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

Form #2

Do Not Mark In This Box
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2002 JUN 14 A 11:46
OFFICE WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF A COMMENT PERIOD ON A PROPOSED RULE

AGENCY: DHHR and the WV Insurance Commission TITLE NUMBER: 64

RULE TYPE: Legislative CITE AUTHORITY: WV Code §§16-1A-2, 16-1-4 and 33-2-10

AMENDMENT TO AN EXISTING RULE: YES ___ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: ___

TITLE OF RULE BEING AMENDED: ___

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: 89

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

IN LIEU OF A PUBLIC HEARING, A COMMENT PERIOD HAS BEEN ESTABLISHED DURING WHICH ANY INTERESTED PERSON MAY SEND COMMENTS CONCERNING THESE PROPOSED RULES. THIS COMMENT PERIOD WILL END ON July 15, 2002 AT 4:30 p.m. ONLY WRITTEN COMMENTS WILL BE ACCEPTED AND ARE TO BE MAILED TO THE FOLLOWING ADDRESS:

Martha O. Barnitt
DHHR - Office of the Secretary
State Capitol Complex
Building 3 - Room 206
Charleston, WV 25305

THE ISSUES TO BE HEARD SHALL BE LIMITED TO THIS PROPOSED RULE.

Phillip A. Lynch Deputy Sec'y
Authorized Signature

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

SCANNED

$12.40

STATE OF WEST VIRGINIA

Offices of the Insurance Commissioner

Legal Division

BOB WISE
Governor

JANE L. CLINE
Insurance Commissioner

June 5, 2002

Ms. Judy Cooper, Director
Administrative Law Division
Office of Secretary of State
Building 1, Suite 157K
State Capitol Complex
1900 Kanawha Blvd., East
Charleston, West Virginia 25305-0770

Re: Uniform Credentialing of Health Care Practitioners
Joint Legislative Rule of the Secretary of the Department of Health and Human Services and the Insurance Commissioner

Dear Judy:

The West Virginia Legislature passed H.B. 3242 during the regular 2001 Legislative Session, which called on the Secretary of the Department of Health and Human Resources and the Insurance Commissioner to jointly propose rules to implement uniform credentialing in West Virginia, and to set forth the forms for credentialing and recredentialing health care practitioners as well as designate the health care practitioners to whom the forms are applicable. The original deadline to propose legislative rules of January 1, 2002, was extended on March 8, 2002 by the Legislature in H.B. 4509 to June 1, 2002.

The division of efforts between the Insurance Commission and the Department of Health and Human Resources on this joint rule requires the Department of Health and Human Resources to file the rule for public comment and follow it through the rule making process. The purpose of this letter, however, is to let you know that this is a jointly filed rule between the Department of Health and Human Resources and the Insurance Commission.

Please let me know if there is anything further you need from me in connection with the filing of this rule.

Very truly yours,

Jane L. Cline
West Virginia Insurance Commissioner

JLC/MJP/kb

Post Office Box 50540
Charleston, West Virginia 25305-0540

"We are an Equal Opportunity Employer"

Telephone (304) 558-0401
Facsimile (304) 558-1362

UNIFORM CREDENTIALING OF HEALTH CARE PRACTITIONERS

STATEMENT OF CIRCUMSTANCES

Credentialing and recredentialing health care practitioners has traditionally been an entity-specific task, meaning that a practitioner has needed to complete many different applications to submit to each health plan, hospital, or other health care entity with which the practitioner wishes to do business. Generally the information is similar, but the forms are different. This has caused unnecessary administrative burdens for health care practitioners. The legislature addressed this situation during its regular 2001 session when it passed H.B. 3242, which amended chapter 16 of the West Virginia Code by adding a new article, designated 1A. The new article requires the Secretary of the Department of Health and Human Resources and the Insurance Commissioner to jointly propose rules for legislative approval which will set forth uniform application forms for credentialing or recredentialing and to specify the health care practitioners who may use the forms. The bill further required the appointment of an advisory committee to develop the forms and assist with the implementation of the uniform credentialing process in the state. The advisory committee met on eight occasions from September, 2001 through March, 2002 and as a result of those meetings, this rule and the forms and list of practitioners attached as appendices to the rule were developed. The rule requires use of the uniform forms by all health care entities that credential health care practitioners. The rule makes it clear that the uniform forms are to be completed, and then may be duplicated as necessary (with the practitioner only needing to verify the accuracy when submitted) in order to reduce the redundancy inherent in the current system. The rule allows health care entities to supplement the forms with additional information requests, as long as the information is not a repetition of or does not substantially alter the uniform forms. The rule provides that the forms and list of practitioners subject to the forms may be amended as necessary by procedural rule. All credentials data will be confidential peer review documents under the rule. A violation of the rule will result in penalties set forth in the rule.

UNIFORM CREDENTIALING OF HEALTH CARE PRACTITIONERS

BRIEF SUMMARY OF RULE

This rule, jointly proposed by the Secretary of the Department of Health and Human Resources and the Insurance Commissioner, requires the use of uniform forms by all health care entities that credential health care practitioners. The rule makes it clear that the uniform forms are to be completed by the practitioner and then may be duplicated as necessary in order to reduce the redundancy in the current system. The rule allows health care entities to supplement the forms with additional information requests, as long as the information is not a repetition of or does not substantially alter the uniform forms. The rule also provides that the forms and the list of practitioners subject to the forms may be amended as necessary by procedural rule. All credentials data will be considered confidential peer review documents under the rule.

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Uniform Credentialing for Health Care Practitioners 64CSR 89

Type of Rule: _X_ **Legislative** __ **Interpretive** _ **Procedural**

Agency: (Jointly Proposed Rule)
Department of Health and Human Resources and Insurance Commissioner

Address:

Dep't of Health and Human Resources
State Capitol Complex
Building 3 - Room 206
Charleston, W. Va. 25305

Insurance Commissioner
Post Office Box 50540
1124 Smith Street - Greenbrooke Bldg.
Charleston, WV 25305-0540

1. Effect of the 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 & Alterations	None	None	None	None	None
Equipment	None	None	None	None	None
Other	None	None	None	None	None
Revenue					

2. Explanation of above estimates.

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

3. Objectives of this rule:

The objective of this rule is to simplify the administrative task of credentialing and recredentialing health care practitioners. Traditionally, each health care entity that credentials practitioners has used its own unique forms, requiring a practitioner to complete many different applications to submit to each health plan, hospital, or other health care entity with which the practitioner wishes to do business. This has caused unnecessary administrative burdens for health care practitioners. This rule will set forth uniform application forms for credentialing

and recredentialing and will specify the health care practitioners who may use the forms. The rule clarifies that the uniform forms are to be completed by the practitioner, and then may be duplicated as necessary (with the practitioner only needing to verify the accuracy when submitted) in order to reduce the redundancy in the current system.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None.

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

This rule will have no economic impact on political subdivisions or specific groups of citizens. It will require health care entities that credential health care practitioners to change to the new uniform credentialing and recredentialing forms, and develop new supplemental forms to gather additional, entity-specific information as allowed by the rule, but these should be one-time changes, and there should be no other changes in credentialing methods as a result of these rules.

C. Economic Impact on Citizens/Public at Large.

There could be an economic benefit to health care practitioners as a result of the promulgation of this rule because it will limit the amount of time and resources devoted to completion of credentialing and recredentialing forms.

Date: June 13, 2002

Signature of Agency Head or AuthorizedRepresentative

Phillip A. Leach for

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: June 14, 2002

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: (Agency name, Address & Phone No.) Department of Health and Human Resources
And West Virginia Insurance Commissioner

DHHR	Insurance Commissioner
State Capitol Complex, Bldg 3, Room 206	P.O. Box 50540
Charleston, WV 25305	Charleston, WV 25305-0540
Telephone: (304) 558-5598	Tel: (304) 558-0401, ext. 159

LEGISLATIVE RULE TITLE: Uniform Credentialing of Health Care Practitioners

1. Authorizing statute(s) citation: WV Code Section 16-1A-2, 16-1-4, and 33-2-10

2. a. Date filed in State Register with Notice of Hearing or Public Comment Period:
June 14, 2002

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

Notice of the proposed rule was sent to interested parties, mainly health care entities.

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

July 15, 2002

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

Attached_____ No comments received _____

e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing (be exact):

_____

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

Martha Barnitt - DHHR
Building 3, Room 206, Capitol Complex
Charleston, West Virginia 25305
Tel: 304-558-5598

Mary Jane Pickens
Associate Counsel
WV Insurance Commission
Charleston, WV 25305-0540
Tel: 304-558-0401, Ext. 159

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 Street; Charleston, WV 25305-0540
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 a hearing for the taking of evidence and a general description of the issues to be decided.

N/A

b. Date of hearing or comment period:

N/A

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefore?

N/A

d. Attach findings and determinations and reasons:

Attached N/A

TITLE 64

WEST VIRGINIA JOINT LEGISLATIVE RULE
SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN RESOURCES
and THE WEST VIRGINIA INSURANCE COMMISSIONER

SERIES 89
UNIFORM CREDENTIALING OF HEALTH CARE PRACTITIONERS

TITLE 64
JOINT LEGISLATIVE RULES

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 to assess and verify the practitioner's education, training, experience and competence, and specifies the health care practitioners who shall use the forms. The W. Va. Code is available in public librarier and on the Legislature's web page, http://www.legis.state.wv.us/.

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

1.3. Filing Date. --

1.4. Effective Date. --

§64-89-2. Application.

2.1. Except as otherwise provided, this rule applies to all hospitals, insurers, managed care organizations, third party administrators and 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.

§ 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 an individual who is licensed, certified, or otherwise authorized to provide health care services, as designated in Appendix 64-89 C of this rule.

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 by the health care entity continues to meet its 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 for credentialing health care practitioners and the recredentialing form provided in Appendix 64-89 B of this rule 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 the uniform credentialing form or recredentialing form until the date on which the health care practitioner would otherwise be required to reapply or provide updated credentialing information.

4.2. The health care practitioners required to use the uniform credentialing and recredentialing forms are set forth in Appendix 64-89 C of this rule.

4.3. Once completed by the health care practitioner, he or she may duplicate the uniform credentialing and recredentialing forms as necessary for submission to multiple health care entities with the knowledge that each health care entity that credentials or recredentials a health care practitioner shall require the health care practitioner to submit with the uniform credentialing and recredentialing forms:

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 recredentialing forms. The request for additional information may not require repetition of or substantially alter the information required in the uniform credentialing or recredentialing forms. The additional information shall be requested by the health care entity on supplemental sheets attached to the uniform credentialing or recredentialing forms.

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

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

5.1. The secretary and the commissioner shall reconvene the committee at least annually to review and recommend amendments if necessary to the uniform credentialing form, the recredentialing form or the list of health care practitioners who shall 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 recredentialing form or list of health care practitioners, by filing a procedural rule.

§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 be confidential peer review documents, as provided by law, and shall not be redisclosed 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 delegation, such as to a certified verification organization, or to any other entity, of credentialing or recredentialing activities as long as the entity to whom the activities have been delegated follows the requirements set forth in this rule.

§64-89-8. Violation.

8.1. 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:

8.1.a. Actual damages established by the health care practitioner, payable to that health care practitioner; and

8.1.b. An administrative penalty, payable to the Department or the insurance 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
Standardized Credentialing Form

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

Provider's Name	Date

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
Standardized 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:	Name:
Date Name Used	From: To:	From: To:

Area(s) of Specialty (please be specific and list any primary focus)

Specialty:	Sub-specialty:

Citizenship

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

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 ☐ Partnership ☐ Group ☐ 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?**
☐ Yes ☐ By referral only ☐ No ☐ NA	☐ Yes ☐ No ☐ NA If Yes, please list:

Handicap Accessible?	**Public Transit Available?**
☐ Yes ☐ 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**
☐ Yes ☐ No ☐ NA	

Office Manager's Name	**Nurse Manager's Name**
☐ NA	☐ NA

Office Hours

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

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

Services Provided
(Please check below if these services are available)

☐ Lab Services	☐ On-Site	Reference Lab Name:	CLIA Number and Type of Certification:	
☐ Radiology Services	☐ EKG	☐ Sigmoidoscopy	☐ Audiology Services	☐ Treadmill
☐ Other (Please list):				
☐ List any special diagnostic or treatment procedures performed in your office:				

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

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

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? ☐ 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. ☐ Yes ☐ No

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

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

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

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

Training Institution		Program		
		☐ Internship ☐ Residency	☐ Fellowship ☐ Preceptorship	☐ Other:
Street Address		**City**		
State	**Country**		**Zip Code**	
Telephone # (If known)		**Fax # (If known)**		
( ) -		( ) -		
Type of Training/Specialty	**Dates of Training (Mo/Yr)**		**Was program successfully completed?**	
			☐ Yes ☐ No If no, explain:	
Your Program Director's Name		**Current Program Director's Name (If known)**		

Training Institution		Program		
		☐ Internship ☐ Residency	☐ Fellowship ☐ Preceptorship	☐ Other:
Street Address		**City**		
State	**Country**		**Zip Code**	
Telephone # (If known)		**Fax # (If known)**		
( ) -		( ) -		
Type of Training/Specialty	**Dates of Training (Mo/Yr)**		**Was program successfully completed?**	
			☐ 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	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:		

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

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:

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)
(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):

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

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

8. Professional Peer References

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

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

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

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

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

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**	**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**	**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			

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

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)		
☐ 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	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	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			

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

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:	
	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:

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

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	

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

15. Professional Liability Insurance Coverage Disclosure:

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

A. Has your professional liability insurance coverage ever been terminated by action of the insurance company?	☐ 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

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

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 your behalf.**

All information is held in strict confidence and used for credentialing and recredentialing purposes only. Failure to supply sufficient details may prevent your application from being approved. In addition to completion of this form, practitioner may also submit any additional supporting documentation.

☐ **Check here if entire section is not applicable to applicant.**

1. Case Number	2. Carrier Name
3. Name of Plaintiff	**4. Date of Incident**
5. Date Filed	**6. Date Closed**
7. What was/is your status in the case?	**8. What is the status of the case?**
☐ Primary Defendant ☐ Co-Defendant ☐ Other, please explain:	☐ Dropped ☐ Pending ☐ Settled Out of Court ☐ Found for Defendant ☐ Dismissed Without Payment ☐ 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 Standardized Credentialing Form: Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

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

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

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 Standardized Credentialing Form (WVSCF) 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 WVSCF 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 WVSCF 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 WVSCF 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 WVSCF 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 WVSCF/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.

ADDENDUM

VERIFICATION OF PROFESSIONAL LIABILITY

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

_____

(Enter Current Professional Liability Insurance Carrier Name)

_____

(Enter Street Address) (City) (State & Zip)

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

(Entity Specific)

_____

(Entity Specific)

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

(Entity Specific)

of any changes in 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.

Attach additional sheets where necessary.

(Clearly indicating 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)	

Information submitted on the application should be representative of activity/information that occurred or changed on or after above date.

Provider's Name	**Date**

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 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 (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	( ) -

Language(s) Spoken (other than English)				

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

2. Office Practice Information: (Complete only for information changed since last date of credentialing)

☐ Check if entire section unchanged since last date of credentialing

If you have more than one office site or more than one billing address or entity, please make a photocopy of this section before completing it and provide information for each site or billing entity (i.e., multiple tax identifiers), as needed. Indicate below whether the office is the primary or an additional site. (NOTE: Only one primary site should be designated.)

☐ Primary Office Site # 1	☐ Additional Office Site #

Group/Practice Name	
Type of Practice	☐ Individual ☐ Partnership ☐ Group ☐ 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?
☐ Yes ☐ By referral only ☐ No ☐ NA	☐ Yes ☐ No ☐ NA If Yes, please list:

Handicap Accessible?	Public Transit Available?
☐ Yes ☐ 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
☐ Yes ☐ No ☐ NA	

Office Manager's Name	Nurse Manager's Name
☐ NA	☐ NA

Office Hours

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

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

Services Provided
(Please check below if these services are available)

☐ Lab Services	☐ On-Site	Reference Lab Name:	CLIA Number and Type of Certification:	
☐ Radiology Services	☐ EKG	☐ Sigmoidoscopy	☐ Audiology Services	☐ Treadmill
☐ Other (Please list):				
☐ List any special diagnostic or treatment procedures performed in your office:				

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Patient Population	
Do you limit the age of patients you treat?	**If yes, what ages do you treat?**
☐ 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 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:		

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Back-up Coverage
(Please list the name, specialty, and phone number of partner(s) or associate(s) or physician(s) covering your practice in your absence.)

Name	Specialty	Partner, Associate, Or Covering	Phone Number
			( ) -
			( ) -
			( ) -
			( ) -

Admitting Service

Do you admit patients to the hospital under your own service?	If no, to whom do you admit?
☐ 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? ☐ 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. ☐ Yes ☐ No

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 on a separate sheet and attach.)

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

State	License #	Issue Date	Expiration Date	Status (Please check)	Is/was license restricted?	Reason License is/was Inactive or Restricted
				☐ 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.**

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

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

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

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

Other Certificate(s)
(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 on 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
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

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 on 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)**		
☐ 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**	**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**	**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			

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 on 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)**		
☐ 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**	**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**	**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			

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 on 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 by your State Licensing Board during the past two (2) years OR the required CME/CEU hours (if applicable) from the State licensing board in which you are currently practicing?	☐ Yes	☐ No

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

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

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?	☐ 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, 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?

- ☐ Primary Defendant
- ☐ Co-Defendant
- ☐ Other, please explain:

8. What is the status of the case?

- ☐ Dropped
- ☐ Pending
- ☐ Settled Out of Court
- ☐ Found for Defendant
- ☐ Dismissed Without Payment
- ☐ 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

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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 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 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 your 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 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

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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.

ADDENDUM

VERIFICATION OF PROFESSIONAL LIABILITY

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

_____

(Enter Current Professional Liability Insurance Carrier Name)

_____

(Enter Street Address) (City) (State & Zip)

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

(Entity Specific)

_____

(Entity Specific)

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

(Entity Specific)

of any changes in 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.)

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
Message 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