WEST VIRGINIA
SECRETARY OF STATE
JOE MANCHIN, III
ADMINISTRATIVE LAW DIVISION

Form #3

Do Not Mark In This Box

FILED

2004 AUG 27 P 2:42

OFFICE WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

AGENCY: DHHR - Bureau for Public Health TITLE NUMBER: 64

CITE AUTHORITY: §§16-1A-2 et seq., 16-1-4 & 33-2-10

AMENDMENT TO AN EXISTING RULE: YES X NO ____

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 89

TITLE OF RULE BEING AMENDED: Uniform Credentialing of Health Care Practitioners

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: ____

TITLE OF RULE BEING PROPOSED: ____

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE FOR THEIR REVIEW.

Paul 2 Nurse
Authorized Signature

$13.20

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.

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.

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Uniform Credentialing of Health Care Practitioners

Title 64, Series 89

Type of Rule: **Legislative XX Interpretive ___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

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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. The amendments will delete the appendices to the rule, which consist of the uniform credentialing and recredentialing forms and the list of health care practitioners who are subject to the forms and rule. A new procedural rule will be promulgated by the Secretary and Commissioner to incorporate the uniform forms and list of health care practitioners, so that the forms and list may be updated more frequently if needed.

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.

The amendments to this 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 amendments to this rule.

Date: August 27, 2004

Signature of Agency Head or Authorized Representative

Paul L. Nusbaum, Secretary
Department of Health and Human Resources

QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period, Proposed Rule, and if needed, Emergency and Modified Rule.)

DATE: August 27, 2004

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: (Jointly Proposed Rule)
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
ATTN: John Law
Building 3, Room 206
1900 Kanawha Blvd., East
Charleston, West Virginia 25305

West Virginia Insurance Commissioner
P.O. Box 50540
1124 Smith St.
Charleston, WV 25305-0540

LEGISLATIVE RULE TITLE: UNIFORM CREDENTIALING OF HEALTH CARE PRACTITIONERS (TITLE 64, SERIES 89)

1. **Authorizing statute(s) citation:**

   West Virginia Code §§ 33-2-10 and 16-1A-2.

2. a. **Date filed in State Register with Notice of Hearing or Public Comment Period:**

      June 16, 2004

   b. **What other notice, including advertising, did you give of the hearing?**

      None

   c. **Date of Public Hearing(s) *or* Public Comment Period ended:**

      Comment period ended July 16, 2004.

   d. **Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.**

      Attached _____ **No comments received** ___X___

   e. **Date you filed in State Register the agency approved**

proposed Legislative Rule following public hearing: (be exact)

August 27, 2004

f. Name, title, address and phone/fax/e-mail numbers of agency person(s) to receive all *written correspondence* regarding this rule: (Please type)

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
ATTN: John Law
Building 3, Room 206
1900 Kanawha Blvd., East
Charleston, West Virginia 25305

Phone: (304) 558-0684
Fax: (304) 558-1130
E-mail:johnlaw@wvdhhr.org

g. IF DIFFERENT FROM ITEM 'f', please give Name, title, address and phone number(s) of agency person(s) who wrote and/or has responsibility for the contents of this rule: (Please type)

Mary Jane Pickens, Associate Counsel
West Virginia Insurance Commission
P.O. Box 50540
1124 Smith St.
Charleston, WV 25305-0540

Phone: 304-558-0401 ext. 159
Fax: 304-558-1362
e-mail: pickensm@mail.wvnet.edu

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

Not applicable

b. Date of hearing or comment period:

Comment period ran from June 16 to July 16, 2004.

c. On what date did you file in the State Register the

findings and determinations required together with the reasons therefor?

Not applicable

d. Attach findings and determinations and reasons:

Not applicable

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

SERIES 89

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:

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.

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.

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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

SERIES 89

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:

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

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

Provider's Name	Date
Social Security Number	**Date of Birth**

Credentialing Entity Name

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

- [ ] Copy of current State License(s)
- [ ] Copy of current DEA Registration (if applicable)
- [ ] Copy of current State Controlled Dangerous Substance (CDS) Certificate (if applicable)
- [ ] Copy of current professional liability insurance policy face sheet, showing expiration dates, limits, and provider's name
- [ ] Copy of Board Certification Certificate(s) (if applicable), or other National Certification Certificates
- [ ] Copy of certificate(s) or letter(s) certifying formal post-graduate training
- [ ] Copy of Curriculum Vitae/Resume (Include work history)
  (Not accepted as a substitute for completion of application.)
- [ ] Copy of ECFMG Certificate (if applicable)
- [ ] Copy of W-9 for verification of each tax identification number used (required for payers only)
- [ ] Copy of Visa or work permit (if not a U.S. citizen)
- [ ] Copies of CME/CEU session certificates (if required by Credentialing Entity)
- [ ] Signature requirements per each entity
- [ ]

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

State of West Virginia
Credentialing Form

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

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

1. Applicant Information

Last Name (as shown on state license)	First Name	Middle Name	Maiden Name	Suffix (e.g., Jr., Sr., etc.)

Degree (e.g., MD, DO, DDS, DPM, PA-C, RN)	Gender	Birth Date	Birthplace
	[ ] Male [ ] Female		

Other Name(s) Also Known By

Name(s):		Name:	
Date Name 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? [ ] Yes	[ ]	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
( )	Yes [ ]	[ ] 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.)

[ ] Primary Office Site #1 [ ] Additional Office Site #

Group/Practice Name	
Type of Practice	[ ] Individual [ ] Group [ ] Corporation [ ] Hospital Based [ ] Partnership [ ] 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? [ ] By referral only [ ] Yes [ ] No [ ] NA	Have you closed your practice to any plans or programs? [ ] Yes If Yes, please list [ ] No [ ] NA
Handicap Accessible? [ ] Yes [ ] No [ ] NA	Public Transit Available? [ ] Yes [ ] No [ ] NA
Does the office have other services available for disabled? (TTY, ASL, Mental/physical impairments, etc.) [ ] Yes [ ] No [ ] NA	If yes, list below what services are available
Office Manager's Name [ ] NA	Nurse Manager's Name [ ] NA

[ ] Check if not applicable

Office Hours

Check if practitioner is not available to see patient during hours indicated

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

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~~	

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.)

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	[ ]	Sigmoidoscopy [ ] Audiology Services [ ] Treadmill	
[ ] Other (Please list):			
[ ] 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?	
Yes [ ] [ ]	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 [ ]	No
Group/Practice Name (Check Payable to):			
Address (Building, Street, Suite #)	City	State	Zip Code
Billing Office Phone Number		Billing Manager's Name	
( )			
Tax ID Number (must 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?	[ ] 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?	[ ] No		If yes, provide details on separate sheet

Practice Classification	
[ ]	Primary Care Physician (Family Practioners, Internists, or Pediatricians who deliver primary health care services)
[ ]	Specialist Physician (Physicians other than primary care physicians in their designated clinical practice)
[ ]	Allied Health Professional (Licensed, certified, or registered non-physician providers of direct patient care services)
[ ]	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?	
[ ] Yes [ ]	No	[ ] Yes [ ]	No

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~~Please indicate, in preference order, how you wish to be listed in the directory.~~	
~~Primary Specialty:~~	~~Secondary Specialty:~~

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After-Hours Coverage

Do you provide 24-hour coverage?			Describe Coverage
[ ] Yes	[ ] 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?**
[ ] Yes	[ ] No	NA	[ ] Yes [ ] 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? _____
[ ] Yes	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?	[ ] Yes	[ ] 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 active return to work philosophy?	[ ] No	
	b. Modified or alternative duty is actively evaluated for each Workers' Compensation claimant.	[ ] 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. [ ] Yes	[ ] No	
	d. Staff are available and willing to provide compensation representatives information regarding a claimant's care.	[ ] No	

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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	
	[ ] Internship [ ] Fellowship [ ] 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:	[ ]	Yes	[ ]	No	If no, explain:

Your Program Director's Name	Current Program Director's Name (if known)

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Training Institution		Program	
	[ ] Internship [ ] Fellowship [ ] 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: [ ]	Yes [ ]	No If no, explain:
Your Program Director's Name		**Current Program Director's Name (if known)**	
Training Institution		**Program**	
	[ ] Internship [ ] Fellowship [ ] 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: [ ]	Yes [ ]	No If no, explain:
Your Program Director's Name		**Current Program Director's Name (if known)**	

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Training Institution	Program	
[ ] [ ] [ ]	Internship [ ] Fellowship [ ] 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:	[ ]	Yes	[ ]	No	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 (Please check)	Is/was license restricted?	Reason License is/was Inactive or Restricted
			[ ] [ ]	Active [ ] Inactive [ ]	Yes No	
			[ ] [ ]	Active [ ] Inactive [ ]	Yes No	
			[ ] [ ]	Active [ ] Inactive [ ]	Yes No	
			[ ] [ ]	Active [ ] Inactive [ ]	Yes No	
			[ ] [ ]	Active [ ] Inactive [ ]	Yes No	

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?		
	[ ]	Yes [ ]	No	If no, explain:

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State DEA or CDS Certificate(s)

[ ] Not applicable

(Submit copy of current State Controlled Dangerous Substance Certificates, if applicable)

Certificate #	Expiration Date	Unlimited?				
	[ ]	Yes	[ ]	No		If no, explain:

Other Certificate(s)/Formal Training

(Please check below if currently certified. Submit copy[s])

[ ]	Basic Life Support (BLS)	[ ]		Anesthesia Permit
[ ]	Advanced Cardiac Life Support (ACLS)	[ ]		Health Care Provider (Core C)
[ ]	Pediatric Advanced Life Support (PALS)	[ ]		Neonatal Resuscitation Program (NRP)
[ ]	Advanced Trauma Life Support (ATLS)	[ ]		Therapeutics Classification Number (Optometrists only)
[ ]	Neonatal Advanced Life Support (NALS)	[ ]		Other (please list below or on a separate sheet and include descriptions):

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

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

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

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

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

If not certified, please indicate your status in the certifying process:

[ ] Failed to pass specialty board examination
- How many times have you taken the exam but failed to pass?
- Last date(s) exam was taken:

[ ] Date(s) board examination was taken/retaken and date board exam is scheduled, if applicable:
- Date(s) taken/retaken
- Date scheduled, if applicable

[ ]

[ ] Not eligible to take specialty boards

Not planning to take specialty boards

Admissible with exam pending

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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.)			

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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)	
[ ] Yes [ ] No 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)	
[ ] Yes [ ] No 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)	
[ ] [ ] Yes [ ] No, 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)	
[ ] [ ] Yes [ ] No, 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)	
[ ] [ ] Yes [ ] No, explain: From:	To:	
Reason for leaving, if applicable		

Name of Affiliation/Hospital/Healthcare Entity	Type of Affiliation	
Street Address	City	State

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Department/Service			Department Chair's Name	
Staff Status			#Admits/Month	Percent of time spent at facility
Restricted?			Dates of Affiliation (Mo/Yr)	
[ ] [ ] Yes	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)	
[ ] [ ] Yes	If yes, explain:	From:	To:	
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)	
[ ] Yes	[ ] 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)			
[ ] [ ] Yes/No, 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)**		
( )	( )		

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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:	
	From: To:	
Professional Training	From: To:	
	From: To:	
	From: To:	
Hospital/Facility Affiliations	From: To:	
	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 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 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?
	[ ] Claims Made [ ] Occurrence	[ ] No [ ] 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?
	[ ] Claims Made [ ] Occurrence	[ ] No [ ] 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?
	[ ] Claims Made [ ] Occurrence	[ ] No [ ] 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?**
	[ ] Claims Made [ ] Occurrence	[ ] No [ ] 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 every been terminated by action of the insurance company? [ ]	No [ ]	Yes
B. Have you ever been denied professional liability insurance coverage? [ ]	No [ ]	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 [ ]	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? [ ]	No [ ]	Yes
E. Have any restrictions ever been placed on your professional liability insurance coverage? [ ]	No [ ]	Yes
F. Have you ever practiced without professional liability coverage? [ ]	No [ ]	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.)? [ ]	No [ ]	Yes

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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?

[ ] Primary Defendant
[ ] Co-Defendant
[ ] Other, please explain:

[ ]
[ ]
[ ]

8. What is the status of the case?

[ ] Dropped
[ ] Settled Out of Court
[ ] Under Appeal
[ ] Found for Defendant
[ ] Pending
[ ] Dismissed Without Payment
[ ] 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

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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? [ ]	No [ ]	Yes	
B.	Has your license to practice in any state ever been voluntarily or involuntarily relinquished, restricted, denied, reduced, limited, suspended, placed on probation, revoked, or subject to any disciplinary action including reprimand?	No [ ]	Yes	
C.	Have you ever been suspended, sanctioned, or otherwise restricted from participating or been the subject of an investigation in any private, federal, or state health insurance program (e.g., Medicare, Medicaid)?	No [ ]	Yes	
D.	Has your narcotics (DEA) registration certificate (federal or state) ever been voluntarily or involuntarily relinquished, limited, suspended, not renewed, placed on probation, revoked, or challenged?	No [ ]	Yes [ ]	NA
E.	Have you ever been convicted of or plead no contest to any criminal (felony or misdemeanor) charges including a drug or alcohol-related offense or motor vehicle offenses, but not including minor traffic or parking violations? Are any such proceedings currently pending? [ ]	No [ ]	Yes	
F.	Have you ever had an academic appointment denied, limited, revoked, suspended, reduced, placed on probation, not renewed, or other adverse action taken? [ ]	No [ ]	Yes [ ]	NA
G.	Have you ever been discharged or asked to resign from any position for any reason? [ ]	No [ ]	Yes	
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? [ ]	No [ ]	Yes	
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? [ ]	No [ ]	Yes [ ]	NA
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?	No [ ]	Yes	
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? [ ]	No [ ]	Yes	
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? [ ]	No [ ]	Yes	
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? [ ]	No [ ]	Yes	
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? [ ]	No [ ]	Yes	

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.)

O.	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? [ ]	No [ ]	Yes	
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? [ ]	No [ ]	Yes	
Q.	Do you have any knowledge of any civil actions pending against you by any hospital, law enforcement agency, professional group or society? [ ]	No [ ]	Yes	
R.	Have you had any charges of unprofessional conduct brought against you? [ ]	No [ ]	Yes	
S.	Have you had any charges of fraud brought against you? [ ]	No [ ]	Yes	
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. [ ]	No [ ]	Yes	

Health Status

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

A.	Are you physically and mentally able to perform all the essential functions or services necessary to exercise the privileges or services applied for with or without a reasonable accommodation? [ ]	Yes [ ]	No	
B.	Are you able to perform these functions without significant risk of injury to yourself or others? [ ]	Yes [ ]	No	
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 [ ]	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 [ ]	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.)

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.

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)

_____ 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 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
(Use this checklist as a guide)

- [ ] Copy of current State License(s)
- [ ] Copy of current DEA Registration (if applicable)
- [ ] Copy of current State Controlled Dangerous Substance (CDS) Certificate (if applicable)
- [ ] Copy of current professional liability insurance policy face sheet, showing expiration dates, limits, and provider's name
- [ ] Copy of Board Certification Certificate(s) (if applicable), or other National Certification Certificates **(if changed since date of last credentialing)**
- [ ] Copies of CME/CEU session certificates (if required by Credentialing Entity)
- [ ] 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
( ) -	[ ] Yes	[ ] No	( ) -

If citizenship status or VISA status has changed, please indicate below and attach an explanation as well as pertinent documentation.

[ ]	Citizenship/VISA status has changed.

Language(s) Spoken (other than English

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?
[B]y r[q]Walsonly [ ] No [ ] NA		Yes [ ] [ ] No NA If yes, explain:
Handicap Accessible?		Public Transit Available?
[ ] Yc[s] No [ ] NA[ ]		Yes [ ] No [ ] NA
Does the office have other services available for disabled? (TTY, ASI, Mental/physical impairments, etc.)		If yes, list below what services are available
[ ] Y[s] No [ ] NA		
Office Manager's Name		Nurse Manager's Name
[ ] – NA		[ ] – NA
Office H[u]rs	Check if not applicable [ ]	Check if practitioner is not available to see patient during hours indicated

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	

Services Provided (Please check below if these services are available)			
[ ] Lab[S]rvices	On-Site Reference Lab Name:		CLIA Number and Type of Certification:
[ ] Radiology Services	EKG [ ]	Sigmoidoscopy/Audiology Services	Treadm[ill]
[ ] 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?	
[ ] Yes [ ] No	Minimum:	Maximum:	

Remittance/Billing Information
(NOTE: Must match box 33 on HCFA/CMS 1500)

Are all services payable to one practice/group name/address?	[ ] Yes	[ ] 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?	[ ] Yes	[ ] 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?	[ ] Yes	[ ] No	If yes, provide details on separate sheet.

Practice Classification

[ ] Primary Care Physician (Family Practitioners, Internists, or Pediatricians who deliver primary health care services)
[ ] Specialist Physician (Physicians other than primary care physicians in their designated clinical practice)
[ ] Allied Health Professional (Licensed, certified, or registered non-physician providers of direct patient care services)
[ ] 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?	
[ ] Yes [ ] No		[ ] Yes	[ ] 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
[ ] Yes [ ]	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?
[ ] Yes [ ]	No [ ]	NA [ ] Yes	[ ] No [ ] NA

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 informationprovided 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?
[ ] Yes [ ] No	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.

[ ] Physician's Assistant: [ ]	Nurse Practitioner:
[ ] Nurse Midwife: [ ]	Other (specify):

Workers' Compensation Information

Do you accept Workers' Compensation Patients? [ ]	Yes [ ] No

If yes, please provide the following information:

[ ]	Yes	[ ]	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?
[ ]	Yes	[ ]	No	b. Modified or alternative duty is actively evaluated for each Workers' Compensation claimant.
[ ]	Yes	[ ]	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.
[ ]	Yes	[ ]	No	d. Staff are available and willing to provide compensation representatives information regarding a claimant's care.

NOTE: Section 3 (Medical/Professional Education) and Section 4 (Professional Training) have 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.)

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

License #State	Issue Date	Expiration Date	Status (Please check)		Is/was license restricted?	Reason License is/was Inactive or Restricted
			[ ] Active [ ]	Inactive [ ] [ ]	Yes No	
			[ ] Active [ ]	Inactive [ ] [ ]	Yes No	
			[ ] Active [ ]	Inactive [ ] [ ]	Yes No	
			[ ] Active [ ]	Inactive [ ] [ ]	Yes No	
			[ ] Active [ ]	Inactive [ ] [ ]	Yes No	

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 or if no changes since last credentialing date.

[ ] Not applicable — **Federal DEA Certificate (Submit copy of current DEA Certificate)**

Certificate #	Expiration Date	Unlimited?	
	[ ] Yes [ ] No	If no, explain:	

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

Certificate #	Expiration Date	Unlimited?	
	[ ] Yes [ ] No	If no, explain:	

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

[ ] [ ] [ ] [ ] [ ]	Basic Life Support (BLS Advanced Cardiac Life Support (ACLS) Pediatric Advanced Life Support (PALS) Advanced Trauma Life Support (ATLS) Neonatal Advanced Life Support (NALS)	[ ]	Anesthesia Permit Health Care Provider (Core C) Neonatal Resuscitation Program (NRP Therapeutics Classification Number (Optometrists only) Other (please list below or on a separate sheet and include descriptions):

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

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

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

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

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

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)		
[ ] No [ ] Yes If 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 If 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 If 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.)

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 Affiliations	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 b 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?	
	[ ] Claims Made [ ] Occurrence		[ ] No [ ] 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?	
	[ ] Claims Made [ ] Occurrence		[ ] No [ ] 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?	
	[ ] Claims Made [ ] Occurrence		[ ] No [ ] 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?
[ ] Claims Made	[ ] Occurrence	[ ] No [ ] 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?	[ ] Yes	
B. Have you ever been denied professional liability insurance coverage? [ ] No	[ ] 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	[ ] Yes	
D. During the time of your professional practice, have you had any professional liability claims, suits, settlements, or judgements filed against you or are any currently pending?	[ ] Yes	
E. Have any restrictions ever been placed on your professional liability insurance coverage? [ ] No	[ ] Yes	
F. Have you ever practiced without professional liability coverage? [ ] No	[ ] 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.)? [ ] No	[ ] 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?			
☐	Primary Defendant	☐	Dropped	☐			Found for Defendant
☐	Co-Defendant	☐	Pending	☐			Dismissed Without Payment
☐	Other, please explain:	☐	Settled Out of Court	☐			Found for Plaintiff
				☐			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?	☐ 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 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.

A. Have any investigations been initiated or any pending against you by any state licensure board, registration board, or regulatory agency?	Yes ☐		
B. Has your license to practice in any state ever been voluntarily or involuntarily relinquished, restricted, denied, reduced, limited, suspended, placed on probation, revoked, or subject to any disciplinary action including reprimand?	Yes ☐		
C. Have you ever been suspended, sanctioned, or otherwise restricted from participating or been the subject of an investigation in any private, federal, or state health insurance program (e.g., Medicare, Medicaid)?	Yes ☐		
D. Has your narcotics (DEA) registration certificate (federal or state) ever been voluntarily or involuntarily relinquished, limited, suspended, not renewed, placed on probation, revoked, or challenged? No ☐	Yes ☐ ☐	NA	
E. Have you ever been convicted of or plead 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? No ☐	Yes ☐		
F. Have you ever had an academic appointment denied, limited, revoked, suspended, reduced, placed on probation, not renewed, or other adverse action taken? No ☐	Yes ☐ ☐	NA	
G. Have you ever been discharged or asked to resign from any position for any reason? No ☐	Yes ☐		
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? No ☐	Yes ☐		
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? No ☐	Yes ☐ ☐	NA	
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? No ☐	Yes ☐		
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? No ☐	Yes ☐		

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?	No ☐ Yes ☐		
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?	No ☐ Yes ☐		

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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?	No ☐ Yes		
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?	No ☐ Yes		
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?	No ☐ Yes		
Q. Do you have any knowledge of any civil actions pending against you by any hospital, law enforcement agency, professional group or society?	No ☐ Yes		
R. Have you had any charges of unprofessional conduct brought against you? ☐	No ☐ Yes		
S. Have you had any charges of fraud brought against you? ☐	No ☐ Yes		
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.	No ☐ Yes		

Health Status

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

A. Are you physically and mentally able to perform all the essential functions or services necessary to exercise the privileges or services applied for with or without a reasonable accommodation?	Yes ☐	No
B. Are you able to perform these functions without significant risk of injury to yourself or others ☐	Yes ☐	No

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 ☐	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 ☐	No

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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 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 WVRF/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~~
~~Homeopaths~~
~~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~~