

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

Form #3

Do Not Mark In This Box

FILED

2002 JUL 18 P 3:55

OFFICE WEST VIRGINIA
SECRETARY OF STATE

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

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

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

AMENDMENT TO AN EXISTING RULE: YES NO

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

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



Authorized Signature

SCANNED

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.

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.

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:

Signature of Agency Head or Authorized Representative



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

QUESTIONNAIRE

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

DATE: 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

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

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 X

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

July 18, 2002

- 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

Mary Jane Pickens

Building 3, Room 206, Capitol Complex

Associate Counsel

Charleston, West Virginia 25305

WV Insurance Commission

Tel: 304-558-5598

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**

- 64-89-1. General.
- 64-89-2. Scope.
- 64-89-3. Definitions.
- 64-89-4. Mandatory Use of Uniform Credentialing Form and Uniform Recredentialing Form.
- 64-89-5. Amendment of Uniform Credentialing and Recredentialing Forms.
- 64-89-6. Confidentiality of Credentialing and Recredentialing Data.
- 64-89-7. Delegation of Credentialing or Recredentialing Activities.
- 64-89-8. Violation.

Appendix 64-89 A: Uniform Credentialing Form

Appendix 64-89 B: Uniform Recredentialing Form

Appendix 64-89 C: List of Practitioners Who Shall Use the Uniform Forms

FILED

**TITLE 64
JOINT LEGISLATIVE RULES**

2002 JUL 18 P 3: 55

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

OFFICE WEST VIRGINIA
SECRETARY OF STATE

**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 libraries 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 <input type="checkbox"/> Female <input type="checkbox"/> | | | |
| Other Name(s) Also Known By | | | | |
| Name(s) | Name: | | Name: | |
| Date Name Used | From: | To: | From: | To: |
| Area(s) of Specialty (please be specific and list any primary focus) | | | | |
| Specialty: | | Sub-specialty: | | |
| Citizenship | | | | |
| Are you a US Citizen? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Please provide the following information if you are not a US Citizen: | If no, what is your citizenship? | | | |
| | If no, what is status of your Visa? | | | |
| | If no, do you hold a permanent work permit? | | | |
| | Type of Visa: | | Expiration of Visa: | |
| Social Security # | National Provider ID # (if available) | ECFMG # (if applicable, attach copy) | ECFMG Certificate Date | |
| | | | | |
| Current Home Address | | City | State | Zip Code |
| | | | | |
| Home Telephone | | Is this # unlisted? | Home Fax | |
| () - | | <input type="checkbox"/> Yes <input type="checkbox"/> No | () - | |
| Language(s) Spoken (other than English) | | | | |
| | | | | |

2. Office Practice Information

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

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?

- Yes By referral only No NA

Have you closed your practice to any plans or programs?

- Yes No NA
 If Yes, please list:

Handicap Accessible?

- Yes No NA

Public Transit Available?

- Yes No NA

Does the office have other services available for disabled?
 (TTY, ASI, Mental/physical impairments, etc.)

- Yes No NA

If yes, list below what services are available

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:

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

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

3. Medical/Professional Education:

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

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

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

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

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

| | | | |
|-----------------------------|-------------------------------------|--|---------------------------------|
| Training Institution | Program | | |
| | <input type="checkbox"/> Internship | <input type="checkbox"/> Fellowship | <input type="checkbox"/> Other: |
| | <input type="checkbox"/> Residency | <input type="checkbox"/> Preceptorship | |
| Street Address | City | | |
| | | | |
| State | Country | Zip Code | |

| | | | |
|-------------------------------------|---|--|--|
| Telephone # (if known) | Fax # (if known) | | |
| () - | () - | | |
| Type of Training/Specialty | Dates of Training (Mo/Yr) | Was program successfully completed? | |
| | From: To: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | If no, explain: | |
| Your Program Director's Name | Current Program Director's Name (if known) | | |

| | | | |
|-----------------------------|-------------------------------------|--|---------------------------------|
| Training Institution | Program | | |
| | <input type="checkbox"/> Internship | <input type="checkbox"/> Fellowship | <input type="checkbox"/> Other: |
| | <input type="checkbox"/> Residency | <input type="checkbox"/> Preceptorship | |
| Street Address | City | | |
| | | | |
| State | Country | Zip Code | |

| | | | |
|-------------------------------------|---|--|--|
| Telephone # (if known) | Fax # (if known) | | |
| () - | () - | | |
| Type of Training/Specialty | Dates of Training (Mo/Yr) | Was program successfully completed? | |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | If no, explain: | |
| Your Program Director's Name | Current Program Director's Name (if known) | | |

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

6. Certifications/Registrations

Check here if entire section is not applicable to applicant.

Federal DEA Certificate

Not applicable

(Submit copy of current DEA Certificate)

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

State DEA or CDS Certificate(s)

Not applicable

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

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

Other Certificate(s)

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

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

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

Check here if entire section is not applicable to applicant.

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

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

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

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

8. Professional Peer References

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

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

9. Hospital/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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Dates of Affiliation (Mo/Yr) | | |
| 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Dates of Affiliation (Mo/Yr) | | |
| 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Dates of Affiliation (Mo/Yr) | | |
| If yes, explain: | | From: | To: | |
| Reason for leaving, if applicable | | | | |

9. Additional Affiliations:

(Photocopy this page for additional affiliations)

| | | | | |
|--|--|-------------------------------------|--|------------|
| Name of Affiliation/Hospital/Healthcare Entity | | Type of Affiliation | | |
| Street Address | | City | State | Zip |
| Department/Service | | Department Chair's Name | | |
| Staff Status | | # Admits/Month | Percent of time spent at facility | |
| Restricted? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Dates of Affiliation (Mo/Yr) | | |
| 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Dates of Affiliation (Mo/Yr) | | |
| 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Dates of Affiliation (Mo/Yr) | | |
| 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: | | | |
| Practice/Employer | | Contact Name | | |
| Street Address | | City | State | Zip |
| Phone Number | | Fax Number (if known) | | |
| () - | | () - | | |
| Dates of Employment | | Reason for leaving, if applicable | | |
| From: | To: | | | |

11. Time Gaps

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

Check here if entire section is not applicable to applicant.

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

12. Continuing Education Requirements

Check here if entire section is not applicable to applicant.

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

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.)

| 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: |

14. Professional Liability Insurance Coverage:

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

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

15. Professional Liability Insurance Coverage Disclosure:

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

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

Professional Liability Information Addendum

(Photocopy this form for each case/action)

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? <input type="checkbox"/> Primary Defendant <input type="checkbox"/> Co-Defendant <input type="checkbox"/> Other, please explain: | 8. What is the status of the case? <input type="checkbox"/> Dropped <input type="checkbox"/> Pending <input type="checkbox"/> Settled Out of Court <input type="checkbox"/> Found for Defendant <input type="checkbox"/> Dismissed Without Payment <input type="checkbox"/> Found for Plaintiff <input type="checkbox"/> Under Appeal |
| 9. Amount of Any Settlement or Award? | 10. Date of any Settlement or Award |

Please explain the following in detail. (If an item does not apply please check "N/A")

| | |
|---|------------------------------|
| 11. What was the alleged harm to the patient? | <input type="checkbox"/> N/A |
| 12. What were you alleged to have done incorrectly or failed to do? | <input type="checkbox"/> N/A |
| 13. Describe the patient's illness and related effects of the alleged harm. | <input type="checkbox"/> N/A |
| 14. Describe any other details you believe are pertinent to the case. | <input type="checkbox"/> N/A |
| 15. Identify any other parties named in the suit. | <input type="checkbox"/> N/A |

| | |
|-----------|------|
| Signature | Date |
| | |

| 16. Practice Disclosure Information | | | |
|--|-----------------------------|------------------------------|-----------------------------|
| If the answer to any question below is yes, please provide a full explanation of the details on a separate sheet and attach. | | | |
| A. Have any investigations been initiated or are any pending against you by any state licensure board, registration board, or regulatory agency? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| B. Has your license to practice in any state ever been voluntarily or involuntarily relinquished, restricted, denied, reduced, limited, suspended, placed on probation, revoked, or subject to any disciplinary action including reprimand? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| C. Have you ever been suspended, sanctioned, or otherwise restricted from participating or been the subject of an investigation in any private, federal, or state health insurance program (e.g., Medicare, Medicaid)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| D. Has your narcotics (DEA) registration certificate (federal or state) ever been voluntarily or involuntarily relinquished, limited, suspended, not renewed, placed on probation, revoked, or challenged? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> NA |
| E. Have you ever been convicted of or plead no contest to any criminal (felony or misdemeanor) charges including a drug or alcohol-related offense or motor vehicle offenses, but not including minor traffic or parking violations? Are any such proceedings currently pending? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| F. Have you ever had an academic appointment denied, limited, revoked, suspended, reduced, placed on probation, not renewed, or other adverse action taken? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> NA |
| G. Have you ever been discharged or asked to resign from any position for any reason? | <input type="checkbox"/> No | <input type="checkbox"/> 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? | <input type="checkbox"/> No | <input type="checkbox"/> 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? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> 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? | <input type="checkbox"/> No | <input type="checkbox"/> 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? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| L. Have you ever withdrawn your application for appointment, reappointment or request for clinical privileges or resigned from the medical or allied health staff of a hospital, managed care organization, or other health care facility while under investigation or before a decision about your appointment or reappointment or clinical privileges was rendered by the governing board of any hospital, managed care organization or any other health care facility? | <input type="checkbox"/> No | <input type="checkbox"/> 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? | <input type="checkbox"/> No | <input type="checkbox"/> 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? | <input type="checkbox"/> No | <input type="checkbox"/> 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? | <input type="checkbox"/> No | <input type="checkbox"/> 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? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| Q. Do you have any knowledge of any civil actions pending against you by any hospital, law enforcement agency, professional group or society? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| R. Have you had any charges of unprofessional conduct brought against you? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |
| S. Have you had any charges of fraud brought against you? | <input type="checkbox"/> No | <input type="checkbox"/> 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. | <input type="checkbox"/> No | <input type="checkbox"/> Yes | |

Health Status

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

| | | |
|--|------------------------------|-----------------------------|
| A. Are you physically and mentally able to perform all the essential functions or services necessary to exercise the privileges or services applied for with or without a reasonable accommodation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B. Are you able to perform these functions without significant risk of injury to yourself or others? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C. Do you presently have a physical or mental health condition, including alcohol or drug dependence that affects, or is reasonably likely to affect your ability to perform professional or medical staff duties appropriately? If yes, give a full explanation of the details on a separate sheet. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| D. Do you currently take any medication that may affect either your clinical judgment or motor skills? If yes, give a full explanation of the details on a separate sheet. | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 |
| () - | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | () - |
| Language(s) Spoken (other than English) | | | | |
| | | | | |

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

Check if entire section unchanged since last date of credentialing

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

Primary Office Site # 1 Additional Office Site #

Group/Practice Name

Type of Practice

| | |
|---|---|
| <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Group <input type="checkbox"/> Corporation | <input type="checkbox"/> Hospital Based <input type="checkbox"/> Teaching or Research <input type="checkbox"/> Other (specify): |
|---|---|

Address (Building, Street, Suite #) City

State Zip Code County

Telephone Number Fax Number Answering Service/After-Hours Number

() - () - () -

Alternate Telephone Number Cell Phone Number Beeper/Pager Number

() - () - () -

E-Mail Address Long Range Beeper Number

() -

Medicare Number UPIN Number Medicaid Number

Are you currently accepting new patients? Have you closed your practice to any plans or programs?

| | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> By referral only <input type="checkbox"/> No <input type="checkbox"/> NA | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA If Yes, please list: |
|--|--|

Handicap Accessible? Public Transit Available?

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 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.)

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

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.)

| Back-up Coverage (Please list the name, specialty, and phone number of partner(s) or associate(s) or physician(s) covering your practice in your absence.) | | | |
|--|-----------|---------------------------------|--------------|
| Name | Specialty | Partner, Associate, Or Covering | Phone Number |
| | | | () - |
| | | | () - |
| | | | () - |
| | | | () - |

| Admitting Service | |
|--|-------------------------------------|
| Do you admit patients to the hospital under your own service? | If no, to whom do you admit? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA | |

| Practitioner Extenders Please check any of the following practitioner extender types and list individual names who you either employ or utilize for direct patient care. | |
|--|--|
| <input type="checkbox"/> Physician's Assistant: | <input type="checkbox"/> Nurse Practitioner: |
| <input type="checkbox"/> Nurse Midwife: | <input type="checkbox"/> Other (specify): |

| Workers' Compensation Information | |
|--|--|
| Do you accept Workers' Compensation Patients? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, please provide the following information: | a. Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Modified or alternative duty is actively evaluated for each Workers' Compensation claimant. <input type="checkbox"/> Yes <input type="checkbox"/> No c. Office will accommodate urgent walk-ins (or non-urgent appointments within 48 hours) to treat injured or ill workers and facilitate their return to work, if possible. <input type="checkbox"/> Yes <input type="checkbox"/> No d. Staff are available and willing to provide compensation representatives information regarding a claimant's care. <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

| 5. State License(s): List all <u>current</u> professional licenses (Submit copy of current licenses) | | | | | | |
|---|-----------|------------|-----------------|--|---|--|
| State | License # | Issue Date | Expiration Date | Status (Please check) | Is/was license restricted? | Reason License is/was Inactive or Restricted |
| | | | | <input type="checkbox"/> Active <input type="checkbox"/> Inactive | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | <input type="checkbox"/> Active <input type="checkbox"/> Inactive | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | <input type="checkbox"/> Active <input type="checkbox"/> Inactive | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | <input type="checkbox"/> Active <input type="checkbox"/> Inactive | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | <input type="checkbox"/> Active <input type="checkbox"/> Inactive | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Does the scope of your practice require the supervision of another practitioner? | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If Yes, please list name of each supervising practitioner: | | | | Practitioner Name: | | |

| 6. Certifications/Registrations | | |
|---|---|---|
| <input type="checkbox"/> Check here if entire section is not applicable to applicant or if no changes since last credentialing date. | | |
| Federal DEA Certificate <input type="checkbox"/> Not applicable (Submit copy of current DEA Certificate) | | |
| Certificate # | Expiration Date | Unlimited? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain: |
| | | |
| State DEA or CDS Certificate(s) <input type="checkbox"/> Not applicable (Submit copy of current State Controlled Dangerous Substance Certificates, if applicable) | | |
| Certificate # | Expiration Date | Unlimited? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain: |
| | | |
| Other Certificate(s) (Please check below if currently certified. Submit copy(s)) | | |
| <input type="checkbox"/> Basic Life Support (BLS) <input type="checkbox"/> Advanced Cardiac Life Support (ACLS) <input type="checkbox"/> Pediatric Advanced Life Support (PALS) <input type="checkbox"/> Advanced Trauma Life Support (ATLS) <input type="checkbox"/> Neonatal Advanced Life Support (NALS) | <input type="checkbox"/> Anesthesia Permit <input type="checkbox"/> Health Care Provider (Core C) <input type="checkbox"/> Neonatal Resuscitation Program (NRP) <input type="checkbox"/> Therapeutics Classification Number (Optometrists only) <input type="checkbox"/> Other (please list below or on a separate sheet and include descriptions): | |

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

| | |
|---|--|
| <p>If not certified, please indicate your status in the certifying process:</p> | <p><input type="checkbox"/> Failed to pass specialty board examination</p> <ul style="list-style-type: none"> • How many times have you taken the exam but failed to pass? _____ • Last date(s) exam was taken: _____ <p><input type="checkbox"/> Date(s) board examination was taken/retaken and date board exam is scheduled, if applicable:</p> <ul style="list-style-type: none"> • Date(s) taken/retaken: _____ • Date scheduled, if applicable: _____ <p><input type="checkbox"/> Not eligible to take specialty boards</p> <p><input type="checkbox"/> Not planning to take specialty boards</p> <p><input type="checkbox"/> Admissible with exam pending</p> |
|---|--|

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

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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Dates of Affiliation (Mo/Yr) | | |
| 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Dates of Affiliation (Mo/Yr) | | |
| 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Dates of Affiliation (Mo/Yr) | | |
| If yes, explain: | | From: | To: | |
| Reason for leaving, if applicable | | | | |

9. Additional Affiliations:

(Photocopy this page for additional affiliations)

| | | | | |
|--|--|-------------------------------------|--|------------|
| Name of Affiliation/Hospital/Healthcare Entity | | Type of Affiliation | | |
| Street Address | | City | State | Zip |
| Department/Service | | Department Chair's Name | | |
| Staff Status | | # Admits/Month | Percent of time spent at facility | |
| Restricted? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Dates of Affiliation (Mo/Yr) | | |
| 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Dates of Affiliation (Mo/Yr) | | |
| 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Dates of Affiliation (Mo/Yr) | | |
| 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: | | | |

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

15. Professional Liability Insurance Coverage Disclosure: (Respond only for actions since date of last credentialing.)

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

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

Professional Liability Information Addendum

(Photocopy this form for each case/action)

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/ls your status in the case? | 8. What is the status of the case? |
| <input type="checkbox"/> Primary Defendant <input type="checkbox"/> Co-Defendant <input type="checkbox"/> Other, please explain: | <input type="checkbox"/> Dropped <input type="checkbox"/> Pending <input type="checkbox"/> Settled Out of Court <input type="checkbox"/> Found for Defendant <input type="checkbox"/> Dismissed Without Payment <input type="checkbox"/> Found for Plaintiff <input type="checkbox"/> Under Appeal |
| 9. Amount of any Settlement or Award? | 10. Date of any Settlement or Award |

Please explain the following in detail. (If an item does not apply please check "N/A")

| | |
|---|------------------------------|
| 11. What was the alleged harm to the patient? | <input type="checkbox"/> N/A |
| 12. What were you alleged to have done incorrectly or failed to do? | <input type="checkbox"/> N/A |
| 13. Describe the patient's illness and related effects of the alleged harm. | <input type="checkbox"/> N/A |
| 14. Describe any other details you believe are pertinent to the case. | <input type="checkbox"/> N/A |
| 15. Identify any other parties named in the suit. | <input type="checkbox"/> N/A |

| | |
|-----------|------|
| Signature | Date |
| | |

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 |