notice will be published in the Federal Register to notify the public of such action.

List of Subjects in 45 CFR Part 60

Health professions, Malpractice, Insurance companies.

Accordingly, the Department of Health and Human Services adds a new part 60 to title 45 of the Code of Federal Regulations, as set forth below:

Dated: September 7, 1989.

James O. Mason,

Assistant Secretary for Health.

Approved October 11, 1989.

Louis W. Sullivan,

Secretary.

PART 60—NATIONAL PRACTITIONER DATA BANK FOR ADVERSE INFORMATION ON PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS

Subpart A—General Provisions

Authority: Secs. 421–422 of the Health Care Quality Improvement Act of 1986, Pub. L. 99-660, 100 Stat. 3784–3794, as amended by section 402 of Pub. L. 100-177, 101 Stat. 1007–1008 (42 U.S.C. 11101–11152).

Subpart A—General Provisions

§ 60.1 The National Practitioner Data Bank.

The Health Care Quality Improvement Act of 1986 (the Act), title IV of Pub. L. 99-660, as amended, authorizes the Secretary to establish (either directly or by contract) a National Practitioner Data Bank to collect and release certain information relating to the professional competence and conduct of physicians, dentists and other health care practitioners. These regulations set forth the reporting and disclosure requirements for the National Practitioner Data Bank.

§ 60.2 Applicability of these regulations.

These regulations establish reporting requirements for entities that make payments in settlement of, or in satisfaction of a judgment in, medical malpractice actions or claims; for hospitals that take adverse clinical privileges actions; for boards of medical examiners that take adverse licensure actions; for health care entities that take adverse clinical privileges actions; for boards of medical examiners; professional societies of physicians, dentists or other health care practitioners which take adverse licensure or professional review actions; and individuals and entities (including insurance companies) making payments as a result of medical malpractice actions or claims. They also establish procedures to enable individuals or entities to obtain information from the National Practitioner Data Bank or to dispute the accuracy of National Practitioner Data Bank information.

§ 60.3 Definitions.

Act means the Health Care Quality Improvement Act of 1986, title IV of Pub. L. 99-660, as amended.

Adversely affecting means reducing, restricting, suspending, revoking, or denying clinical privileges or membership in a health care entity.

Board of Medical Examiners, or "Board," means a body or subdivision of such body which is designated by a State for the purpose of licensing, monitoring and disciplining physicians or dentists. This term includes a Board of Osteopathic Examiners or its subdivision, a Board of Dentistry or its subdivision, or an equivalent body as determined by the State. Where the Secretary, pursuant to section 423(c)(2) of the Act, has designated an alternate entity to carry out the reporting activities of § 60.9 due to a Board's failure to comply with § 60.8, the term "Board of Medical Examiners" or "Board" refers to this alternate entity.

Clinical privileges means the authorization by a health care entity to a physician, dentist or other health care practitioner for the provision of health care services, including privileges and membership on the medical staff.

Dentist means a doctor of dental surgery, doctor of dental medicine, or the equivalent who is legally authorized to practice dentistry by a State (or who, without authority, holds himself or herself out to be so authorized).

Formal peer review process means the conduct of professional review activities through formally adopted written procedures which provide for adequate notice and an opportunity for a hearing.

Health care entity means:

(a) A hospital;

(b) An entity that provides health care services, and engages in professional review activity through a formal peer review process for the purpose of furthering quality health care, or a committee of that entity; or

(c) A professional society or a

determined based on the following criteria:

(1) *Use of electronic data processing equipment to obtain information*—the actual cost for the service, including computer search time, runs, printouts, and time of computer programmers and operators, or other employees.

(2) Photocopying or other forms of reproduction, such as magnetic tapes—actual cost of the operator's time, plus the cost of the machine time and the materials used.

(3) Postage—actual cost, and

(4) Sending information by special methods requested by the applicant, such as express mail or electronic transfer—the actual cost of the special service.

(c) *Assessing and collecting fees.* (1) A request for information from the Data Bank will be regarded as also an agreement to pay the associated fee.

(2) Normally, a bill will be sent along with or following the delivery of the requested information. However, in order to avoid sending numerous small bills to frequent requesters, the charges may be aggregated for certain periods. For example, such a requester may receive a bill *monthly* or *quarterly*.

(3) In the event that a requester has failed to pay previous bills, the requester will be required to pay the fee before a request for information is processed.

(4) Fees must be paid by check or money order made payable to "U.S. Department of Health and Human Services" or to the unit stated in the billing and must be sent to the billing unit. Payment must be received within 30 days of the billing date or the applicant will be charged interest and a late fee on the amount overdue.

§ 60.13 Confidentiality of National Practitioner Data Bank information.

(a) *Limitations on disclosure.* Information reported to the Data Bank is considered confidential and shall not be disclosed outside the Department of Health and Human Services, except as specified in § 60.10, § 60.11 and § 60.14. Persons and entities which receive information from the Data Bank either directly or from another party must use it solely with respect to the purpose for which it was provided. Nothing in this paragraph shall prevent the disclosure of information by a party which is authorized under applicable State law to make such disclosure.

(b) *Penalty for violations.* Any person who violates paragraph (a) shall be subject to a civil money penalty of up to $10,000 for each violation. This penalty will be imposed pursuant to procedures at 42 CFR part 1003.

§ 60.14 How to dispute the accuracy of National Practitioner Data Bank information.

(a) *Who may dispute National Practitioner Data Bank information.* Any physician, dentist or other health care practitioner may dispute the accuracy of information in the Data Bank concerning himself or herself. The Secretary will routinely mail a copy of any report filed in the Data Bank to the subject individual.

(b) *Procedures for filing a dispute.* A physician, dentist or other health care practitioner has 60 days from the date on which the Secretary mails the report in question to him or her in which to dispute the accuracy of the report. The procedures for disputing a report are:

(1) *Informing* the Secretary and the reporting entity, in writing, of the disagreement, and the basis for it.

(2) Requesting *simultaneously* that the disputed information be entered into a "disputed" status and be reported to inquirers as being in a "disputed" status, and

(3) *Attempting* to enter into *discussion* with the reporting entity to resolve the dispute.

(c) *Procedures for revising disputed information.* (1) If the reporting entity revises the information originally submitted to the Data Bank, the Secretary will notify all entities to whom reports have been sent that the original information has been revised.

(2) If the reporting entity does not revise the reported information, the Secretary will, upon request, review the written information submitted by both parties (the physician, dentist or other health care practitioner), and the reporting entity. After review, the Secretary will either—

(i) If the Secretary concludes that the information is accurate, include a brief statement by the physician, dentist or other health care practitioner *describing* the disagreement concerning the information, and an explanation of the basis for the decision that it is accurate, or

(ii) If the Secretary concludes that the information was incorrect, send corrected information to previous *inquirers*.

(Approved by the Office of Management and Budget under control number 0915-0126)

[FR Doc. 89-24425 Filed 10-16-89; 8:45 am]

BILLING CODE 4160-15-M

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

DCN: 01199506502080000
Process Date: 03/10/1995

PT

E. REPORT STATUS

Unless one or more boxes below are checked, the subject of this report identified in Section B has not contested this report.

☐ If box is checked, this report has been disputed by the subject identified in Section B.

☐ If box is checked, at the request of the subject identified in Section B, this report is being reviewed by the Secretary of the U.S. Department of Health and Human Services to determine its accuracy and/or whether it complies with reporting requirements. No decision has been reached.

☒ If box is checked, at the request of the subject identified in Section B, this report was reviewed by the Secretary of the U.S. Department of Health and Human Services. The Secretary's decision is shown below:

Date Submitted: 04/29/1997

THIS REQUEST FOR DISPUTE RESOLUTION HAS BEEN DETERMINED TO BE OUTSIDE THE DEPARTMENT'S SCOPE OF REVIEW SINCE IT DISPUTES THE MERITS OF THE ACTION REPORTED, NOT THE ACCURACY OF THE REPORT ITSELF. UNDER THE DISPUTE RESOLUTION PROCESS ONLY THE ACCURACY OF THE INFORMATION IN THE REPORT MAY BE CHALLENGED (45 CFR 60.14).

Date of Initial Report: 03/10/1995

Date of Most Recent Change: 03/10/1995

END OF REPORT

CONFIDENTIAL

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

www.npdb-hipdb.com

Exhibit (2 pages)
Exhibit # 23

DCN# 5500000015683292
Process Date: 12/22/1999, 06:36

For authorized use by:
CQHCA

ENTITY REGISTRATION VERIFICATION

[redacted]

Data Bank ID (DBID): 399700000052560
Network Mailbox: 399700052560
Mailbox Password:
Entity Name: CQHCA
Address: 2269 EAST BLVD.
SUITE 106
MONTGOMERY, AL 36117-
Telephone: (334) 277-5040
Entity Status: ACTIVE (10)
Entity Type (Code): PROFESSIONAL SOCIETY - ALLOPATHIC (40)

Taxpayer ID #: 363035154
ORI #:

Governmental Designation: PRIVATE

[redacted]

An entity's authority/responsibility to report to and/or query the Data Bank(s) is based on the entity's primary function or service, as defined by the relevant statute.

Primary Function/Service under Title IV: OTHER HEALTH CARE ENTITY

Querying: Yes
Reporting: Yes

Primary Function/Service under Section 1921: OTHER HEALTH CARE ENTITY, INCLUDING PROFESSIONAL SOCIETY

Querying: Yes
Reporting: No

Primary Function/Service under Section 1128E: NONE OF THESE

Querying: No
Reporting: No

Note: Entities that certified eligibility under Section 1921 of the Social Security Act will not be able to report or query under this authority until final regulations have been established. If applicable, your Section 1921 certification election will be stored until that time. Reporting under Section 1128E of the Social Security Act is required; querying under Section 1128E will be available by Spring 2000.

[redacted]

Query preference is applicable only if the entity is eligible under law to query both Data Banks. Note: Hospitals must query the NPDB under Title IV. Therefore, a hospital that is registered to query both Data Banks cannot opt to query the HIPDB only.

NPDB/Title IV Query Preference: Yes
NPDB/Section 1921 Query Preference: Yes
HIPDB/Section 1128E Query Preference: No

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**
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National Practitioner Data Bank
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Exhibit 11(4)-(2)

DCN# 5500000015683292
Process Date: 12/22/1999, 06:36
Page: 2 of 2

For authorized use by:
CQHCA

[redacted]

Authorized Agent(s):
Address:

Agent Phone:
Agent Start Date:
Response Routing:

[redacted]

Bank Routing Code:
Bank Account No:
Start Date:

[redacted]

I certify that the entity identified above qualifies under law as specified in Section B and is eligible to perform the querying and/or reporting functions. I understand that the entity may be subject to sanctions under Federal statute for failure to report final adverse actions as required in the statutes and regulations or for the use of information obtained from the NPDB or the *HIPDB for purposes* other than that for which it was provided. I *further* certify that I am authorized to submit this registration information to the NPDB/HIPDB and that the information provided is true, correct, and complete. If I become aware that any information in this form is not true, correct, or complete, I agree to notify the NPDB/HIPDB of this fact immediately.

Name of Certifying Official: FRANCIS SAVARIRAYAN, M.D., FICS.
Title of Certifying Official: CHAIRMAN AND CEO
Date of Signature: 12/14/1999

If there are any errors or omissions, or if you need to change this information, clearly mark your corrections on the document, then sign, date, and return this report to the NPDB–HIPDB address at the top of this page. If the information is correct, please retain for your files.

Printed Name of Certifying Official _____ Printed Title _____

Signature _____

( ) _____ Date Signed _____
Telephone Number

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**
**

Exhibit #III (2 pages)
#124

itioner Data Bank
, ntegrity and Protection Data Bank
x 10832
ntly, VA 20153-0832

://www.npdb-hipdb.com

ENTITY UPDATE CONFIRMATION

nk you for *submitting* this *entity registration update*. *These changes* have been saved to NPDB-HIPDB and are in effect immediately. Please print and keep it for your records.

TITY IDENTIFICATION INFORMATION

a Bank *Identification Number (DBID):*	399700000052560
ne of Entity:	CQHCA
partment or Office:	FRANCIS SAVARIRAYAN M.D., FICS
eet Address:	169 RADIO LANE
y, State, ZIP:	SPARTA, TN 38583
nail Address:	savariray@aol.com
partment Fax Number:	
xpayer Identification Number (TIN):	920191870
nership of the Entity:	Private Sector Organization

IGIBILITY/STATUTORY AUTHORITY

DB - Title IV Function/Service:	Other Health Care Entity
uerying:	Optional
eporting:	Mandatory
DB - Section 1921 Function/Service:	Other Health Care Entity, including Professional Society
uerying:	*Optional*
eporting:	No Requirement
PDB - Section 1128E Function/Service:	None of These
uerying:	Prohibited
eporting:	Prohibited

IMARY FUNCTION OF ENTITY

mary Function of Entity (Code):	Professional Society - Allopathic (40)

IERY OPTIONS

III-(2)

Query Preferences:	NPDB Only

POINT OF CONTACT FOR REPORTS

Name or Office:	CQHCA
Title or Department:	REVIEW
Telephone:	(931) 739-1010

ENTITY ADMINISTRATOR

Name:	FRANCIS J. SAVARIRAYAN MD.,DABU.,FICS
Title:	CHAIRMAN & CEO
Telephone:	(931) 739-1010

CERTIFICATION

I certify that the entity identified above qualifies under law as specified in the ELIGIBILITY/STATUTORY AUTHORITY section and is eligible to perform the querying and/or reporting functions. I understand that the entity may be subject to sanctions under Federal *statute for failure to report final adverse actions as required in the statutes and regulations or* for the use of information obtained from the NPDB or the HIPDB other than the purposes for which it was provided. I further certify that I am authorized to submit this registration information to the NPDB-HIPDB and that the information provided is true, correct, and *complete. If I become aware that any information in this form is not true, correct, or complete, I* agree to notify the NPDB-HIPDB of this fact immediately. *I understand that any omission,* misrepresentation, or falsification of any information contained in this form or contained in any communication supplying information to the NPDB-HIPDB to complete or clarify this form may *be punishable by criminal, civil, or other administrative actions including fines, penalties, and/or* imprisonment under Federal law.

Name of Certifying Official:	FRANCIS J. SAVARIRAYAN MD.,DABU.,FICS
Title of Certifying Official:	CEO & CHAIRMAN
Telephone:	(931) 739-1010
Certification Date:	12/21/2005

END OF DOCUMENT

Exhibit # 25

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services Administration

Bureau of Health Professions

Rockville MD 20857

JAN 3 1 2007

Francis J. Savatirayan, M.D.
Chairman and CEO, CQHCA
169 Radio Lane
Sparta, TN 38583

Re: NPDB Registration: 339700000052560

Dear Dr. Savatirayan:

This is to inform you that the U.S. Department of Health and Human Services has suspensed the National Practitioner Data Bank (NPDB) registration of CQHCA [Commission for Quality Health Care in America] pending an examination of CQHCA's qualifications to query and report to the NPDB. In addition, we have voided all reports on practitioners filed by CQHCA

This action has been taken because several significant questions regarding CQHCA's NPDB eligibility have arisen. First, practitioners reported by CQHCA state that they were never members of CQHCA and never have had any connection with CQHCA. Second, CQHCA's by-laws provide a very questionable basis for authority to query and report to the NPDB. In particular, the NPDB is concerned about the by-laws assertion that "Any practicing physician within the USA and its territories, is automatically granted associate membership in the entity. There shall be no annual fee for this membership."

While its registration is suspended, CQHCA will be able to make no queries of the NPDB and submit no reports.

We request that CQHCA provide us any evidence it may have of the legitimacy of its registration with the NPDB in accordance with the requirements of 45 C.F.R. § 60.3(b). We also specifically request a written response as soon as possible to the questions posed in our letter to you dated January 19, 2006.

Sincerely,

Mark S. Pincus, M.H.S.
Chief
Practitioner Data Bank Branch
Office of Workforce Evaluation and Quality Assurance

Exhibit #26

Compliance: The DIET is Working for You

The Data Banks are working hard to assure that queriers receive accurate, timely and comprehensive information. For the past four years, the Practitioner Data Banks Branch (PDBB) has had a team of staff members who work on compliance issues. This team is known as the Data Integrity and Evaluation Team (DIET). The DIET's objectives are to monitor compliance with National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB) reporting requirements and intervene when patterns of non-compliance are observed.

The DIET has developed a work plan to assist them with their compliance activities including ongoing efforts to monitor an entity's eligibility to register with the Data Banks, review the frequency and timeliness of reporting as well as the accuracy and completeness of individual reports, and investigate alleged breaches of confidentiality or unauthorized queries. The objectives of the DIET plan are to identify all areas of non-compliance; prioritize the intervention efforts; evaluate the effectiveness of the interventions annually; use available resources efficiently; highlight any need for additional resources; and request assistance from the Office of Inspector General (OIG), when necessary. The OIG, not PDBB, has the authority to sanction entities or individuals determined to be in non-compliance with the Data Banks. The DIET plan enables PDBB to monitor and retune its efforts as needed while continuing to focus on current priorities.

One major focus of the DIET team concerns timely reporting. The DIET is making a concerted effort to encourage reporters to submit complete and accurate reports within 30 days of taking a final action or making a medical malpractice payment. Special attention is being given to the timeliness of State licensure adverse action reports.

Improving timely reporting is only one of numerous compliance activities managed by the PDBB. The following are the priorities established for 2006 – 2007: Review the registrations of entities registered as "other" to determine if new, more descriptive, categories are needed; continue the current intervention activities to improve reporting accuracy, completeness, and frequency with the Drug Enforcement Administration, the State Medicaid Fraud Control Units, medical malpractice reporters, and other reporters; and investigate and resolve all complaints of breach of confidentiality.

You can help the Data Banks fulfill its DIET objectives by reviewing your reporting processes to improve the accuracy, completeness and timeliness of submitting reports. As a querier, you also can assist by reporting potential non-compliance issues to the Customer Service Center at 1-800-767-6732 or e-mail at *npdb-hipdb@sra.com*.

Helpful Hints From

Is Your Computer System Protected From Viruses?

Any person connected to the Internet has the potential to have their workstation infected by viruses such as spyware, worms, adware, malware, etc. Spyware is technology that gathers information about a person or *organization without their knowledge*. A form of *spyware* that can compromise your computer data and all data you may enter into Web sites is known as keystroke loggers. Keystroke loggers are designed to log keystrokes that are typed on an infected machine and transmit a record of those keystrokes to another machine on the Internet. Thus, even if the infected user is accessing a secure Web site protected by strong data encryption with user names and passwords, the keystroke loggers will transmit all typed entries in the clear to a potential hacker or thief, compromising the integrity of any application being used on the infected machine.

There have been *incidents* where *keystroke* loggers have infected Internet users including health care entities. Keystroke loggers typically attempt to compromise information associated with credit card numbers as well as other information that could be used for identity theft. Don't let this happen to you. Don't let your business

Exhibit # 27 a

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
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http://www.npdb-hipdb.hrsa.gov

DCN: 5500000044695384 (3 pages)
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For authorized use by:
CQHCA

Page 1

ADVERSE ACTION REPORT

PROFESSIONAL SOCIETY ACTION

Report Number 5500000044695384

This report is maintained in: [X] **The National Practitioner Data Bank**

[ ] **The Healthcare Integrity and Protection Data Bank**

A. REPORTING ENTITY

Entity Name: CQHCA
Address: 169 RADIO LANE
City, State, ZIP: SPARTA, TN 38583
Entity Internal Report Reference (e.g., claim number): 002
Name or Office: CQHCA
Title or Department: REVIEW
Telephone: (931) 739-1010
Type of Report: INITIAL REPORT

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name: BARRETT, DANIEL
Other Name(s) Used:
Gender: MALE
Date of Birth: 06/28/1958
Organization Name:
Work Address: BLUE CROSS BLUE SHIELD OF TENNESSEE
801 PINE STREET
City, State, ZIP: CHATTANOOGA, TN 37402
Country:
Home Address:
City, State, ZIP:
Country:
Deceased: NO
Date of Death:
Social Security Numbers (SSN):
Professional School(s) & Year(s) of Graduation: EMORY UNIVERSITY 1984
Occupation/Field of Licensure (Code): PHYSICIAN (MD) (010)
State License Number, State of Licensure: 31559, TN
Other, as Specified:

Exhibit 27 a (P-2)

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http://www.npdb-hipdb.hrsa.gov

Drug Enforcement Administration (DEA) Numbers:

C. INFORMATION REPORTED

Type of Adverse Action: PROFESSIONAL SOCIETY

Adverse Action Classification Code(s): OTHER RESTRICTION/LIMITATION ON PROFESSIONAL SOCIETY MEMBERSHIP, SPECIFY (1745)
Other, as Specified: PERFORMANCE MONITORED
Date Action Was Taken: 01/10/2007
Date Action Became Effective: 01/15/2007
Length of Action: PERMANENT
Years:
Months:
Days:
Description of Act(s) or Omission(s) or Other *Reasons for Action Taken:* INVESTIGATION OF THE SUBJECT PHYSICIAN, AN EMPLOYEE AND CREDENTIALING CHAIRMAN OF BLUE CROSS BLUE SHIELD OF TN, BASED ON COMPLAINT FILED BY A BOARD CERTIFIED, BOSTON UNIVERSITY TRAINED PHYSICIAN, A VETERAN COMMANDING OFFICER OF THE USAF/R, REVEALED APARTHEID-CREDENTIALING, CRIMINAL FRAUD, MALPRACTICE AND ANTI-TRUST.

Basis for Action: OTHER - NOT CLASSIFIED, SPECIFY (99)
Other, as Specified: CRIMINAL FRAUD
Basis for Action: OTHER - NOT CLASSIFIED, SPECIFY (99)
Other, as Specified: 713 NEGLIGENT CREDENTIALING
Basis for Action: MALPRACTICE (12)
Other, as Specified:
Basis for Action: OTHER - NOT CLASSIFIED, SPECIFY (99)
Other, as Specified: ANTITRUST

D. SUBJECT STATEMENT

If the subject identified in Section B of this report has submitted a statement, it appears in this section.

Exh # 27-a

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
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Chantilly, VA 20153-0832

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DCN: 5500000044695384
Process Date: 01/15/2007
Page: 3 of 3
For authorized use by:
CQHCA

CP-3

E. REPORT STATUS

Unless one or more boxes below are checked, the subject of this report identified in Section B has not contested this report.

☐ If box is checked, this report has been disputed by the subject identified in Section B

☐ If box is checked, at the request of the subject identified in Section B, this report is being reviewed by the Secretary of the U.S. Department of Health and Human Services to determine its accuracy and/or whether it complies with reporting requirements. No decision has been reached.

☐ If box is checked, at the request of the subject identified in Section B, this report was reviewed by the Secretary of the U.S. Department of Health and Human Services. The Secretary's decision is shown below:

Date of Original Submission: 01/15/2007

Date of Most Recent Change: 01/15/2007

END OF REPORT

Exhibit #4. (4 pgs (# 2nd) #27(b)(2) (Page one)

Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

Process Date: 09/06/2006
Page: 1 of 1
COBURD, KAREN DENISE
For authorized use by:
CQHCA

NPDB QUERY RESPONSE

A. SEARCH RESULT

Based on the subject identification information provided by you in Section B below, a search of the NPDB has located the following 1 report(s).

Type of Report(s)	Report Number(s)
Medical Malpractice Payment Report(s):	5500000021022857

Recipients should verify that the subject identified in Section B is, in fact, the subject of interest.

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name:	COBURD, KAREN DENISE
Gender:	FEMALE
Date of Birth:	03/01/1962
Other Name(s) Used:	
Organization Name:	
Organization Type:	
Work Address:	TARBORO CLINIC 101 CLINIC DRIVE
City, State, ZIP:	TARBORO, NC 27886
Home Address:	
City, State, ZIP:	
Social Security Number (SSN):	
Individual Taxpayer Identification Number (ITIN):	
Professional School(s) & Year of Graduation:	EAST CAROLINA UNIVERSITY (1989)
Occupation/Field of Licensure (Code):	PHYSICIAN (MD) (010)
State License Number, State of Licensure:	35236, NC
Specialty:	GENERAL PRACTICE/FAMILY PRACTICE (33)
Drug Enforcement Administration (DEA) Numbers:	
National Provider Identifiers (NPI):	
Federal Employer Identification Numbers (FEIN):	
Unique Physician Identification Numbers (UPIN):	

C. ENTITY INFORMATION

Data Bank Identification Number(DBID):	399700000052560
Entity Name:	CQHCA
Authorized Agent:	
Authorized Submitter's Name:	FRANCIS J. SAVARIRAYAN MD.,DABU.,FICS
Authorized Submitter's Title:	CEO & CHAIRMAN
Authorized Submitter's Telephone:	(931) 739-1010

Edit # 27(b2)

Page 1 (2)

Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

Process Date: 03/30/2001

For authorized use by:
CDHCA

MEDICAL MALPRACTICE PAYMENT REPORT

Report Number 5980800021022857

This report is maintained in: [X] The National Practitioner Data Bank
[ ] The Healthcare Integrity and Protection Data Bank

A. REPORTING ENTITY

Entity Name: THE MEDICAL PROTECTIVE COMPANY
Address: 5814 REED RD., PO BOX 15021
City, State, ZIP: FT. WAYNE, IN 46885-5021
Entity Internal Report Reference (e.g., claim number):
Name or Office: KARINA DORNBERSTEIN
Title or Department: CLAIMS OPERATIONS LEADER
Telephone: (800)463-3776 EXT.6490
Type of Report: INITIAL REPORT

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name: COWARD, KAREN DENISE
Other Name(s) Used:
Gender: FEMALE
Organization Name: KAREN D. COWARD, MD
Work Address: 101 CLINIC DR.
City, State, ZIP: TARBORO, NC 27886-1935
Country:
Home Address:
City, State, ZIP:
Country:
Social Security Numbers (SSN):
Date of Birth: 03/01/1962
Deceased: NO
Professional School(s) & Year(s) of Graduation: EAST CAROLINA UNIV. 1989
Occupation/Field of Licensure (Code): PHYSICIAN (MD) (010)
State License Number, State of Licensure: 35236,NC
Other, as Specified:
Drug Enforcement Administration (DEA) Numbers:

Exhibit # 27(b2)

Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

Hospital Affiliation(s):

C. INFORMATION REPORTED

Date of Report: 03/30/2001
Act/Omission Code: TREATMENT: NOT OTHERWISE CLASSIFIED (690)
Date of Act/Omission: 10/15/1998
Act/Omission Code: ANESTHESIA: IMPROPER INTUBATION (170)
Date of Act/Omission: 10/15/1998
Payment Date: 03/01/2001
Multiple or Single Payment: SINGLE
Amount of This Payment: $800,000.00
Total Amount of Judgment or Settlement: $3,500,000.00
Payment Result of: SETTLEMENT
Number of Practitioners for Whom Payment is Made: 1
Relationship of Entity to the Practitioner: INSURANCE COMPANY
Date of Judgment/Settlement:
Adjudicative Case Number:
Adjudicative Body Name:
Court File Number:

Reporter's Description of the Act or Omission: 38 YEAR OLD MALE PATIENT WITH ANKLOSING SPONDYLIAS ADMITTED TO ICU WITH SEPSIS SECONDARY TO UTI. PATIENT DEVELOPED SOB AND PULMONARY CONSULT REQUESTED. AFTER SEVERAL ATTEMPTS, PATIENT WAS INTUBATED AND SUBSEQUENTLY DIAGNOSED A QUADRIPLEGIC. ALLEGED NEGLIGENT TREATMENT. #253552

Reporter's Description of the Judgment or Settlement: CASE SETTLED AS A RESULT OF MEDIATION. MEDICAL PROTECTIVE PAID $800,000; TOTAL PAID FOR ALL DEFENDANTS WAS $3,500,000. NO ADMISSION OF LIABILITY.

D. SUBJECT STATEMENT

If the subject identified in Section B of this report has submitted a statement, it appears in this section.

Exhibit # 27 (b1)
Page 3 (4)

Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

Process Date: 03/30/2001
Page: 3 of 3
For authorized use by:
CQBCA

E. REPORT STATUS

Unless one or more boxes below are checked, the subject of this report identified in Section B has not contested this report.

☐ If box is checked, this report has been disputed by the subject identified in Section B.

☐ If box is checked, at the request of the subject identified in Section B, this report is being reviewed by the Secretary of the U.S. Department of Health and Human Services to determine its accuracy and/or whether it complies with reporting requirements. No decision has been reached.

☐ If box is checked, at the request of the subject identified in Section B, this report was reviewed by the Secretary of the U.S. Department of Health and Human Services. The Secretary's decision is shown below:

Date of Initial Report: 03/30/2001

Date of Most Recent Change: 03/30/2001

END OF REPORT

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

DCN: 5500000043874882
Process Date: 10/30/2006
Page: 1 of 3
For authorized use by:
CQHCA

Exhibit 27-(b2
(Page 1)

ADVERSE ACTION REPORT

PROFESSIONAL SOCIETY ACTION

Report Number 5500000043874882

This report is maintained in: [X] **The National Practitioner Data Bank**

[ ] **The Healthcare Integrity and Protection Data Bank**

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Title IV of Public Law 99-660, as amended; and 45 CFR Part 60. All information is confidential and may be used only for the purpose for which it was disclosed. Disclosure or use of confidential information for other purposes is a violation of Federal law. For additional information or clarification, contact the reporting entity identified in Section A.

A. REPORTING ENTITY

Entity Name: CQHCA
Address: 169 RADIO LANE

City, State, ZIP: SPARTA, TN 38583

Entity Internal Report Reference (e.g., claim number): 001

Name or Office: CQHCA
Title or Department: REVIEW
Telephone: (931) 739-1010

Type of Report: INITIAL REPORT

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name: CONARD, KAREN DENISE

Other Name(s) Used:

Gender: FEMALE

Date of Birth: 03/01/1962

Organization Name:

Work Address: TARBORO CLINIC
101 CLINIC DRIVE

City, State, ZIP: TARBORO, NC 27886

Country:

Home Address:

City, State, ZIP:

Country:

Deceased: NO
Date of Death:

Social Security Number (SSN):

Professional School(s) & Year(s) of Graduation: EAST CAROLINA UNIVERSITY 1989

Occupation/Field of Licensure (Code): PHYSICIAN (MD) (010)

State License Number, State of Licensure: 35236, NC

Other, as Specified:

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Exhibit # 27 (b)(2) (Page 2)

Drug Enforcement Administration (DEA) Numbers:

C. INFORMATION REPORTED

Type of Adverse Action: PROFESSIONAL SOCIETY

Adverse Action Classification Code(s): OTHER RESTRICTION/LIMITATION ON PROFESSIONAL SOCIETY MEMBERSHIP, SPECIFY (1745)
Other, as Specified: PERFORMANCE MONITORED
Date Action Was Taken: 10/27/2006
Date Action Became Effective: 10/27/2006
Length of Action: PERMANENT
Years:
Months:
Days:
Description of Act(s) or Omission(s) or Other Reasons for Action Taken: INVESTIGATION OF THE SUBJECT PHYSICIAN, BASED ON COMPLAINT FILED BY A PHYSICIAN, REVEALED NEGLIGENT PROCESSING OF PHYSICIAN'S CREDENTIALS, FRAUD, INCOMPETENCE AND MALPRACTICE.

Basis for Action: FRAUD - UNSPECIFIED (05)
Other, as Specified:
Basis for Action: OTHER - NOT CLASSIFIED, SPECIFY (99)
Other, as Specified: 713 NEGLIGENT CREDENTIALING
Basis for Action: INCOMPETENCE (11)
Other, as Specified:
Basis for Action: MALPRACTICE (12)
Other, as Specified:

D. SUBJECT STATEMENT

If the subject identified in Section B of this report has submitted a statement, it appears in this section.

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

DCN: 5500000043874882
Process Date: 10/30/2006

For authorized use by:
COECA

Exh. #27 (b-2) (pg. 3)

E. REPORT STATUS

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Date of Original Submission: 10/30/2006

Date of Most Recent Change: 10/30/2006

END OF REPORT

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

DCN: 5500000031138266
Process Date: 10/01/2003
Page: 1 of 3
For authorized use by:
CQHCA

27-C
(Total = 3 pages) (Page) 1

MEDICAL MALPRACTICE PAYMENT REPORT

Report Number 5500000031138266

This report is *maintained* in: [X] **The National Practitioner Data Bank**

[ ] **The Healthcare Integrity and Protection Data Bank**

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Title IV of Public Law 99-660, as amended, and 45 CFR Part 60. All information is confidential and may be used only for the purpose for which it was disclosed. For additional information or clarification, contact the reporting entity identified in Section A.

A. REPORTING ENTITY

Entity Name: MAG MUTUAL INSURANCE COMPANY
Address: 3525 PIEDMONT ROAD, BLDG 8, SUITE 600
City, State, ZIP: ATLANTA, GA 30305
Entity Internal Report Reference (e.g., claim number):
Name or Office: E. DALE NELLUMS
Title or Department: CLAIMS DIRECTOR
Telephone: (404)842-5600 EXT.5662
Type of Report: INITIAL REPORT

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name: PATE, DONALD WAYNE
Other Name(s) Used:
Gender: MALE
Organization Name: CUMBERLAND PLATEAU SURGICAL ASSOCIATES
Work Address: 431 SEWELL DRIVE
P O BOX 57
City, State, ZIP: SPARTA, TN 38583-1223
Country:
Home Address:
City, State, ZIP:
Country:
Social Security Numbers (SSN):
Date of Birth: 05/10/1951
Deceased: UNKNOWN
Professional School(s) & Year(s) of Graduation: EAST FLORIDA EYE INSTITUTE 1991
Occupation/Field of Licensure (Code): PHYSICIAN (MD) (010)
State License Number, State of Licensure: 36249,TN
Other, as Specified:
Drug Enforcement Administration (DEA) Numbers:

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

DCN: 5500000031138266
Process Date: 10/01/2003
Page: 2 of 3
For authorized use by: CQHCA

27-C (Pg 2)

Hospital Affiliation(s):

C. INFORMATION REPORTED

Date of Report: 10/01/2003
Act/Omission Code: DIAGNOSIS: DELAY IN DIAGNOSIS (050)
Date of Act/Omission: 03/16/2001
Payment Date: 09/30/2003
Multiple or Single Payment: SINGLE
Amount of This Payment: $1,200,000.00
Total Amount of Judgment or Settlement: $1,200,000.00
Payment Result of: SETTLEMENT
Number of Practitioners for Whom Payment is Made: 1
Relationship of Entity to the Practitioner: INSURANCE COMPANY
Date of Judgment/Settlement: 09/30/2003
Adjudicative Case Number:
Adjudicative Body Name:
Court File Number:

Reporter's Description of the Act or Omission: PLAINTIFF ALLEGES DELAY IN DIAGNOSIS OF MENINGITIS BY INSURED GENERAL SURGEON CONTRIBUTED TO PLAINTIFF'S BLINDNESS.

Reporter's Description of the Judgment or Settlement: $1,200,000.00 AS FULL AND FINAL SETTLEMENT ON BEHALF OF DONALD W. FATE, M. D..

D. SUBJECT STATEMENT

If the subject identified in Section B of this report has submitted a statement, it appears in this section.

E. REPORT STATUS

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National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.hrsa.gov

DCN: 5580000844695384
Process Date: 01/15/2007
Page: 3 of 3
For authorized use by: CDHCA
Exhibit # 27-C
<Page 3>

E. REPORT STATUS

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Date of Original Submission: 01/15/2007

Date of Most Recent Change: 01/15/2007

END OF REPORT

furnished to regulatory authorities such as the National Practitioner Data B the Nebraska Board of Medicine and Surgery. This resulted in loss of refe business to the plaintiff, including employment opportunities.

13. In February 1995, Padden, Wallace, Forney, and BBGH, amon placed false information in the National Practitioner Data Bank, stating plaintiff had resigned staff privileges at BBGH pending investigation requests for corrective action filed by the hospital administrator.

14. In January 1997, Padden and Wallace, among others, provi information, including information contained in the plaintiff's personn BBGH and the results of the peer review, to Central Alabama Veterans He System (CAVHCS) in connection with the plaintiff's application for reapp to the staff of CAVHCS. The information was provided only after the signed a special release form, prepared by or at the direction of Padden, Forney, and Curtiss, among others, which provided absolute immunity t its officers, directors, employees, representatives, and staff physicians. B the false information, the plaintiff was denied staff advancement at CAV was subsequently terminated, resulting in loss of income for 6 months employment opportunities elsewhere because of the plaintiff's lack of adv at CAVHCS.

15. In October 1999, Padden and BBGH, among others, failed t to a request for information from Geneva Regional Medical Center (G connection with plaintiff's application for staff privileges at GRMC. Aft to respond to this request for approximately 3 months, BBGH, through its Curtiss, stated that no information would be provided unless the plaintiff special release form which provided absolute immunity to BBGH, its directors, employees, and staff physicians. Because the information provided, the plaintiff's application was tabled indefinitely by GRMC an that had been made to the plaintiff to associate with and to purchase

Doc # 28
page 2

DATED this 7th day of August, 2000.

BY THE COURT:

Richard G. Kopf
United States District Judge

Exhibit 29
(3 pgs

TENNESSEE.GOV

Department of Health
Kenneth S. Robinson, MD, Commissioner

EXHIBIT #10

PRACTITIONER PROFILE DATA

This information is provided by the licensee
as *required* by law.

SAVARIRAYAN MD, FRANCIS JESUDASSON			
PRACTICE ADDRESS:	TENNESSEE UROLOGY CLINIC PC 435 SEWELL RD #A SPARTA, TN 38583		
LANGUAGES: (Other than English)	None Reported		
SUPERVISING PHYSICIAN:	None Reported		
GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING			
PROGRAM/ INSTITUTION	CITY STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
CHRISTIAN MEDICAL COLLEGE	MADRAS MADRAS INDIA	04/01/1960	MD
OTHER EDUCATION AND TRAINING			
PROGRAM/ INSTITUTION	CITY STATE/ COUNTRY	FROM	TO
LAWREBCE & MEMORIAL HOSPS/INTERNSHIP	NEW LONDON CT	07/01/1963	06/30/1964
TRUESDALE HOSP/SURGICAL RESIDENCY	FALL RIVER MA	07/01/1964	06/30/1965
LAHEY CLINIC/UROLOGY RESIDENCY	BOSTON MA	07/01/1965	06/30/1967
BOSTON UNIV/UROLOGY-CHIEF RESIDENT	BOSTON MA	07/01/1967	06/30/1968
SPECIALTY BOARD CERTIFICATIONS			
CERTIFYING BODY/ BOARD/ INSTITUTION	CERTIFICATION/ SPECIALTY/ SUBSPECIALTY		
AM BD OF UROLOGY	UROLOGY		
FACULTY APPOINTMENTS			
TITLE	INSTITUTION		CITY/STATE
None Reported			
STAFF PRIVILEGES			
This practitioner currently holds staff privileges at the following hospitals			

#29
(p2)

[redacted]

HOSPITAL	CITY/STATE
KEWEENAW MEMORIAL MEDICAL CTR HOSP	LAURIUM, MI
ONTONAGON MEMORIAL HOSP	ONTONAGON, MI

This practitioner currently participates in the following TennCare plans

None Reported

FINAL DISCIPLINARY ACTION

ACTIONS BY STATE REGULATORY BOARD

AGENCY	VIOLATION	ACTION

None Reported

RESIGNATIONS IN LIEU OF TERMINATION

HOSPITAL	ACTION

None Reported

ACTIONS BY HOSPITAL

HOSPITAL	VIOLATION	ACTION

None Reported

CRIMINAL OFFENSES

OFFENSE	JURISDICTION

None Reported

LIABILITY CLAIMS

Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence. At the same time, the Legislature believes that consumers should have access to malpractice information. In these profiles, the Department has given you information about both the malpractice history of the physician's specialty and the physician's history of payments. The Legislature has placed payment amounts into three statistical categories: below average, average, and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history.

When considering malpractice data, please keep in mind:

- Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make individual doctor's history more meaningful.
- The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to move through the legal system.
- Some doctors work primarily with high risk patients. These doctors may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.
- Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the provider. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

You may wish to discuss information provided in this report, and malpractice generally, with your doctor. The Department can refer you to other articles on this subject.

The Health Department started getting reports for claims paid after May, 1990.

Settlements valued below $25,000 are not included here.

DATE	Settlement amount was:

None Reported

29
(P 3)

[redacted]

OPTIONAL INFORMATION

COMMUNITY SERVICE / AWARD / HONOR

DESCRIPTION	ORGANIZATION
(PAST) MAJOR-USAF/R	USA ARMED FORCES

PUBLICATIONS

TITLE	PUBLICATION	DATE
SYNCOPE FOLLOWING URETEROSIGMOIDOSTOMY	J OF UROLOGY	06/01/1969
PEDIATRIC POST-OPERATIVE CARE IN A COMMUNITY HOSITAL	J OF THE CMAI	07/01/1971
ALLERGY: NEWER CONCEPTS IN DIAGNOSIS & TREATMENT	J OF THE CMAI	05/01/1962

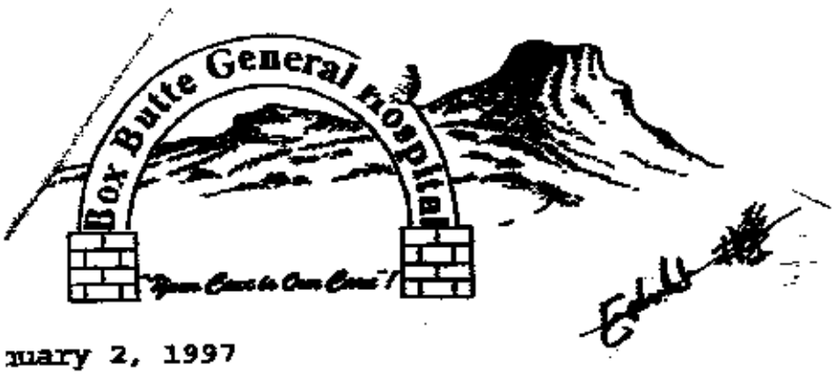

Exhibit #30

2101 BOX BUTTE AVENUE
P.O. BOX 810
ALLIANCE, NE 69301-0810
TEL: (308) 762-6660
FAX: (308) 762-1923

nuary 2, 1997

die B. Warren, M.D.
:ing Chief, Surgery
partment of Veterans Affairs
lical Center
)0 Hospital Road
skegee, Alabama 36083-5001

: Francis Savarirayan, M.D.

ir Doctor Warren:

m in receipt of your request for information regarding the above-noted actitioner and his privileges at Box Butte General Hospital. Our February , 1995 report to the National Practitioner Data Bank is as follows:

- "Physician resigned medical staff privileges during the pendency of investigations by the executive medical staff committee of Box Butte General Hospital pursuant to two separate 'requests for corrective action' filed by hospital administration."

: physician's response on file at the Data Bank is:

> "I currently serve as Chief of Urology at a 700 bed teaching hospital with medical school affiliation. Box Butte General Hospital is a non-teaching hospital with less than 20 active beds. 25% of its executive committee members have been cited for alcohol abuse and have been on mandatory urine screen programs. I am unaware of the two separate instances referred to by the hospital on receipt of specific charges. I will provide a more complete response. We are in the process of filing a federal court action against this hospital and this might have triggered the hospital to file false charges against me."

: to the physician's resignation during our review of the requests for rrective action, there are no final findings by the Medical Staff ecutive Committee. I would suggest you obtain from the physician copies our correspondence. These documents should be available to you through : physician. Upon receipt of the attached specific consent and release, would provide these source documents as well.

: may also wish to request references from Regional West Medical Center, ttsbluff, Nebraska, where I also understand he had privileges at one ne.

ncerely,

Wallace, M.D.