



NETWORKS

CREDENTIALING APPLICATION

EASY AS 1, 2, 3!!!

1. Complete the simple application, including consent form: sign and date.
(DDN does NOT accept STAMPED signatures)
2. Make copies of the supporting documents listed below:
 - ✓ Dental License (provide copies for EVERY state in which you are licensed)
 - ✓ DEA Registration for **EVERY STATE** the DDS is practicing in (or documentation DEA is pending)
 - ✓ Board/Specialty Certificate (if applicable)
 - ✓ Professional Liability Insurance Declaration Page - to include name of each provider covered, effective and expiration dates, insurance carrier, coverage limits of no less than \$1million/\$3 million.
-If expiration date is within weeks of this application, updated documentation must be submitted.
 - ✓ W-9 Form or Taxpayer Identification Number Request
3. Mail the application along with a signed DeCare Dental Networks, LLC Contracting Dentist Agreement to:

DeCare Dental Networks, LLC
Attn: National Credentialing
P.O. Box 1175
Minneapolis, MN 55440-1175

OR, *TO EXPEDITE*, APPLICATION CAN BE FAXED TO:

FAX: (866) 286-8840
QUESTIONS? Call (866)232-8658

| | |
|------------------|---|
| Name: | _____ |
| Individual NPI: | _____ - _____ - _____ |
| DEA Information: | Do you currently hold a DEA registration? <input type="checkbox"/> Yes <input type="checkbox"/> No If DEA is PENDING: Above DDS will not write prescriptions until DEA is finalized. _____ <div style="text-align: right;">DDS' Initials</div> |

| | |
|--|-----------------------|
| ER/After Hours Number: | (_____) _____ |
| Corporate NPI: | _____ - _____ - _____ |
| If more than one location please ATTACH A SEPARATE SHEET with the above information. | |

| |
|---|
| <h3>OSHA STATEMENT</h3> <p>I certify that my office protocols for infection control are in compliance with current CDC/OSHA guidelines.</p> |
|---|

PROFESSIONAL LIABILITY ADDENDUM

Complete addendum if you answered "YES" to any Disclosure Questions.
Attach separate sheet if necessary.

| |
|--|
| Board Action(s) |
| Date of Occurrence: _____ Date of Satisfaction/Closure: _____ Amount of Fine Paid: _____ |
| Details of Action (conditions, limitations, etc.) Attach copy of Board Action/Corrective Action: _____ |
| _____ |
| _____ |
| _____ |



NETWORKS

Request for Taxpayer Identification Number and Certification (SUBSTITUTE FORM W-9)

Instructions: Please type or print clearly. Sign, date and return to requester in the enclosed envelope. Do not send to the IRS

Business Entity: Name of the entity that provides dental services per IRS. (As used to apply for your Tax Identification Number (TIN). This appears on Form SS-4, on your Quarterly Withholding Form 941, or on your annual IRS Tax Return.)

Business Name: (Name used to advertise for business, if different from above name.)

Business Address:

Address (number, street and apt or suite no.)

City, State and ZIP code

Taxpayer Identification Number (TIN)

Enter your TIN, which corresponds to the business entity listed above. This may be an Employer Identification Number (EIN) or your Social Security Number (SSN) dependent upon how you file your tax returns with the IRS. This is the Tax Identification Number you use when you submit claims.

TIN

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|

Check one: This is my EIN or SSN

Please check appropriate box: Individual/Sole Proprietor Corporation Partnership Other _____

If you use a different Tax Identification Number at another office location, please copy this form and complete the copied form with the additional Tax Identification Number and office location information.

Qualifying Exemption Exempt from tax under 501(a)

Reason, if any (check) The United States or any of its agencies or instrumentalities

A state, the District of Columbia, a possession of the United States, or any of their political subdivisions.

Certification: (1) I certify under penalty of perjury that the Taxpayer Identification Number I have provided is correct.
(2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
(3) I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you failed to report all interest and dividends on your tax return.

Signature: _____

Office Phone: () _____

Print signer's name & title: _____

Date: _____

DeCare Dental Networks, LLC
ATTN: National Network
P.O. Box 1175 • Minneapolis, MN 55440-1175
FAX: 1-866-286-8840

See back of form for additional information.

Purpose of Form

A person who is registered to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Corporations.

What is backup withholding?

Persons making certain payments to you must withhold and pay to the IRS 28% of such payments under certain conditions. This is called "backup withholding". Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real Estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. **Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part III instructions on page 2 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

State of West Virginia Credentialing Form

Please complete each section thoroughly.
Attach additional sheets where necessary.
(Indicate clearly the practitioner name and section on each attachment)
Type or print clearly in black ink.
Sign and date the application.

| | |
|----------------------------------|----------------------|
| Practitioner's Name | Date |
| | |
| Social Security Number | Date of Birth |
| | |
| Credentialing Entity Name | |
| | |

**YOU MUST INCLUDE THE FOLLOWING WITH THIS
COMPLETED APPLICATION**
(Use this checklist as a guide)

- Copy of ALL current State License(s): For purposes of this application, State License shall include licensure from all 50 states, the District of Columbia, and U.S. Territories.
- Copy of current DEA Registration (if applicable)
- Copy of current State Controlled Dangerous Substance (CDS) Certificate (if applicable)
- Copy of current professional liability insurance policy face sheet, showing expiration dates, limits, and Practitioner's name
- Copy of Board Certification Certificate(s) (if applicable), or other National Certification Certificates
- Copy of certificate(s) or letter(s) certifying formal post-graduate training
- Copy of Curriculum Vitae/Resume (Include work history)
(Not accepted as a substitute for completion of application.)
- Copy of ECFMG Certificate (if applicable)
- Copy of W-9 for verification of each tax identification number used (required for payers only)
- Copy of Visa or work permit (if not a U.S. citizen)
- Copies of CME/CEU session certificates (if required by Credentialing Entity)
- Signature requirements per each entity
- Professional Peer References (if required by Credentialing Entity)

CREDENTIALING ENTITIES MAY SUPPLEMENT THIS CHECKLIST OF REQUIRED ITEMS AS NEEDED TO MEET CREDENTIALING REQUIREMENTS.

State of West Virginia Credentialing Form

Responses must be legible. Any response, which cannot be completed in the space provided, may be included on supplementary sheets of paper and attached. DO NOT LEAVE ANY FIELDS BLANK. If an item is not applicable, indicate N/A. Please note you will be held responsible for all information or omissions in this application, regardless of whether such statements were prepared by you, an employee, agent or representative. For time gaps greater than three (3) months provide information in Section 11. After completion of the application, you may photocopy and then submit with a signed attestation to each entity to which you wish to apply.

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

| 1. Applicant Information | | | | |
|--|---|--|-------------------------------|--|
| Last Name (as shown on state license) | First Name | Middle Name | Maiden Name | Suffix (e.g., Jr., Sr., etc.) |
| | | | | |
| Degree (e.g., MD, DO, DDS, DPM, PA-C, RN) | Gender | Birth Date | Birthplace | |
| | Male <input type="checkbox"/> Female <input type="checkbox"/> | | | |
| Other Name(s) Also Known By | | | | |
| Name(s) | Name: | | Name: | |
| Date Name Used | From: | To: | From: | To: |
| Area(s) of Specialty (please be specific and list any primary focus) | | | | |
| Specialty: | | Sub-specialty: | | |
| Citizenship | | | | |
| Are you a US Citizen? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Please provide the following information if you are not a US Citizen: | If no, what is your citizenship? | | | |
| | If no, what is status of your Visa? | | | |
| | If no, do you hold a permanent work permit? | | | |
| | Type of Visa: | | Expiration of Visa: | |
| Social Security # | National Provider ID # (if available) | ECFMG # (if applicable, attach copy) | ECFMG Certificate Date | |
| | | | | |
| Current Home Address | | City | State | Zip Code |
| | | | | |
| Home Telephone | | Is this # unlisted? | Home Fax | |
| () - | | <input type="checkbox"/> Yes <input type="checkbox"/> No | () - | |
| Language(s) Spoken (other than English) | | | | |
| | | | | |

| 2. Office Practice Information | | | | | | | | | |
|--|---|---|-----------------|--|-----------------|--|-------------------------|---|---|
| If you have more than one office site or more than one billing address or entity, please make a photocopy of this section before completing it and provide information for each site or billing entity (i.e., multiple tax identifiers), as needed. Indicate below whether the office is the primary or an additional site. (NOTE: Only one primary site should be designated.) | | | | | | | | | |
| <input type="checkbox"/> Primary Office Site # 1 | | | | <input type="checkbox"/> Additional Office Site # | | | | | |
| Group/Practice Name | | | | | | | | | |
| <table style="width:100%; border: none;"> <tr> <td style="width: 20%; border: none;">Type of Practice</td> <td style="border: none;"> <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Group <input type="checkbox"/> Corporation </td> <td style="border: none; padding-left: 20px;"> <input type="checkbox"/> Hospital Based <input type="checkbox"/> Teaching or Research <input type="checkbox"/> Other (specify): </td> </tr> </table> | | | | | | | Type of Practice | <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Group <input type="checkbox"/> Corporation | <input type="checkbox"/> Hospital Based <input type="checkbox"/> Teaching or Research <input type="checkbox"/> Other (specify): |
| Type of Practice | <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Group <input type="checkbox"/> Corporation | <input type="checkbox"/> Hospital Based <input type="checkbox"/> Teaching or Research <input type="checkbox"/> Other (specify): | | | | | | | |
| Address (Building, Street, Suite #) | | | | City | | | | | |
| | | | | | | | | | |
| State | | Zip Code | | County | | | | | |
| | | | | | | | | | |
| Telephone Number | | Fax Number | | Answering Service/After-Hours Number | | | | | |
| () - | | () - | | () - | | | | | |
| Alternate Telephone Number | | Cell Phone Number | | Beeper/Pager Number | | | | | |
| () - | | () - | | () - | | | | | |
| E-Mail Address | | | | Long Range Beeper Number | | | | | |
| | | | | () - | | | | | |
| Medicare Number | | UPIN Number | | Medicaid Number | | | | | |
| | | | | | | | | | |
| Are you currently accepting new patients? | | | | Have you closed your practice to any plans or programs? | | | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> By referral only <input type="checkbox"/> No <input type="checkbox"/> NA | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA If Yes, please list: | | | | | |
| Handicap Accessible? | | | | Public Transit Available? | | | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA | | | | | |
| Does the office have other services available for disabled? (TTY, ASI, Mental/physical impairments, etc.) | | | | If yes, list below what services are available | | | | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA | | | | | | | | | |
| Office Manager's Name | | Nurse Manager's Name | | Credentialing Contact | | | | | |
| <input type="checkbox"/> N/A | | <input type="checkbox"/> N/A | | Name <input type="checkbox"/> N/A Phone # | | | | | |
| Office Hours _____ | | | | | | | | | |
| <input type="checkbox"/> Check if not applicable <input type="checkbox"/> Check if practitioner is not available to see patient during hours indicated | | | | | | | | | |
| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday | | | |
| AM | AM | AM | AM | AM | AM | AM | | | |
| PM | PM | PM | PM | PM | PM | PM | | | |
| Services Provided | | | | | | | | | |
| (Please check below if these services are available) | | | | | | | | | |
| <input type="checkbox"/> Lab Services | | <input type="checkbox"/> On-Site | | Reference Lab Name: | | CLIA Number and Type of Certification: | | | |
| <input type="checkbox"/> Radiology Services | | <input type="checkbox"/> EKG | | <input type="checkbox"/> Sigmoidoscopy | | <input type="checkbox"/> Audiology Services <input type="checkbox"/> Treadmill | | | |
| <input type="checkbox"/> Other (Please list): | | | | | | | | | |
| <input type="checkbox"/> List any special diagnostic or treatment procedures performed in your office: | | | | | | | | | |

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| Patient Population | | | |
|---|---|--|---|
| Do you limit the age of patients you treat? | | If yes, what ages do you treat? | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Minimum: | Maximum: |
| Remittance/Billing Information (NOTE: Must match box 33 on HCFA/CMS 1500) | | | |
| Are all services payable to one practice or group name/address? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Group/Practice Name (Check Payable To): | | | |
| Address (Building, Street, Suite #) | | City | State |
| | | | Zip Code |
| Billing Office Phone Number | | Billing Manager's Name | |
| () - | | | |
| Tax ID Number (must match W-9) | | Name affiliated with Tax ID Number (must match W-9) | |
| | | | |
| Business Interests | | | |
| Do you or your business entity own, operate, have an interest in, or participate in any medical enterprise or business? | | <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details on separate sheet. | |
| Do you have a financial relationship with a hospital, clinical lab, nursing home, pharmacy, radiology lab, emergency room, or any other medical related organization? | | <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details on separate sheet. | |
| Practice Classification | | | |
| <input type="checkbox"/> Primary Care Physician (Family Practitioners, Internists, or Pediatricians who deliver primary health care services) | | | |
| <input type="checkbox"/> Specialist Physician (Physicians other than primary care physicians in their designated clinical practice) | | | |
| <input type="checkbox"/> Allied Health Professional (Licensed, certified, or registered non-physician Practitioners of direct patient care services) | | | |
| <input type="checkbox"/> Dual Role (Serve as both a Primary Care Physician as well as a Specialist) | | | |
| Directory Listing | | | |
| Should this office be listed in the directory? | | Should this office receive correspondence? | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Please indicate, in preference order, how you wish to be listed in the directory. | | | |
| Primary Specialty: | | Secondary Specialty: | |
| | | | |
| After-Hours Coverage | | | |
| Do you provide 24-hour coverage? | | Describe Coverage | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> NA | | |
| Do you have an answering service/machine? | | Is your answering service/machine available at all times when you are not in the office? | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> NA | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> NA |
| List below other after-hours arrangements or special instructions to patients for after-hours care needs: | | | |
| | | | |

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| Back-up Coverage | | | |
|---|---|--|--------------|
| (Please list the name, specialty, and phone number of partner(s) or associate(s) or physician(s) covering your practice in your absence.) | | | |
| Name | Specialty | Partner, Associate, Or Covering | Phone Number |
| | | | () - |
| | | | () - |
| | | | () - |
| | | | () - |
| Admitting Service | | | |
| Do you admit patients to the hospital under your own service? | | If no, to whom do you admit? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA | | | |
| Practitioner Extenders | | | |
| Please check any of the following practitioner extender types and list individual names who you either employ or utilize for direct patient care. | | | |
| <input type="checkbox"/> Physician's Assistant: | | <input type="checkbox"/> Nurse Practitioner: | |
| <input type="checkbox"/> Nurse Midwife: | | <input type="checkbox"/> Other (specify): | |
| Workers' Compensation Information | | | |
| Do you accept Workers' Compensation Patients? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If yes, please provide the following information: | <p>a. Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Modified or alternative duty is actively evaluated for each Workers' Compensation claimant. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Office will accommodate urgent walk-ins (or non-urgent appointments within 48 hours) to treat injured or ill workers and facilitate their return to work, if possible. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Staff are available and willing to provide compensation representatives information regarding a claimant's care. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | | |

3. Medical/Professional Education:

(Attach copy of diploma. If international graduate, submit ECFMG Certificate.) If additional space is needed, please photocopy this page and attach. All time gaps greater than three (3) months must be accounted for in Section 11.

| | | | |
|-----------------------|-------------------------------|---|------------------------|
| Name of School | Degree Received | Dates of Attendance (List Mo/Yr) | |
| | | From: | To: |
| Street Address | Phone # (if known) | Fax # (if known) | Graduation Date |
| | () - | () - | |
| City | State | Country | Zip Code |
| | | | |
| Name of School | Degree Received | Dates of Attendance (List Mo/Yr) | |
| | | From: | To: |
| Street Address | Telephone # (if known) | Fax # (if known) | Graduation Date |
| | () - | () - | |
| City | State | Country | Zip Code |
| | | | |

4. Professional Training - Internship/Residency/Fellowship/Preceptorship/Other

List all, completed or not. (Attach copies of all program certificates.) All time gaps greater than three (3) months must be accounted for in Section 11.

| | | | |
|-------------------------------------|----------------------------------|--|---|
| Training Institution | | Program | |
| | | <input type="checkbox"/> Internship | <input type="checkbox"/> Fellowship <input type="checkbox"/> Other: |
| | | <input type="checkbox"/> Residency | <input type="checkbox"/> Preceptorship |
| Street Address | | City | |
| | | | |
| State | Country | Zip Code | |
| | | | |
| Telephone # (if known) | | Fax # (if known) | |
| () - | | () - | |
| Type of Training/Specialty | Dates of Training (Mo/Yr) | Was program successfully completed? | |
| | From: To: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | If no, explain: | |
| Your Program Director's Name | | Current Program Director's Name (if known) | |
| | | | |
| Training Institution | | Program | |
| | | <input type="checkbox"/> Internship | <input type="checkbox"/> Fellowship <input type="checkbox"/> Other: |
| | | <input type="checkbox"/> Residency | <input type="checkbox"/> Preceptorship |
| Street Address | | City | |
| | | | |
| State | Country | Zip Code | |
| | | | |
| Telephone # (if known) | | Fax # (if known) | |
| () - | | () - | |
| Type of Training/Specialty | Dates of Training (Mo/Yr) | Was program successfully completed? | |
| | From: To: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | If no, explain: | |
| Your Program Director's Name | | Current Program Director's Name (if known) | |
| | | | |

State of West Virginia Credentialing Form: Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

| Training Institution | | | | Program | | |
|--|-----------|----------------------------------|---|---|---|---|
| | | | | <input type="checkbox"/> Internship <input type="checkbox"/> Residency | <input type="checkbox"/> Fellowship <input type="checkbox"/> Preceptorship | <input type="checkbox"/> Other: |
| Street Address | | | | City | | |
| | | | | | | |
| State | | Country | | Zip Code | | |
| | | | | | | |
| Telephone # (if known) | | | Fax # (if known) | | | |
| () - | | | () - | | | |
| Type of Training/Specialty | | Dates of Training (Mo/Yr) | | Was program successfully completed? | | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain: | | |
| Your Program Director's Name | | | Current Program Director's Name (if known) | | | |
| | | | | | | |
| Training Institution | | | | Program | | |
| | | | | <input type="checkbox"/> Internship <input type="checkbox"/> Residency | <input type="checkbox"/> Fellowship <input type="checkbox"/> Preceptorship | <input type="checkbox"/> Other: |
| Street Address | | | | City | | |
| | | | | | | |
| State | | Country | | Zip Code | | |
| | | | | | | |
| Telephone # (if known) | | | Fax # (if known) | | | |
| () - | | | () - | | | |
| Type of Training/Specialty | | Dates of Training (Mo/Yr) | | Was program successfully completed? | | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain: | | |
| Your Program Director's Name | | | Current Program Director's Name (if known) | | | |
| | | | | | | |
| 5. State License(s): List <u>all</u> current and past professional licenses (Submit copy of current licenses) | | | | | | |
| State | License # | Issue Date | Expiration Date | Status (Please check) | Is/was license restricted? | Reason License is/was Inactive or Restricted |
| | | | | <input type="checkbox"/> Active <input type="checkbox"/> Inactive | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | <input type="checkbox"/> Active <input type="checkbox"/> Inactive | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | <input type="checkbox"/> Active <input type="checkbox"/> Inactive | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | <input type="checkbox"/> Active <input type="checkbox"/> Inactive | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | <input type="checkbox"/> Active <input type="checkbox"/> Inactive | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Does the scope of your practice require the supervision of another practitioner? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If Yes, please list name of each supervising practitioner: | | | | Practitioner Name: | | |

6. Certifications/Registrations

Check here if entire section is not applicable to applicant.

Federal DEA Certificate
 Not applicable
 (Submit copy of current DEA Certificate)

| Certificate # | Expiration Date | Unlimited? |
|---------------|-----------------|---|
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain: |

State DEA or CDS Certificate(s)
 Not applicable
 (Submit copy of current State Controlled Dangerous Substance Certificates, if applicable)

| Certificate # | Expiration Date | Unlimited? |
|---------------|-----------------|---|
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain: |

Other Certificate(s)/Formal Training
 (Please check below if currently certified. Submit copy(s))

- | | |
|---|---|
| <input type="checkbox"/> Basic Life Support (BLS) | <input type="checkbox"/> Anesthesia Permit |
| <input type="checkbox"/> Advanced Cardiac Life Support (ACLS) | <input type="checkbox"/> Health Care Practitioner (Core C) |
| <input type="checkbox"/> Pediatric Advanced Life Support (PALS) | <input type="checkbox"/> Neonatal Resuscitation Program (NRP) |
| <input type="checkbox"/> Advanced Trauma Life Support (ATLS) | <input type="checkbox"/> Therapeutics Classification Number (Optometrists only) |
| <input type="checkbox"/> Neonatal Advanced Life Support (NALS) | <input type="checkbox"/> Other (please list below or on a separate sheet and include descriptions): |

7. Specialty Board Certification: Submit copies of board certifications and/or qualification confirmation letter.

Check here if entire section is not applicable to applicant.

Are you board certified? Yes No (If yes, list below)

| Certifying Board Name & Specialty | Initial Certification Date | Most Recent Recertification Date | Next Expiration Date |
|-----------------------------------|----------------------------|----------------------------------|----------------------|
| | | | |
| | | | |
| | | | |
| | | | |

If not certified, are you qualified to sit for the examination? Yes No

- If not certified, please indicate your status in the certifying process:**
- Failed to pass specialty board examination
 - How many times have you taken the exam but failed to pass? _____
 - Last date(s) exam was taken: _____
 - Date(s) board examination was taken/retaken and date board exam is scheduled, if applicable:
 - Date(s) taken/retaken: _____
 - Date scheduled, if applicable: _____
 - Not eligible to take specialty boards
 - Not planning to take specialty boards
 - Admissible with exam pending

8. Professional Peer References

Please list three (3) professional peer references who have personal knowledge of your current clinical abilities, ethical character, health status, and ability to work cooperatively with others, and who will provide specific written comments on these and other relevant matters upon request. References will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you. These individuals must have acquired the requisite knowledge through observation of your professional practice over a reasonable period of time. At least one reference must be from the same specialty area, not formerly, currently or about to become associated with you in practice. At least one must be from an individual who has had organizational responsibility in a medical setting (e.g., Department Chair, Medical Director). If your training was completed within the past three (3) years, you may list your Program Director(s) as a professional reference. If you have been out of training for more than three (3) years, it is important to name individuals who are more currently familiar with your professional practice. The individuals should not be related to you by family or financial association.

| | | | | |
|---|--|------------------------------|--------------|------------|
| Reference Name 1 | | Title | | |
| | | | | |
| Street Address | | City | State | Zip |
| | | | | |
| Telephone Number | | Fax Number (if known) | | |
| () - | | () - | | |
| Relationship: (instructor, department chair, chief of staff, colleague, etc.) | | | | |
| Reference Name 2 | | Title | | |
| | | | | |
| Street Address | | City | State | Zip |
| | | | | |
| Telephone Number | | Fax Number (if known) | | |
| () - | | () - | | |
| Relationship: (instructor, department chair, chief of staff, colleague, etc.) | | | | |
| Reference Name 3 | | Title | | |
| | | | | |
| Street Address | | City | State | Zip |
| | | | | |
| Telephone Number | | Fax Number (if known) | | |
| () - | | () - | | |
| Relationship: (instructor, department chair, chief of staff, colleague, etc.) | | | | |

9. Hospital/Health Care Entity Affiliations (list current affiliation first)

Check here if entire section is not applicable to applicant.

List ALL health care facilities at which you currently have, or have had, privileges. Explain gaps greater than three (3) months in Section 11.

| Name of Current Primary Hospital Affiliation | | Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.) | | |
|---|--|--|-----------------------------------|-----|
| Street Address | | City | State | Zip |
| Telephone Number () - | | Fax Number () - | | |
| Department/Service | | Department Chair's Name | | |
| Staff Status | | # Admits/Month | Percent of time spent at facility | |
| Restricted? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Dates of Affiliation (Mo/Yr) From: To: | | |
| If yes, explain: | | | | |
| Reason for leaving, if applicable | | | | |

| Name of Affiliation/Hospital/Healthcare Entity | | Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.) | | |
|---|--|--|-----------------------------------|-----|
| Street Address | | City | State | Zip |
| Telephone Number () - | | Fax Number () - | | |
| Department/Service | | Department Chair's Name | | |
| Staff Status | | # Admits/Month | Percent of time spent at facility | |
| Restricted? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Dates of Affiliation (Mo/Yr) From: To: | | |
| If yes, explain: | | | | |
| Reason for leaving, if applicable | | | | |

| Name of Affiliation/Hospital/Healthcare Entity | | Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.) | | |
|--|--|--|-------|-----|
| Street Address | | City | State | Zip |
| Telephone Number () - | | Fax Number () - | | |
| Department/Service | | Department Chair's Name | | |

State of West Virginia Credentialing Form: Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

| | | | |
|---|-------------------------------------|--|--|
| Staff Status | # Admits/Month | Percent of time spent at facility | |
| | | | |
| Restricted? | Dates of Affiliation (Mo/Yr) | | |
| If yes, explain: <input type="checkbox"/> Yes <input type="checkbox"/> No | From: | To: | |
| Reason for leaving, if applicable | | | |
| | | | |

9. Additional Affiliations:

(Photocopy this page for additional affiliations)

| | | | |
|---|---|--|------------|
| Name of Affiliation/Hospital/Healthcare Entity | Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.) | | |
| | | | |
| Street Address | City | State | Zip |
| | | | |
| Telephone Number | Fax Number | | |
| () - | () - | | |
| Department/Service | Department Chair's Name | | |
| | | | |
| Staff Status | # Admits/Month | Percent of time spent at facility | |
| | | | |
| Restricted? | Dates of Affiliation (Mo/Yr) | | |
| If yes, explain: <input type="checkbox"/> Yes <input type="checkbox"/> No | From: | To: | |
| Reason for leaving, if applicable | | | |
| | | | |

| | | | |
|---|---|--|------------|
| Name of Affiliation/Hospital/Healthcare Entity | Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.) | | |
| | | | |
| Street Address | City | State | Zip |
| | | | |
| Telephone Number | Fax Number | | |
| () - | () - | | |
| Department/Service | Department Chair's Name | | |
| | | | |
| Staff Status | # Admits/Month | Percent of time spent at facility | |
| | | | |
| Restricted? | Dates of Affiliation (Mo/Yr) | | |
| If yes, explain: <input type="checkbox"/> Yes <input type="checkbox"/> No | From: | To: | |
| Reason for leaving, if applicable | | | |
| | | | |

| | | | |
|---|---|--------------|------------|
| Name of Affiliation/Hospital/Healthcare Entity | Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.) | | |
| | | | |
| Street Address | City | State | Zip |
| | | | |

State of West Virginia Credentialing Form: Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

| | | | |
|--|--|-------------------------------------|--|
| | | | |
| Telephone Number | | Fax Number | |
| () - | | () - | |
| Department/Service | | Department Chair's Name | |
| | | | |
| Staff Status | | # Admits/Month | Percent of time spent at facility |
| | | | |
| Restricted? | | Dates of Affiliation (Mo/Yr) | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: | | From: | To: |

Reason for leaving, if applicable

10. Work History/Experience:

List in chronological order (beginning with current) all current and previous professional work history including Military Service. You must explain gaps greater than three (3) months in Section 11. (If additional space is needed, please photocopy this page and attach.)

| | | | |
|---|--|--------------|------------|
| Practice/Employer | Contact Name | | |
| | | | |
| Street Address | City | State | Zip |
| | | | |
| Telephone Number | Fax Number (if known) | | |
| () - | () - | | |
| Dates of Employment (Month/Year) | Job Title or Type of Work Performed | | |
| From: To: | | | |

Reason for leaving, if applicable

| | | | |
|---|--|--------------|------------|
| Practice/Employer | Contact Name | | |
| | | | |
| Street Address | City | State | Zip |
| | | | |
| Telephone Number | Fax Number (if known) | | |
| () - | () - | | |
| Dates of Employment (Month/Year) | Job Title or Type of Work Performed | | |
| From: To: | | | |

Reason for leaving, if applicable

| | | | |
|---|--|--------------|------------|
| Practice/Employer | Contact Name | | |
| | | | |
| Street Address | City | State | Zip |
| | | | |
| Telephone Number | Fax Number (if known) | | |
| () - | () - | | |
| Dates of Employment (Month/Year) | Job Title or Type of Work Performed | | |

State of West Virginia Credentialing Form: Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

| | | | | |
|---|-----|--|--------------|------------|
| From: | To: | | | |
| Reason for leaving, if applicable | | | | |
| | | | | |
| Practice/Employer | | Contact Name | | |
| | | | | |
| Street Address | | City | State | Zip |
| | | | | |
| Telephone Number | | Fax Number (if known) | | |
| () - | | () - | | |
| Dates of Employment (Month/Year) | | Job Title or Type of Work Performed | | |
| From: | To: | | | |
| Reason for leaving, if applicable | | | | |
| | | | | |

11. Time Gaps

Provide information for all time frames of three (3) months or more that are not covered in Medical/Professional Education, Professional Training, Hospital/Health Care Entity Affiliations, or Work History/Experience sections (such as extended travel, maternity leave, relocation, etc.).

Check here if entire section is not applicable to applicant.

| Section | Dates | Explanation |
|---|-------|-------------|
| Medical/Professional Education | From: | |
| | To: | |
| | From: | |
| Professional Training | To: | |
| | From: | |
| | To: | |
| Hospital/Health Care Entity Affiliations | From: | |
| | To: | |
| | From: | |
| Work History/Experience | To: | |
| | From: | |
| | To: | |

14. Professional Liability Insurance Coverage:

Submit a copy of your current professional liability insurance coverage face sheet showing coverage in your practice specialty. Please list current and previous insurance carriers for the last ten (10) years in chronological order beginning with most current. (If additional space is needed, please photocopy this page and attach.)

| Current Insurance Carrier | | Telephone Number | | |
|----------------------------------|--------------------------------------|-------------------------------------|----------------------------------|---|
| | | () - | | |
| Address | | City | State | Zip |
| | | | | |
| Coverage Effective Date | Coverage Termination Date | Amount of Coverage | | If Umbrella/Excess coverage, amount of coverage |
| | | \$ million/occurrence | | \$ |
| | | \$ million/aggregate | | |
| Policy Number | Type of Coverage | | Do you have prior acts coverage? | |
| | <input type="checkbox"/> Claims Made | <input type="checkbox"/> Occurrence | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Second Current Insurance Carrier | | Telephone Number | | |
| | | () - | | |
| Address | | City | State | Zip |
| | | | | |
| Coverage Effective Date | Coverage Termination Date | Amount of Coverage | | If Umbrella/Excess coverage, amount of coverage |
| | | \$ million/occurrence | | \$ |
| | | \$ million/aggregate | | |
| Policy Number | Type of Coverage | | Do you have prior acts coverage? | |
| | <input type="checkbox"/> Claims Made | <input type="checkbox"/> Occurrence | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Previous Insurance Carrier | | Telephone Number | | |
| | | () - | | |
| Address | | City | State | Zip |
| | | | | |
| Coverage Effective Date | Coverage Termination Date | Amount of Coverage | | If Umbrella/Excess coverage, amount of coverage |
| | | \$ million/occurrence | | \$ |
| | | \$ million/aggregate | | |
| Policy Number | Type of Coverage | | Do you have prior acts coverage? | |
| | <input type="checkbox"/> Claims Made | <input type="checkbox"/> Occurrence | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Previous Insurance Carrier | | Telephone Number | | |
| | | () - | | |
| Address | | City | State | Zip |
| | | | | |
| Coverage Effective Date | Coverage Termination Date | Amount of Coverage | | If Umbrella/Excess coverage, amount of coverage |
| | | \$ million/occurrence | | \$ |
| | | \$ million/aggregate | | |
| Policy Number | Type of Coverage | | Do you have prior acts coverage? | |
| | <input type="checkbox"/> Claims Made | <input type="checkbox"/> Occurrence | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

15. Professional Liability Insurance Coverage Disclosure:

If the answer to any of these questions is yes, please provide a full explanation of the details of each and every matter on the attached Professional Liability Information Addendum. The explanation must include the name of the court in which the suit was filed, the caption and docket number of the case, and the name and address of the attorney defending you, and all other relevant details. Include suits in which a judgment or settlement was made against a professional corporation of which you are/were a member, shareholder, or employee in any matter in which you were involved in the patient's care.

| | | |
|---|-----------------------------|------------------------------|
| A. Has your professional liability insurance coverage ever been terminated by action of the insurance company? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| B. Have you ever been denied professional liability insurance coverage? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| C. Has any (current or previous) professional liability insurance carrier excluded any specific procedures or specific area of practice (e.g., obstetrics, surgery, etc.) from your coverage? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| D. During the time of your professional practice, have you had any professional liability claims, suits, settlements, or judgments filed against you or are any currently pending? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| E. Have any restrictions ever been placed on your professional liability insurance coverage? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| F. Have you ever practiced without professional liability coverage? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| G. Are there any incidents for which you have been contacted by an attorney regarding potential professional liability (e.g., settlement requests, writ of summons, etc.)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Professional Liability Information Addendum

(Photocopy this form for each case/action)

| | | |
|---|--|------------------------------|
| <p>Please supply the following and sign and date this form:</p> <ul style="list-style-type: none"> Information for each professional liability action you have had taken against you, including those pending. Information for each settlement, or decision for the plaintiff that has ever occurred on your behalf. Practitioner Signature and Date <p>All information is held in strict confidence and used for credentialing and recredentialing purposes only. Failure to supply sufficient details may prevent your application from being approved. In addition to completion of this form, practitioner may also submit any additional supporting documentation.</p> | | |
| <input type="checkbox"/> Check here if entire section is not applicable to applicant (and sign below even if no suits or settlements). <input type="checkbox"/> Check here if no professional liability actions/claims filed (and sign below even if no suits or settlements). | | |
| 1. Case Number | 2. Carrier Name | |
| | | |
| 3. Name of Plaintiff | 4. Date of Incident | |
| | | |
| 5. Date Filed | 6. Date Closed | |
| | | |
| 7. What was/is your status in the case? | 8. What is the status of the case? | |
| <input type="checkbox"/> Primary Defendant <input type="checkbox"/> Co-Defendant <input type="checkbox"/> Other, please explain: | <input type="checkbox"/> Dropped <input type="checkbox"/> Pending <input type="checkbox"/> Settled Out of Court <input type="checkbox"/> Found for Defendant <input type="checkbox"/> Dismissed Without Payment <input type="checkbox"/> Found for Plaintiff <input type="checkbox"/> Under Appeal | |
| 9. Amount of Any Settlement or Award? | 10. Date of any Settlement or Award | |
| | | |
| Please explain the following in detail. (If an item does not apply please check "N/A") | | |
| 11. What was the alleged harm to the patient? | | <input type="checkbox"/> N/A |
| 12. What were you alleged to have done incorrectly or failed to do? | | <input type="checkbox"/> N/A |
| 13. Describe the patient's illness and related effects of the alleged harm. | | <input type="checkbox"/> N/A |
| 14. Describe any other details you believe are pertinent to the case. | | <input type="checkbox"/> N/A |
| 15. Identify any other parties named in the suit. | | <input type="checkbox"/> N/A |
| Practitioner Signature (REQUIRED) | Date (REQUIRED) | |
| | | |

| 16. Practice Disclosure Information | | | |
|--|-----------------------------|------------------------------|-----------------------------|
| If the answer to any question below is yes, please provide a full explanation of the details on a separate sheet and attach. | | | |
| A. Have any investigations been initiated or are any pending against you by any state licensure board, registration board, or regulatory agency? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| B. Has your license to practice in any state ever been voluntarily or involuntarily relinquished, restricted, denied, reduced, limited, suspended, placed on probation, revoked, or subject to any disciplinary action including reprimand? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| C. Have you ever been suspended, sanctioned, or otherwise restricted from participating or been the subject of an investigation in any private, federal, or state health insurance program (e.g., Medicare, Medicaid)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| D. Has your narcotics (DEA) registration certificate (federal or state) ever been voluntarily or involuntarily relinquished, limited, suspended, not renewed, placed on probation, revoked, or challenged? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> NA |
| E. Have you ever been convicted of or plead no contest to any criminal (felony or misdemeanor) charges including a drug or alcohol-related offense or motor vehicle offenses, but not including minor traffic or parking violations? Are any such proceedings currently pending? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| F. Have you ever had an academic appointment denied, limited, revoked, suspended, reduced, placed on probation, not renewed, or other adverse action taken? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> NA |
| G. Have you ever been refused membership on the medical or allied health staff of any hospital or institution or been denied advancement in staff status? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> NA |
| H. Has your employment, medical staff status, appointment, reappointment, or clinical privileges, or scope of practice ever been voluntarily or involuntarily suspended, restricted, reduced, revoked, denied, relinquished, not been renewed or subjected to probationary conditions or limited at any hospital, managed care organization or other health care entity? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| I. Have you ever been denied membership or renewal, or been reprimanded, censured, suspended, revoked, placed on probation, or otherwise sanctioned by any health care organization, including but not limited to, hospitals, HMOs, PPOs, IPAs, PHOs, professional associations or societies, professional standards review organization or peer review organizations, or any other health care facilities, based on professional competence? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| J. Have you ever withdrawn your application for appointment, reappointment or request for clinical privileges or resigned from the medical or allied health staff of a hospital, managed care organization, or other health care entity while under investigation or before a decision about your appointment or reappointment or clinical privileges was rendered by the governing board of any hospital, managed care organization or any other health care entity? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| K. Have you ever been allowed to resign your position or voluntarily relinquish specific clinical privileges rather than face any charge or investigation on the part of the medical staff of a hospital, managed care organization, or other health care entity? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| L. Are there currently pending adverse actions on your employment, medical staff appointment, reappointment, clinical privileges or scope of practice at any hospital, managed care organization, or other health care entity? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| M. Has any investigation (other than normal performance improvement reviews) involving your clinical practice, competence or professional conduct ever been initiated by any hospital, managed care organization, governmental agency, other health care entity, or branch of the armed forces? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| N. Has your request for any specific clinical privileges or scope of practice ever been denied (as a result of disciplinary action) or granted with stated limitations or conditions (aside from ordinary initial probationary requirements of proctorship)? Are such proceedings currently pending? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |

State of West Virginia Credentialing Form: Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

| | | | |
|--|-----------------------------|------------------------------|--|
| O. Do you have any knowledge of any civil actions pending against you by any hospital, law enforcement agency, professional group or society? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| P. Have you had any charges of unprofessional conduct brought against you? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| Q. Have you had any charges of fraud brought against you? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| R. Have you received any confirmed Quality Citations from a Peer Review Organization (PRO) in the last two (2) years? If you answered yes, on a separate sheet, indicate the address of the PRO that cited you, the circumstances of the citation and the number of points you were fined. | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |

Health Status

Note: Your application will be processed in the usual manner regardless of how you answer questions A and B. If you have answered "No" to question A or B, please explain completely on a separate sheet. If you are found to be qualified, a representative will contact you to determine what accommodations are necessary and feasible to allow you to practice safely.

| | | |
|---|--|--|
| A. Are you physically and mentally able to perform all the essential functions or services necessary to exercise the privileges or services applied for with or without a reasonable accommodation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B. Are you able to perform these functions without significant risk of injury to yourself or others? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C. Do you illegally use drugs? Have you used illegal drugs within the last two years? | <input type="checkbox"/> Yes <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> No |
| D. Do you currently take any medications that may affect your ability to perform the clinical privileges or scope of practice requested competently and safely? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

| | |
|----------------------------|--|
| Health Care Entity: | |
|----------------------------|--|

WEST VIRGINIA PRACTITIONER ATTESTATION/AUTHORIZATION AND RELEASE OF INFORMATION

By submitting this attestation/authorization and release of information form in conjunction with the West Virginia Credentialing Form (WVCF) and/or the West Virginia Practitioner Attestation/Authorization, I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership and/or participating status with the Health Care Entity indicated on the WVCF for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and/or other qualifications.
2. I further understand and acknowledge that the Health Care Entity or designated Agent will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Health Care Entity as part of the verification and credentialing process.
3. I authorize all individuals, institutions, and entities or organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated Health Care Entity(ies), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the requested clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.
5. I attest to the accuracy and completeness of the information provided. I understand and agree that any misstatements in or omissions from the WVCF Attestation/Authorization and attachments hereto may constitute cause for denial of the application or summary dismissal or termination of membership/clinical privileges/participation agreement.
6. I agree to exhaust all available procedures and remedies as outlined by in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Health Care Entity(ies) where I have membership and/or clinical privileges/participation.
7. I understand that completion and submission of the WVCF Attestation/Authorization and Release of Information does not automatically grant me membership or clinical privileges/participating status with the Health Care Entity(ies) indicated on the WVCF or Attestation/Authorization.
8. I further acknowledge that I have read and understand the foregoing Attestation/Authorization and Release of Information. A photocopy of this Attestation/Authorization and Release of Information shall be as effective as the original, and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation/authorization.
9. I release from liability any and all individuals and organizations who provide information to the credentialing entity in good faith and without malice concerning my professional qualifications and competence, and the credentialing entity, from liability for their acts performed and statements made relating but not limited to verifying, evaluating and acting upon my credentials and qualifications.

Print Name Here: _____

Signature: _____

Date: _____

NOTE: Through above signature, I hereby affirm that contents are current, accurate, and complete as of the signature date.

Modification to the wording or format of the WVCF/Attestation/Authorization and Release of Information may invalidate an application.

Credentialing Entity may supplement additional Attestation/Authorization/Release of Information through an additional release document as required by the entity.

The Entities will treat this application and any information secured in connection therewith in strict confidence in accordance with the Entities' policies and/or Medical Staff Bylaws and preserve with all reasonable safeguards the privacy of the Applicant.

ADDENDUM

VERIFICATION OF PROFESSIONAL LIABILITY

I, the undersigned, authorize my CURRENT professional liability insurance carrier,

(Enter Current Professional Liability Insurance Carrier Name)

(Enter Street Address)

(City)

(State & Zip)

to send verification of my professional liability coverage, to include dates of coverage, amounts of coverage, and any limitations in coverage, to _____

(Entity Specific)

_____ is to hereinafter be

(Entity Specific)

a Certificate Holder and is to be notified of the amount of my coverage and any future changes in my insurance status, to include all information regarding claims history (but not necessarily limited to judgments entered, claims settled, cases and lawsuits pending), and any restriction regarding specific privileges which may be excluded from coverage.

I will notify _____ of any

(Entity Specific)

changes in Professional Liability carriers so that another Verification of Professional Liability form can be completed.

Practitioner's Signature

Date

Printed Name

Policy Number

(Instructions: Please complete, sign, date and return to entity named above with your initial application.)