

**The Department of Health and Human Resources
and The West Virginia Insurance Commission
Joint Legislative Rule
Title 64, Series 89**

UNIFORM CREDENTIALING OF HEALTH CARE PRACTITIONERS

TITLE 64, SERIES 89

STATEMENT OF CIRCUMSTANCES

The amendments to this rule will delete the uniform credentialing and recredentialing forms and the list of practitioners subject to uniform credentialing from the legislative rule. At the same time, a procedural rule will be jointly promulgated by the Secretary of the Department of Health and Human Resources and the Insurance Commissioner that will incorporate the forms and list of practitioners. In 2003, legislation was passed which authorized the Secretary and Commissioner to address any changes to the uniform forms and the list of practitioners by procedural, rather than legislative, rule in order to be able to change the forms and list more quickly. When use of the forms was first mandated in July, 2003, it was expected that many comments would be forthcoming from practitioners and credentialing entities about improvements to the forms. Those comments have in fact been made, and the Uniform Credentialing Advisory Committee has considered all of the comments and has made recommendations to the Secretary and Commissioner regarding improvements to the forms, which will be addressed in the new procedural rule. To avoid confusion, the forms and list must now be deleted from the legislative rule.

**Department of Revenue
Agency Questionnaire**

Re: Joint Legislative Rule to be Filed

UNIFORM CREDENTIALING OF HEALTH CARE PRACTITIONERS

TITLE 64, SERIES 89

Question 1: Are regulations required?

Yes. H.B. 3242, passed by the Legislature during its regular 2001 session, required the Secretary of the Department of Health and Human Resources and the West Virginia Insurance Commissioner to jointly propose rules setting forth uniform forms for credentialing and recredentialing health care practitioners, and to designate the practitioners subject to the forms. Those forms were originally part of this legislative rule, however they are being deleted as part of the amendments so that they may be incorporated into a procedural rule being simultaneously promulgated.

Question 2: Is the rule you are proposing controversial? If yes, what are the pros and the cons?

No, the rule is not expected to be controversial.

Question 3: Is the rule you are proposing a copy of another state's rule? A model rule? Custom-drafted?

The rule is custom-drafted.

Question 4: What are the really important things you think the Secretary of Tax and Revenue should know about this rule and the issues that surround it?

Credentialing and recredentialing health care practitioners has traditionally been an entity-specific task, meaning that a practitioner has needed to complete many different applications to submit to each health plan, hospital, or other health care entity with which the practitioner wishes to do business. The legislature addressed this situation during its regular 2001 session when it passed H.B. 3242. In 2003, the Legislature authorized this legislative rule, and also passed a bill allowing amendments to the forms and list of practitioners to be made a part of a procedural rule at such time as they need to be amended. Amendments are now needed, so the forms and list are being deleted from this legislative rule so that they may be promulgated pursuant to procedural rule. This will expedite the amended requirements for the future.

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: FORMS APPLICABLE TO THE UNIFORM CREDENTIALING OF
HEALTH CARE PRACTITIONERS
Title 64, Series 89A

Type of Rule: ___ **Legislative** ___ **Interpretive** xx **Procedural**

Agency: (Jointly proposed rule)
Department of Health and Human Resources
and Insurance Commissioner

Address: Department of Health and Human Resources
Building 3, Room 206
1900 Kanawha Blvd., East
Charleston, WV 25305

Insurance Commissioner
Post Office Box 50540
1124 Smith Street, Greenbrooke Building
Charleston, West Virginia 25305-0540

=====
1. Effect of Proposed Rule

	ANNUAL FISCAL YEAR				
	Increase	Decrease	Current	Next	Thereafter
ESTIMATED TOTAL COST	None	None	None	None	None
PERSONAL SERVICES	None	None	None	None	None
CURRENT EXPENSE	None	None	None	None	None
REPAIRS AND ALTERNATIONS	None	None	None	None	None
EQUIPMENT	None	None	None	None	None
OTHER	None	None	None	None	None

2. Explanation of above estimates:

The rule will have no additional fiscal impact upon state, local or federal government.

3. Objectives of these rules:

The objective of this rule is to simplify the administrative task of Credentialing and recredentialing health care practitioners by incorporating the uniform credentialing and uniform recredentialing forms, and the list of health care practitioners subject to the forms. These forms and list were originally promulgated as part of the legislative rule 64CSR89. That rule is being amended simultaneously to delete the forms and list from that rule. The objective of this rule is to allow amendments of the forms and list as needed without the time associated with amendments to a legislative rule.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of Citizens.


This new procedural rule should have no economic impact on political subdivisions or specific groups of citizens. Health care entities that credential health care practitioners have been using the uniform forms for almost a year, and the amendments to this rule will not create any changes to their credentialing methods.

C. Economic Impact on Citizens/Public at Large.

There will be no further economic impact on health care practitioners or the public at large due to this new procedural rule.

Date: June 16, 2004

Signature of Agency Head or Authorized Representative



Paul Nusbaum, Secretary
Department of Health & Human Resources

**The Department of Health and Human Resources
and The West Virginia Insurance Commission
Joint Legislative Rule
Title 64, Series 89**

UNIFORM CREDENTIALING OF HEALTH CARE PRACTITIONERS

TITLE 64, SERIES 89

SUMMARY OF RULE

The amendments to this rule will delete the uniform credentialing and recredentialing forms and the list of practitioners subject to uniform credentialing from the legislative rule. At the same time, a procedural rule will be jointly promulgated by the Secretary of the Department of Health and Human Resources and the Insurance Commissioner that will incorporate the forms and list of practitioners. Other amendments have been made to the legislative rule as needed to delete references to the forms and list of practitioners as appendices to the rule.

TITLE 64

JOINT LEGISLATIVE RULE

**THE DEPARTMENT OF HEALTH AND HUMAN RESOURCES
and THE WEST VIRGINIA INSURANCE COMMISSION**

SERIES 89

UNIFORM CREDENTIALING OF HEALTH CARE PRACTITIONERS

Section

- 64-89-1. General.
- 64-89-2. Definitions.
- 64-89-3. Mandatory Use of Uniform Credentialing Form and Uniform Recredentialing Form.
- 64-89-4. Amendment of Uniform Credentialing and Recredentialing Forms.
- 64-89-5. Confidentiality of Credentialing and Recredentialing Data.
- 64-89-6. Delegation of Credentialing or Recredentialing Activities.
- 64-89-7. Violation.

~~Appendix A: Uniform Credentialing Form.~~

~~Appendix B: Uniform Recredentialing Form.~~

~~Appendix C: List of Practitioners Who Shall Use the Uniform Forms.~~

TITLE 64

JOINT LEGISLATIVE RULE

THE DEPARTMENT OF HEALTH AND HUMAN RESOURCES
AND THE WEST VIRGINIA INSURANCE COMMISSION

FILED

2004 JUN 16 A 11:51

SERIES 89

WEST VIRGINIA
SECRETARY OF STATE

UNIFORM CREDENTIALING OF HEALTH CARE PRACTITIONERS

§64-89-1. General.

1.1. Scope -- This rule ~~establishes uniform application forms required to be used for credentialing and recredentialing health care practitioners and specifies the health care practitioners who must use the forms.~~ establishes requirements relating to the use of uniform credentialing and recredentialing forms in this State. The W. Va. Code is available in public libraries and on the Legislature's web page, <http://www.legis.state.wv.us/>.

1.2. Authority . -- W. Va. Code §§16-1A-2 et seq., 16-1-4 and 33-2-10.

1.3. Filing Date. -- ~~April 4, 2003.~~

1.4. Effective Date. -- ~~July 1, 2003.~~

1.5. This is a joint rule of the Department of Health and Human Resources and the West Virginia Insurance Commission.

§64-89-2. Application.

2.1. Except as otherwise provided, this rule applies to all hospitals, insurers, managed care organizations, third party administrators, other health care entities that credential health care practitioners in this state and all health care practitioners ~~listed in Appendix 64-89 C of this rule designated by the secretary and commissioner.~~

§64-89-3. Definitions.

3.1. "Commissioner" means the commissioner of insurance.

3.2. "Committee" means the uniform credentialing advisory committee established pursuant to W. Va. Code §16-1A-3.

3.3. "Credentialing" means the process of assessing and validating the qualifications of a health care practitioner, including but not limited to, an evaluation of licensure status, education, training, experience, competence and professional judgment.

3.4. "Health Care Entity" means any of the following that require the submission of credentials data:

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3.4.a. A clinic or other health care facility or organization licensed or certified to provide medical or health care services in this state;

3.4.b. A hospital;

3.4.c. A managed care organization;

3.4.d. A third party administrator;

3.4.e. An insurer;

3.4.f. A certified verification organization or any other entity to whom the duties of credentialing or recredentialing have been delegated by another health care entity; and

3.4.g. Any other organization that contracts with health care practitioners for health care services and, in the course of its operations, requires practitioners to provide credentialing information.

3.5. "Health Care Practitioner" means a health care provider who is licensed, certified, or otherwise authorized to provide health care services, as designated in ~~Appendix 64-89 C of this rule~~ by the secretary and commissioner to be subject to the uniform credentialing and recredentialing forms.

3.6. "Recredentialing" means the process by which a hospital, insurer, managed care organization, third party administrator or other health care entity ensures that a health care practitioner who is currently credentialed continues to meet the health care entity's credentialing criteria.

3.7. "Secretary" means the secretary of the department of health and human resources.

3.8. "Uniform Credentialing Form" means the form developed by the committee to collect the credentials data commonly requested by health care entities for purposes of credentialing.

3.9. "Uniform Recredentialing Form" means the form developed by the committee to collect the credentials data commonly requested by health care entities for purposes of recredentialing.

§64-89-4. Mandatory Use of Uniform Credentialing Form and Uniform Recredentialing Form.

4.1. Beginning July 1, 2003, all health care entities shall use the uniform credentialing form ~~provided in Appendix 64-89 A of this rule~~ developed by the committee for credentialing health care practitioners and the uniform recredentialing form ~~provided in Appendix 64-89 B of this rule~~ developed by the committee for recredentialing health care practitioners. No health care entity may require any health care practitioner credentialed by that health care entity prior to July 1, 2003 to reapply using these forms until the date on which the health care practitioner would otherwise be required to reapply or provide updated credentialing information.

4.2. ~~Those~~ The health care practitioners who are required to use the uniform credentialing and uniform recredentialing forms are ~~set forth in Appendix 64-89 C of this rule~~ those designated by the secretary and commissioner.

4.3. Once the health care practitioner has completed the uniform credentialing and/or uniform recredentialing forms, he or she may duplicate the forms as necessary for submission to multiple health care entities accompanied by the following:

4.3.a. An affirmation or attestation page that bears an original signature and date and that verifies the accuracy of the information on the form as of the date it is signed; and

4.3.b. An original signed authorization to release information to the health care entity relating to the professional qualifications, ethical standing, competence, and mental and physical health of the health care practitioner.

4.4. A health care entity may request information in addition to the information provided in the uniform credentialing or uniform recredentialing forms. A request for additional information may not require repetition of the information required in, or substitute another form for, the uniform credentialing or uniform recredentialing forms. Additional information shall be requested by the health care entity on supplemental sheets attached to the uniform forms.

4.5. When the uniform credentialing form or uniform recredentialing form is amended as provided in Section 5 of this rule, all health care entities shall use the amended uniform forms to credential or recredential health care practitioners.

§64-89-5. Amendment of Uniform Credentialing and Uniform Recredentialing Forms.

5.1. The secretary and the commissioner shall reconvene the committee at least annually to review and recommend any necessary amendments to the uniform credentialing form, the uniform recredentialing form or the list of health care practitioners who must use the uniform forms.

5.2. The secretary and the commissioner may, upon recommendation by the committee, jointly propose amendments to the uniform credentialing form, the uniform recredentialing form or the list of health care practitioners.

§64-89-6. Confidentiality of Credentialing and Recredentialing Data.

6.1. Any credentials data collected or obtained by a health care entity during the credentialing or recredentialing process shall constitute confidential peer review information, as provided by W. Va. Code §30-3C-3, and shall not be disclosed by the health care entity except as provided by law.

§64-89-7. Delegation of Credentialing or Recredentialing Activities.

7.1. Nothing in this rule may be construed to prohibit a health care entity from delegating credentialing or recredentialing activities to another entity, such as a certified verification organization, as long as the entity to whom the activities have been delegated follows the requirements of this rule.

§64-89-8. Violation.

8.1. Complaints and allegations of violations of this rule can be filed with either the secretary or the commissioner. If the agency to whom the complaint is addressed determines it to be more appropriate for the other agency to process it, then the secretary or the commissioner may refer it to the other agency for processing.

8.2. Notwithstanding any penalty provisions set forth in W. Va. Code §§ 16-1-18 or 33-3-11, any health care entity that violates the provisions of this rule shall be subject to the following:

8.2.a. An award of actual damages established by the health care practitioner, payable to that health care practitioner; and/or

8.2.b. An administrative penalty, payable to the either the Department of Health and Human Resources or the Commissioner, whichever receives the complaint or pursues the action, but not both, in an amount of not less than five hundred (500) dollars and not more than five thousand (5,000) dollars.

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
_____	<input type="checkbox"/> Male <input type="checkbox"/> Female		_____	_____
Other Name(s) Also Known By				
Name(s):	Name:			
Date/Time Used	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 checked="" 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No		(---)
Language(s) Spoken (Other than English)				

State of West Virginia Credentialing Form: Misrepresentations 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.)

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"/> <input type="checkbox"/> Primary Office Site #1 <input type="checkbox"/>						<input type="checkbox"/> <input type="checkbox"/> Additional Office Site #					
Group/Practice Name											
Type of Practice			<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Corporation			<input type="checkbox"/> Hospital Based <input type="checkbox"/> Partnership <input type="checkbox"/> Teaching or Research <input type="checkbox"/> Other (specify): <input type="checkbox"/>					
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"/> By referral only		<input type="checkbox"/> No		<input type="checkbox"/> NA		Yes <input type="checkbox"/>		No <input type="checkbox"/>		NA <input type="checkbox"/>	
						If Yes, please list					
Handicap Accessible?						Public Transit Available?					
<input type="checkbox"/> Yes		<input type="checkbox"/> No		NA <input type="checkbox"/>		<input type="checkbox"/> Yes		<input type="checkbox"/> No		NA <input type="checkbox"/>	
Does the office have other services available for disabled? (FFY, ASI, Mental/physical impairments, etc.)						If yes, list below what services are available					
<input type="checkbox"/> Yes		<input type="checkbox"/> No		NA <input type="checkbox"/>							
Office Manager's Name						Nurse Manager's Name					
<input type="checkbox"/>		<input type="checkbox"/>		NA <input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		NA <input type="checkbox"/>	
<input type="checkbox"/> Check if not applicable						Office Hours					
						Check if practitioner is not available to see patient during hours indicated					
Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	

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State of West Virginia Credentialing Form: Misrepresentations 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.)

AM AM PM PM	AM PM	AM PM	AM PM	AM PM	AM PM	
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Services Provided (Please check below if these services are available)			
<input type="checkbox"/> Lab Services On-Site	Reference Lab Name:	CLIA Number and Type of Certification:	
<input checked="" type="checkbox"/> Radiology Services	<input type="checkbox"/> Sigmoidoscopy	<input checked="" type="checkbox"/> Audiology Services	<input type="checkbox"/> Treadmill
<input checked="" type="checkbox"/> Other (Please list):			
<input checked="" type="checkbox"/> List any special diagnostic or treatment procedures performed in your office:			
Patient Population			
Do you limit the age of patients you treat?		If yes, what ages do you treat?	
<input checked="" 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?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Group/Practice Name (Check Payable to):			
Address (Building, Street, Suite #)	City	State	Zip Code
Billing Office Phone Number		Billing Manager's Name	
<input type="checkbox"/>			
Tax ID Number (must watch W-9)		Name affiliated with Tax ID Number (must watch 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 checked="" 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 checked="" 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 providers 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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State of West Virginia Credentialing Form: Misrepresentations 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.)

Please indicate, in preference order, how you wish to be listed in the directory.

Primary Specialty:	Secondary Specialty:
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State of West Virginia Credentialing Form: Misrepresentations 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.)

After-Hours Coverage			
Do you provide 24-hour coverage?		Describe Coverage	
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	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 checked="" type="checkbox"/> No	NA	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No NA
List below other after-hours arrangements or special instructions to patients for after-hours care needs:			
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 checked="" type="checkbox"/> No	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.			
Physician's Assistant:		Nurse Practitioner:	
Nurse Midwife:		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:	a. _____ Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an attitude consistent with work philosophy? _____	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
	b. _____ Modified or alternative duty is actively evaluated for each Workers' Compensation claimant. _____	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
	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"/> Yes	<input checked="" type="checkbox"/> No
	d. _____ Staff are available and willing to provide compensation representatives information regarding a claimant's care. _____	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

State of West Virginia Credentialing Form: Misrepresentations 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.)

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"/>	<input type="checkbox"/> Residency
	<input type="checkbox"/> Fellowship	<input type="checkbox"/>	<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?	
From:	To:	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> If no, explain:
Your Program Director's Name		Current Program Director's Name (if known)	

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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?		
From:	To:	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	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?		
From:	To:	<input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If no, explain:
Your Program Director's Name			Current Program Director's Name (if known)		

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Training Institution		Program	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Internship <input type="checkbox"/> Fellowship <input type="checkbox"/> Other: _____	Residency _____ 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 <input type="checkbox"/> If no, explain: _____
Your Program Director's Name		Current Program Director's Name (if known)	

5. State License(s): List all current and past professional licenses (Submit copy of current licenses)

State	License #	Issue Date	Expiration Date	States is/was license restricted? (Please check)	Reason License is/was Inactive or Restricted
			<input type="checkbox"/> <input type="checkbox"/>	Active <input type="checkbox"/> Inactive <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
			<input type="checkbox"/> <input type="checkbox"/>	Active <input type="checkbox"/> Inactive <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
			<input type="checkbox"/> <input type="checkbox"/>	Active <input type="checkbox"/> Inactive <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
			<input type="checkbox"/> <input type="checkbox"/>	Active <input type="checkbox"/> Inactive <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
			<input type="checkbox"/> <input type="checkbox"/>	Active <input type="checkbox"/> Inactive <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Does the scope of your practice require the supervision of another practitioner? Yes 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 <input type="checkbox"/> If no, explain: _____

State of West Virginia Credentialing Form: Misrepresentations 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.)

State DEA or CDS Certificate(s)						
<input type="checkbox"/> 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 Provider (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.						
<input type="checkbox"/>	Check here if entire section is not applicable to applicant.					
Are you board certified?	Yes	No	(If yes, list below)			
	<input type="checkbox"/>	<input type="checkbox"/>				
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:			<input type="checkbox"/>	Failed to pass specialty board examination		
			How many times have you taken the exam but failed to pass?			
			Last date(s) exam was taken: _____			
			<input type="checkbox"/>	Date(s) board examination was taken/retaken and date board exam is scheduled, if applicable:		
			<input type="checkbox"/>	Date(s) taken/retaken		
			<input type="checkbox"/>	Date scheduled, if applicable		
<input type="checkbox"/>	Not eligible to take specialty boards					
<input type="checkbox"/>	Not planning to take specialty boards					
<input type="checkbox"/>	Admissible with exam pending					

State of West Virginia Credentialing Form: Misrepresentations 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.)

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.)				

State of West Virginia Credentialing Form: Misrepresentations 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.)

9. Hospital/Facility 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 Affiliation		
Street Address		City	State	Zip
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"/>	If Yes, explain:	From:	To:	
Reason for leaving, if applicable				
Name of Affiliation/Hospital/Healthcare Entity		Type of Affiliation		
Street Address		City	State	
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"/>	If Yes, explain:	From:	To:	
Reason for leaving, if applicable				
Name of Affiliation/Hospital/Healthcare Entity		Type of Affiliation		
Street Address		City	State	
Department/Service		Department Chair's Name		
Staff Status		#Admits/Month	Percent of time spent at facility	

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Restricted?		Dates of Affiliation (Mo/Yr)	
<input type="checkbox"/> Yes, explain:		From:	To:
Reason for leaving, if applicable			
9. Additional Affiliations:			
(Photocopy this page for additional affiliations)			
Name of Affiliation/Hospital/Healthcare Entity		Type of Affiliation	
Street Address		City	State
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, explain:		From:	To:
Reason for leaving, if applicable			
Name of Affiliation/Hospital/Healthcare Entity		Type of Affiliation	
Street Address		City	State
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, explain:		From:	To:
Reason for leaving, if applicable			
Name of Affiliation/Hospital/Healthcare Entity		Type of Affiliation	
Street Address		City	State

State of West Virginia Credentialing Form: Misrepresentations 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.)

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, explain:	From:	To:	
Reason for leaving, if applicable			
Name of Affiliation/Hospital/Healthcare Entity		Type of Affiliation	
Street Address		City	State
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, explain:	From:	To:	
Reason for leaving, if applicable			
Name of Affiliation/Hospital/Healthcare Entity		Type of Affiliation	
Street Address		City	State
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			
Name of Affiliation/Hospital/Healthcare Entity		Type of Affiliation	

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Street Address		City	State	Zip
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, 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
Phone Number		Fax Number (if known)		
()		()		
Dates of Employment		Reason for leaving, if applicable		
From:	To:			
Practice/Employer		Contact Name		
Street Address		City	State	Zip
Phone Number		Fax Number (if known)		
()		()		
Dates of Employment		Reason for leaving, if applicable		
From:	To:			
Practice/Employer		Contact Name		
Street Address		City	State	Zip
Phone Number		Fax Number (if known)		
()		()		

State of West Virginia Credentialing Form: Misrepresentations 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.)

Dates of Employment		Reason for leaving, if applicable		
From:	To:			
Practice/Employer		Contact Name		
Street Address		City	State	Zip
Phone Number		Fax Number (if known)		
()		()		
Dates of Employment		Reason for leaving, if applicable		
From:	To:			

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/Facility 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: To:	
Professional Training	From: To:	
	From: To:	
Hospital/Facility Affiliations	From: To:	
	From: To:	
Work History/Experience	From: To:	
	From: To:	

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From:		
To:		

12. Continuing Education Requirements

— — Check here if entire section is not applicable to applicant.

A. Have you completed the continuing education hours as required by your State Licensing Board during the past two (2) years <u>OR</u> the required CME/CEU hours (if applicable) from the State licensing board in which you are currently practicing?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
---	------------------------------	-----------------------------

B. Attach certificates (if required by Credentialing Entity) for the CME/CEU sessions you have completed in last two (2) years.

13. Professional Associations/Organizations

————— List the associations/organizations related to your profession in which you are a member. Please include dates of affiliations. Include faculty appointments.

Professional Association/Organization	Dates of Affiliation	
From:	To:	
Professional Association/Organization	Dates of Affiliation	
From:	To:	
Professional Association/Organization	Dates of Affiliation	
From:	To:	
Professional Association/Organization	Dates of Affiliation	
From:	To:	
Professional Association/Organization	Dates of Affiliation	
From:	To:	

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

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Policy Number	Expiration Date	Amount of Coverage	If Umbrella/Excess coverage, amount of coverage
	\$ _____ \$ _____	million/occurrence million/aggregate	\$ _____
Years with Carrier	Type of Coverage		Do you have prior acts coverage?
<input type="checkbox"/>	<input type="checkbox"/> Claims Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> No	<input checked="" 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 <input type="checkbox"/>
B. Have you ever been denied professional liability insurance coverage?	<input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
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 <input type="checkbox"/>
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 <input type="checkbox"/>
E. Have any restrictions ever been placed on your professional liability insurance coverage?	<input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
F. Have you ever practiced without professional liability coverage?	<input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
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 <input type="checkbox"/>

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Professional Liability Information Addendum

(Photocopy this form for each case/action)

Please supply the following information for:

~~_____~~ Each professional liability action you have had taken against you, including those pending.

~~_____~~ Each settlement, or decision for the plaintiff that has ever occurred on our behalf.

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.

~~_____ []~~ Check here if entire section is not applicable to applicant.

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"/> Settled <input type="checkbox"/> Out of Court <input type="checkbox"/> Under Appeal <input type="checkbox"/> Found for Defendant <input type="checkbox"/> Pending <input type="checkbox"/> Dismissed Without Payment <input type="checkbox"/> Found for Plaintiff
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?	[] N/A
12. What were you alleged to have done incorrectly or failed to do?	[] N/A
13. Describe the patient's illness and related effects of the alleged harm.	[] N/A
14. Describe any other details you believe are pertinent to the case.	[] N/A
15. Identify any other parties named in the suit.	[] N/A
Signature	Date

State of West Virginia Credentialing Form: Misrepresentations 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.)

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 <input type="checkbox"/>	
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 <input type="checkbox"/>	
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 <input type="checkbox"/>	
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 <input type="checkbox"/>
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 <input type="checkbox"/>	
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 <input type="checkbox"/>
G.	Have you ever been discharged or asked to resign from any position for any reason? <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
H.	Have you ever resigned or retired from a position after being notified you would be disciplined or after questions about your clinical competence were raised? <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
I.	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 <input type="checkbox"/>
J.	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 facility? <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
K.	Have you ever been denied membership or renewal, or been reprimanded, censured, suspended, revoked, placed on probation, or otherwise sanctioned by an health care organization, including but not limited to, hospitals, HMOs, PPOs, IPAs, PHOs, professional associations or societies, professional standards review organizations or peer review organizations, or any other health care facilities, based on professional competence? <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
L.	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 facility 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 facility? <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
M.	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 facility? <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
N.	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 facility? <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	

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State of West Virginia Credentialing Form: Misrepresentations 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.)

<p>Ø. 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 facility, or branch of the armed forces? <input type="checkbox"/></p>	<p>No <input checked="" type="checkbox"/></p>	<p>Yes <input type="checkbox"/></p>	
---	---	-------------------------------------	--

<p>P. 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"/></p>	<p>No <input type="checkbox"/></p>	<p>Yes <input type="checkbox"/></p>	
--	------------------------------------	-------------------------------------	--

<p>Q. 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"/></p>	<p>No <input type="checkbox"/></p>	<p>Yes <input type="checkbox"/></p>	
---	------------------------------------	-------------------------------------	--

<p>R. Have you had any charges of unprofessional conduct brought against you? <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>	<p>Yes <input type="checkbox"/></p>	
--	------------------------------------	-------------------------------------	--

<p>S. Have you had any charges of fraud brought against you? <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>	<p>Yes <input type="checkbox"/></p>	
---	------------------------------------	-------------------------------------	--

<p>T. 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"/></p>	<p>No <input type="checkbox"/></p>	<p>Yes <input type="checkbox"/></p>	
--	------------------------------------	-------------------------------------	--

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.

<p>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"/></p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
---	-------------------------------------	------------------------------------

<p>B. Are you able to perform these functions without significant risk of injury to yourself or others? <input type="checkbox"/></p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
--	-------------------------------------	------------------------------------

<p>C. Do you presently have a physical or mental health condition, including alcohol or drug dependence that affects, or is reasonably likely to affect your ability to perform professional or medical staff duties appropriately? If yes, give a full explanation of the details on a separate sheet. <input type="checkbox"/></p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
--	-------------------------------------	------------------------------------

<p>D. Do you currently take any medication that may affect either your clinical judgment or motor skills? If yes, give a full explanation of the details on a separate sheet. <input type="checkbox"/></p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
--	-------------------------------------	------------------------------------

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Health Care Entity: _____

**WEST VIRGINIA PRACTITIONER
AUTHORIZATION AND RELEASE OF INFORMATION**

By submitting this authorization and release of information form in conjunction with the West Virginia Credentialing Form (WVCF) and/or the West Virginia Practitioner Attestation, 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 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.~~
8. ~~I further acknowledge that I have read and understand the foregoing Authorization and Release of Information. A photocopy of this 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.~~

Print Name Here: _____

Signature: _____ Date: _____

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

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

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State of West Virginia Credentialing Form: Misrepresentations 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.)

~~Credentialing Entity may supplement additional 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.~~

State of West Virginia Credentialing Form: Misrepresentations 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.)

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)

(Entity Specific) is to hereinafter be

a Certificate Holder and is to be notified of the amount of my coverage and any future changes in my insurance status.

I will notify _____ of any changes in
(Entity Specific)

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

Physician's Signature _____ Date

Printed Name

Policy Number

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

State of West Virginia Recredentialing Form

Please complete each section thoroughly. Information submitted on the application should be representative of activity/information that occurred or changed on or after the Date of Last Credentialing listed below.

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.

Date of Last Credentialing (may be obtained from Entity if not provided)	
Provider's Name	Date
Social Security Number	Date of Birth
Credentialing Entity Name	
YOU MUST INCLUDE THE FOLLOWING WITH THIS COMPLETED APPLICATION <i>(Use this checklist as a guide)</i>	
<input type="checkbox"/>	Copy of current State License(s)
<input type="checkbox"/>	Copy of current DEA Registration (if applicable)
<input type="checkbox"/>	Copy of current State Controlled Dangerous Substance (CDS) Certificate (if applicable)
<input type="checkbox"/>	Copy of current professional liability insurance policy face sheet, showing expiration dates, limits, and provider's name
<input type="checkbox"/>	Copy of Board Certification Certificate(s) (if applicable), or other National Certification Certificates (if changed since date of last credentialing)
<input type="checkbox"/>	Copies of CME/CEU session certificates (if required by Credentialing Entity)
<input type="checkbox"/>	Signature requirements per each entity
CREDENTIALING ENTITIES MAY SUPPLEMENT THIS CHECKLIST OF REQUIRED ITEMS AS NEEDED TO MEET CREDENTIALING REQUIREMENTS.	

State of West Virginia *Recredentialing Form*

Responses must be legible. Any responses, 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 (Entire section must be completed)									
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)									
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:					
Current Home Address			City		State	Zip Code			
Home Telephone			Is this # unlisted?		Home Fax				
() —			<input type="checkbox"/> Yes <input type="checkbox"/> No		() —				
If citizenship status or VISA status has changed, please indicate below and attach an explanation as well as pertinent documentation:									
<input type="checkbox"/>			Citizenship/VISA status has changed:						
Language(s) Spoken (other than English)									

State of West Virginia Recredentialing 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 in a separate sheet and attach.)

2. Office Practice Information: (Complete only for information changed since last date of credentialing)						
_____ []		Check if entire section unchanged since last date of credentialing				
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.)						
_____ []		Primary Office Site #1		_____ [] Additional Office Site #2		
Group/Practice Name						
Type of Practice		_____ [] _____ [] _____ []		Individual Partnership _____ [] Gr_____ [] ou_____ [] p_____ [] - _____ [] Corporation		Hospital Based Teaching or Research 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?			
By ref only _____ [] No _____ [] NA _____ []			Yes _____ [] No _____ [] NA If yes, explain: _____			
Handicap Accessible?			Public Transit Available?			
_____ [] Yes _____ [] No _____ [] NA _____ []			Yes _____ [] No _____ [] NA _____ []			
Does the office have other services available for disabled? (TTY, ASL, Mental/physical impairments, etc.)			If yes, list below what services are available			
_____ [] Yes _____ [] No _____ [] NA _____ []			_____			
Office Manager's Name			Nurse Manager's Name			
_____ [] - NA			_____ [] - NA			
Office Hours		Check if not applicable _____ []		Check if practitioner is not available to see patient during hours indicated		
Monday	Tuesday	Wednesday		Thursday	Friday	Saturday
AM PM	AM PM	AM PM		AM PM	AM PM	AM PM
Services Provided (Please check below if these services are available)						
_____ [] Lab Services		On-Site Reference Lab Name:			CLIA Number and Type of Certification:	
_____ [] Radiology Services		EKG _____ []		Sigmoidoscopy/Radiology Services _____ []		Treadmill _____ []
_____ [] Other (Please list):						

List any special diagnostic or treatment procedures performed in your office:

State of West Virginia Recredentialing 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 in a separate sheet and attach.)

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"/>	<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"/>	<input type="checkbox"/> No
Group/Practice Name (Check Payable To):			
Address (Building, Street, Suite #)		City	State
			Zip
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 providers 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	<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"/> Yes <input type="checkbox"/> No	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"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
List below other after-hours arrangements or special instructions to patients for after-hours care needs:			

State of West Virginia Recredentialing 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 in a separate sheet and attach.)

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"/> N/A	

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:	Other (specify):

Workers' Compensation Information			
Do you accept Workers' Compensation Patients? <input type="checkbox"/>		Yes	No
If yes, please provide the following information:			
<input type="checkbox"/>	Yes <input type="checkbox"/>	No	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? b. Modified or alternative duty is actively evaluated for each Workers' Compensation claimant. 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. d. Staff are available and willing to provide compensation representatives information regarding a claimant's care.
<input type="checkbox"/>	Yes <input type="checkbox"/>	No	
<input type="checkbox"/>	Yes <input type="checkbox"/>	No	
<input type="checkbox"/>	Yes <input type="checkbox"/>	No	

State of West Virginia Recredentialing 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 in a separate sheet and attach.)

7. Specialty Board Certification: Complete for information changed SINCE DATE OF LAST CREDENTIALING. Submit copies of board certifications and/or qualification confirmation letter:																														
<input type="checkbox"/> Check here if entire section is not applicable to applicant or if no changes since last credentialing date.																														
Are you board certified? Yes <input type="checkbox"/> No <input type="checkbox"/> (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 <input type="checkbox"/> No <input type="checkbox"/>																														
If not certified, please indicate your status in the certifying process:	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%; text-align: center;"><input type="checkbox"/></td> <td style="padding-left: 10px;">Failed to pass specialty board examination</td> <td style="width:10%;"></td> </tr> <tr> <td></td> <td style="padding-left: 10px;">● How many times have you taken the exam but failed to pass? _____</td> <td></td> </tr> <tr> <td></td> <td style="padding-left: 10px;">● Last date(s) exam was taken: _____</td> <td></td> </tr> <tr> <td></td> <td style="padding-left: 10px;">Date(s) board examination was taken/retaken and date board exam is scheduled, if applicable: _____</td> <td></td> </tr> <tr> <td></td> <td style="padding-left: 10px;">● Date(s) taken/retaken: _____</td> <td></td> </tr> <tr> <td></td> <td style="padding-left: 10px;">● Date scheduled, if applicable: _____</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding-left: 10px;">Not eligible to take specialty boards</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding-left: 10px;">Not planning to take specialty boards</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding-left: 10px;">Admissible with exam pending</td> <td></td> </tr> </table>			<input type="checkbox"/>	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: _____		<input type="checkbox"/>	Not eligible to take specialty boards		<input type="checkbox"/>	Not planning to take specialty boards		<input type="checkbox"/>	Admissible with exam pending	
<input type="checkbox"/>	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: _____																													
<input type="checkbox"/>	Not eligible to take specialty boards																													
<input type="checkbox"/>	Not planning to take specialty boards																													
<input type="checkbox"/>	Admissible with exam pending																													

NOTE: Section 8 (Professional Peer References) has been intentionally omitted.

State of West Virginia Recredentialing 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 in a separate sheet and attach.)

9. Hospital/Facility Affiliations:

Check here if entire section is not applicable to applicant.

List ALL health care facilities at which you currently have privileges or have had privileges SINCE DATE OF LAST CREDENTIALING. Explain gaps greater than three (3) months during the period in Section 11.

Name of Current Primary Hospital Affiliation		Type of Affiliation		
Street Address		City	State	Zip
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/If yes, explain	For: —	From:	
Reason for leaving, if applicable				
Name of Affiliation/Hospital/Healthcare Entity		Type of Affiliation		
Street Address		City	State	Zip
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/If yes, explain	For: —	From:	
Reason for leaving, if applicable				
Name of Affiliation/Hospital/Healthcare Entity		Type of Affiliation		
Street Address		City	State	Zip
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/If yes, explain	For: —	From:	
Reason for leaving, if applicable				

Reason for leaving, if applicable

State of West Virginia Recredentialing 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 in a separate sheet and attach.)

9- Additional Affiliations:

(Photocopy this page for additional affiliations)

Name of Affiliation/Hospital/Healthcare Entity	Type of Affiliation		
Street Address	City	State	Zip
Department/Service	Department Chair's Name		
Staff Status	# Admits/Month	Percent of time spent at facility	
Restricted?	Dates of Affiliation (Mo/Yr)		

[] No Yes, explain: _____ To: _____ From: _____

Reason for leaving, if applicable

Name of Affiliation/Hospital/Healthcare Entity	Type of Affiliation		
Street Address	City	State	Zip
Department/Service	Department Chair's Name		
Staff Status	# Admits/Month	Percent of time spent at facility	
Restricted?	Dates of Affiliation (Mo/Yr)		

[] No Yes, explain: _____ To: _____ From: _____

Reason for leaving, if applicable

Name of Affiliation/Hospital/Healthcare Entity	Type of Affiliation		
Street Address	City	State	Zip
Department/Service	Department Chair's Name		
Staff Status	#Admits/Month	Percent of time spent at facility	
Restricted?	Dates of Affiliation (Mo/Yr)		

[] No Yes, explain: _____ To: _____ From: _____

Reason for leaving, if applicable

State of West Virginia Recredentialing 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 in a separate sheet and attach.)

10. Work History/Experience:

List in Chronological order (beginning with current) all current and previous professional work history SINCE THE LAST CREDENTIALING DATE, 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
Phone Number	Fax Number (if known)		
()	()		
Dates of Employment	Reason for leaving, if applicable		
From: To:			
Practice/Employer	Contact Name		
Street Address	City	State	Zip
Phone Number	Fax Number (if known)		
()	()		
Dates of Employment	Reason for leaving, if applicable		
From: To:			
Practice/Employer	Contact Name		
Street Address	City	State	Zip
Phone Number	Fax Number (if known)		
()	()		
Dates of Employment	Reason for leaving, if applicable		
From: To:			
Practice/Employer	Contact Name		
Street Address	City	State	Zip
Phone Number	Fax Number (if known)		
()	()		
Dates of Employment	Reason for leaving, if applicable		
From: To:			

State of West Virginia Recredentialing 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 in a separate sheet and attach.)

11. Time Gaps

Provide information for all time frames of three (3) months or more SINCE LAST CREDENTIALING DATE that are not covered in Hospital/Facility Affiliations and/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
Hospital/Facility Affiliation	From: To:	
	From: To:	
	From: To:	
Work History/Experience	From: To:	
	From: To:	
	From: To:	

12. Continuing Education Requirements

Check here if entire section is not applicable to applicant.

A. Have you completed the continuing education hours as required by your State Licensing Board during the past two (2) years OR the required CME/CEU hours (if applicable) from the State licensing board in which you are currently practicing? Yes No

B. Attach certificates (if required by Credentialing Entity) for the CME/CEU sessions you completed in the last two (2) years.

13. Professional Associations/Organizations (optional for recredentialing)

List the associations/organizations related to your profession in which you are a member. Please include dates of affiliations. Include faculty appointments.

Professional Association/Organization	Dates of Affiliation
From:	To:
Professional Association/Organization	Dates of Affiliation
From:	To:
Professional Association/Organization	Dates of Affiliation
From:	To:
Professional Association/Organization	Dates of Affiliation
From:	To:
Professional Association/Organization	Dates of Affiliation
From:	To:

State of West Virginia Recredentialing 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 in a separate sheet and attach.)

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 SINCE THE LAST CREDENTIALING DATE beginning with most current. (If additional space is needed, please photocopy this page and attach.)			
Current Insurance Carrier		Telephone Number	
		()	
Address		City	State Zip
Policy Number	Expiration Date	Amount of Coverage	If Umbrella/Excess coverage, amount of coverage
		\$ million/occurrence \$ million/aggregate	— \$
Years with Carrier	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
Policy Number	Expiration Date	Amount of Coverage	If Umbrella/Excess coverage, amount of coverage
		\$ million/occurrence \$ million/aggregate	— \$
Years with Carrier	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
Policy Number	Expiration Date	Amount of Coverage	If Umbrella/Excess coverage, amount of coverage
		\$ million/occurrence \$ million/aggregate	— \$
Years with Carrier	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
Policy Number	Expiration Date	Amount of Coverage	If Umbrella/Excess coverage, amount of coverage
		\$ million/occurrence \$ million/aggregate	— \$
Years with Carrier	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
Policy Number	Expiration Date	Amount of Coverage	If Umbrella/Excess coverage, amount of coverage
		\$ million/occurrence \$ million/aggregate	— \$

Years with Carrier	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

State of West Virginia Recredentialing 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 in a separate sheet and attach.

15. Professional Liability Insurance Coverage Disclosure: (Respond only for actions since date of last credentialing.)		
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"/> 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?	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"/> Yes	
E. Have any restrictions ever been placed on your professional liability insurance coverage?	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

State of West Virginia Recredentialing 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 in a separate sheet and attach

**Professional Liability Information Addendum
(Photocopy this form for each case/action)**

Please supply the following information for:

- Each professional liability action you have had taken against you, with any actions or change of status SINCE LAST DATE OF CREDENTIALING, including those pending.
- Each settlement, or decision for the plaintiff that has occurred on your behalf SINCE LAST DATE OF CREDENTIALING.

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.

Check here if entire section is not applicable to applicant or if no changes since last credentialing date.

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"/> Dropped	<input type="checkbox"/>	Found for Defendant
<input type="checkbox"/> Co-Defendant	<input type="checkbox"/> Pending	<input type="checkbox"/>	Dismissed Without Payment
<input type="checkbox"/> Other, please explain:	<input type="checkbox"/> Settled Out of Court	<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	

Signature	Date

State of West Virginia Recredentialing 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 in a separate sheet and attach

16. Practice Disclosure Information: (Complete based upon activity SINCE LAST DATE OF CREDENTIALING

If the answer to any question below is yes, please provide a full explanation of the details on a separate sheet and attach.

<p>A. Have any investigations been initiated or any pending against you by any state licensure board, registration board, or regulatory agency?</p>	No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>		
<p>B. Has your license to practice in any state ever been voluntarily or involuntarily relinquished, restricted, reduced, limited, suspended, placed on probation, revoked, or subject to any disciplinary action including reprimand?</p>	No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>		
<p>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)?</p>	No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>		
<p>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?</p>	No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>	NA	
<p>E. Have you ever been convicted of or pled no contest to any criminal (felony or misdemeanor) charge 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?</p>	No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>		
<p>F. Have you ever had an academic appointment denied, limited, revoked, suspended, reduced, placed on probation, not renewed, or other adverse action taken?</p>	No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>	NA	
<p>G. Have you ever been discharged or asked to resign from any position for any reason?</p>	No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>		
<p>H. Have you ever resigned or retired from a position after being notified you would be disciplined or after questions about your clinical competence were raised?</p>	No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>		
<p>I. 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?</p>	No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>	NA	
<p>J. 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 subject to probationary conditions or limited at any hospital, managed care organization or other health care facility?</p>	No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>		
<p>K. 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?</p>	No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>		

<p>L. 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 facility 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 facility?</p>	<p>Yes <input type="checkbox"/></p>		
<p>M. 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 facility?</p>	<p>Yes <input type="checkbox"/></p>		

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<p>N. 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 facility?</p>	<p>No <input type="checkbox"/> Yes <input type="checkbox"/></p>		
<p>O. Has any investigation (other than normal performance improvement reviews) involving your clinical practice, competence or professional conduct ever been initiated by an hospital, managed care organization, governmental agency, other health facility, or branch of the armed forces?</p>	<p>Yes <input type="checkbox"/></p>		
<p>P. 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?</p>	<p>Yes <input type="checkbox"/></p>		
<p>Q. Do you have any knowledge of any civil actions pending against you by any hospital, law enforcement agency, professional group or society?</p>	<p>Yes <input type="checkbox"/></p>		
<p>R. Have you had any charges of unprofessional conduct brought against you?</p>	<p>No <input type="checkbox"/> Yes <input type="checkbox"/></p>		
<p>S. Have you had any charges of fraud brought against you?</p>	<p>No <input type="checkbox"/> Yes <input type="checkbox"/></p>		
<p>T. 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.</p>	<p>Yes <input type="checkbox"/></p>		

<p>Health Status</p>		
<p>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.</p>		
<p>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?</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p>B. Are you able to perform these functions without significant risk of injury to yourself or others</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>

C. Do you presently have a physical or mental health condition, including alcohol or drug dependence, that affects, or is reasonably likely to affect your ability to perform professional or medical staff duties appropriately? If yes, give a full explanation of the details on a separate sheet.	Yes <input type="checkbox"/>	No
D. Do you currently take any medication that may affect either your clinical judgment or motor skills? If yes, give a full explanation of the details on a separate sheet.	Yes <input type="checkbox"/>	No

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Health Care Entity	
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~~WEST VIRGINIA PRACTITIONER AUTHORIZATION AND RELEASE OF INFORMATION~~

By submitting this authorization and release of information form in conjunction with the West Virginia Recredentialing Form (WVRF) and/or the West Virginia Practitioner Attestation, 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 WVRF 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 WVRF Attestation 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 WVRF 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 WVRF or Attestation.~~

8. ~~I further acknowledge that I have read and understand the foregoing Authorization and Release of Information. A photocopy of this 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.~~

Print Name Here _____

Signature: _____ Date: _____

~~Note: Through above signature, I hereby affirm that contents are current and accurate as of the signature date. Modification to the wording or format of the WVRP/Attestation/Authorization and Release of Information may invalidate an application.~~

Credentialing Entity may supplement additional 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.

State of West Virginia Recredentialing 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 in a separate sheet and attach

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:

I will notify _____ of any
(Entity Specific)

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

Physicians' Signature

Date

Printed Name

Policy Number

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

APPENDIX C

LIST OF PRACTITIONERS WHO SHALL USE THE UNIFORM FORMS

Acupuncturists

Audiologists

Chiropractors

Dental Assistants

Dental Hygienists

Dentists

Dieticians (RD)

Emergency Medical Technicians (EMT) including but not limited to Basic, Cardiac/Critical, Intermediate and Paramedic

Herbalists

Licensed Practical Nurses and Licensed Vocational Nurses (LVN)

Licensed Professional Counselors (including but not limited to alcohol, substance abuse and family/marriage counselors)

Mental Health Counselors

Massage Therapists

Naturopaths

Nuclear Medicine Technologists

Nurse Anesthetists (CRNA)

Nurse Midwives (CNM)

Nurse Practitioners (NP)

Nutritionists

Occupational Therapists

Optometrists

Orthotics/Prosthetics Fitters

Pharmacists and Nuclear Pharmacists

Physical and Rehabilitation Therapists

Physicians Assistants, Allopathic and Osteopathic

Physicians, Residents and Interns, Allopathic and Osteopathic

Podiatrists

Psychologists, Clinical

Radiation Therapy Technologists

Radiologic Technologists

Registered Nurses (RN)

Respiratory Therapists

Respiratory Therapy Technicians

Social Workers, Clinical

Speech/Language Pathologists