

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

Form #2

Do Not Mark In This Box

FILED

2004 JUL 27 P 2:50

WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF A COMMENT PERIOD ON A PROPOSED RULE

AGENCY: Department of Health and Human Resources and the WV I TITLE NUMBER: 64

RULE TYPE: Procedural CITE AUTHORITY: § § 16-1A-2, 16-1A-3(c), 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: 89A

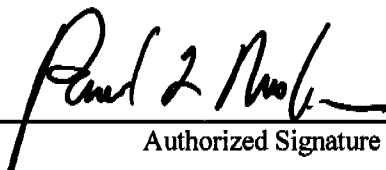
TITLE OF RULE BEING PROPOSED: Forms Applicable to the Uniform Credentialing
of Health Care Practitioners

IN LIEU OF A PUBLIC HEARING, A COMMENT PERIOD HAS BEEN ESTABLISHED DURING WHICH ANY INTERESTED PERSON MAY SEND COMMENTS CONCERNING THESE PROPOSED RULES. THIS COMMENT PERIOD WILL END ON August 27, 2004 AT 12:00 Noon ONLY WRITTEN COMMENTS WILL BE ACCEPTED AND ARE TO BE MAILED TO THE FOLLOWING ADDRESS:

DHHR- John Law or Ann Spaner
Building 3, Room 206
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305

Ins. Commission - Mary Jane Pickens
Post Office Box 50540
1124 Smith Str., Greenbrooke Bldg.
Charleston, West Virginia 25305-0540

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


Authorized Signature

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

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

**FORMS APPLICABLE TO THE UNIFORM
CREDENTIALING OF HEALTH CARE PRACTITIONERS**

TITLE 64, SERIES 89A

STATEMENT OF CIRCUMSTANCES

This new procedural rule incorporates the uniform credentialing form, the uniform recredentialing form, and the list of health care practitioners who are subject to the uniform forms, as these forms are amended. Other than deletion of the uniform forms and list, the uniform credentialing rule, 64CSR89, is not affected by this procedural rule, and its substantive terms will continue to govern uniform credentialing in this State. However, the forms and list will no longer be part of 64CSR89.

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

**FORMS APPLICABLE TO THE UNIFORM
CREDENTIALING OF HEALTH CARE PRACTITIONERS**

TITLE 64, SERIES 89A

SUMMARY OF RULE

This new procedural rule incorporates the uniform credentialing form, the uniform recredentialing form, and the list of health care practitioners who are subject to the uniform forms, as these forms are amended. The uniform credentialing rule, 64CSR89, is not affected by this procedural rule, and its substantive terms will continue to govern uniform credentialing in this State.

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

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

Type of Rule: Legislative Interpretive Procedural

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

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

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

1. Effect of Proposed Rule

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

2. Explanation of above estimates:

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

3. Objectives of these rules:

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

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None

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

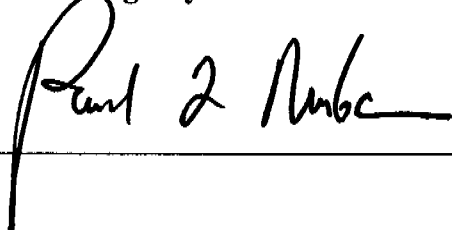
This new procedural rule should have no economic impact on political subdivisions or specific groups of citizens. Health care entities that credential health care practitioners have been using the uniform forms for almost a year, and the amendments to this rule will not create any changes to their credentialing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

C. Economic Impact on Citizens/Public at Large.

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

Date: _____, 2004

Signature of Agency Head or Authorized Representative



64CSR89A

TITLE 64

JOINT PROCEDURAL RULE

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

SERIES 89A

**FORMS APPLICABLE TO THE
UNIFORM CREDENTIALING OF HEALTH CARE PRACTITIONERS**

Section

64-89A-1. General.

64-89A-2. Applicability.

Appendix A: Uniform Credentialing Form.

Appendix B: Uniform Recredentialing Form.

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

64CSR89A

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TITLE 64

2004 JUL 15 P 1:39

JOINT PROCEDURAL RULE

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

SERIES 89A

FORMS APPLICABLE TO THE
UNIFORM CREDENTIALING OF HEALTH CARE PRACTITIONERS

§64-89A-1. General.

1.1. Scope. -- This procedural rule, a joint rule of the Department of Health and Human Resources and the West Virginia Insurance Commission, amends the uniform application forms required to be used for credentialing and recredentialing health care practitioners, and incorporates into this procedural rule those uniform application forms and the list of health care practitioners who must use the forms.

1.2. Authority. -- W. Va. Code §§16-1A-2, 16-1A-3(c), 16-1-4 and 33-2-10.

1.3. Filing Date. --

1.4. Effective Date. --

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

§64-89A-2. Applicability.

2.1. Except as otherwise provided, this rule applies to all hospitals, insurers, managed care organizations, third party administrators, or other health care entities that credential health care practitioners in this state and all health care practitioners listed in Appendix C of this rule. This procedural rule shall be read in *pari materia* with the rule entitled uniform credentialing of health care practitioners (64CSR89, §1, et seq.), which is a joint legislative rule promulgated by the Insurance Commissioner and the Secretary of the Department of Health and Human Resources pursuant to authority granted by the legislature in W. Va. Code §16-1A-2. All of the provisions provided in 64CSR89, §1, et seq., are equally applicable to this procedural rule. W. Va. Code §16-1A-3(c) authorizes the Insurance Commissioner and the Secretary of the Department of Health and Human Resources to amend the uniform application forms and list of health care practitioners who must use the forms by procedural, rather than legislative, rule. This procedural rule amends the uniform forms required to be used for credentialing and

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

recredentialing health care practitioners, and incorporates the uniform forms as well as the list of health care practitioners who must use the forms into this procedural rule. Upon the effective date of this procedural rule, the forms and lists attached to this procedural rule as Appendix A, Appendix B, and Appendix C, will apply to the credentialing and recredentialing of health care practitioners in this state.

State of West Virginia Credentialing Form

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

Practitioner's Name	Date
Social Security Number	Date of Birth

Credentialing Entity Name

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

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

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

State of West Virginia Credentialing Form

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

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

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

2. Office Practice Information

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

<input type="checkbox"/> Primary Office Site #1				<input type="checkbox"/> Additional Office Site #			
Group/Practice Name							
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 If Yes, please list	<input type="checkbox"/> No	<input type="checkbox"/> NA	
Handicap Accessible?				Public Transit Available?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	
Does the office have other services available for disabled? (TTY, ASI, Mental/physical impairments, etc.)				If yes, list below what services are available			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA					
Office Manager's Name			Nurse Manager's Name		Credentialing Contact		
<input type="checkbox"/> NA			<input type="checkbox"/> NA		Name: Phone#	<input type="checkbox"/> NA	
Office Hours							
<input type="checkbox"/>	Check if not applicable			<input type="checkbox"/>	Check if practitioner is not available to see patient during hours indicated		
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
AM	AM	AM	AM	AM	AM	AM	
PM	PM	PM	PM	PM	PM	PM	

Services Provided (Please check below if these services are available)							
<input type="checkbox"/>	Lab Services	<input type="checkbox"/>	On-Site	Reference Lab Name:		CLIA Number and Type of Certification:	
<input type="checkbox"/>	Radiology Services	<input type="checkbox"/>	EKG	<input type="checkbox"/>	Sigmoidoscopy	<input type="checkbox"/>	Audiology Services
<input type="checkbox"/>	Treadmill						
<input type="checkbox"/>	Other (Please list):						
<input type="checkbox"/>	List any special diagnostic or treatment procedures performed in your office:						
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 watch W-9)				Name affiliated with Tax ID Number (must watch W-9)			
Business Interests							
Do you or your business entity own, operate, have an interest in, or participate in any medical enterprise or business?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If yes, provide details on separate sheet	
Do you have a financial relationship with a hospital, clinical lab, nursing home, pharmacy, radiology lab, emergency room, or any other medical related organization?		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	If yes, provide details on separate sheet	
Practice Classification							
<input type="checkbox"/>	Primary Care Physician (Family Practitioners, Internists, or Pediatricians who deliver primary health care services)						
<input type="checkbox"/>	Specialist Physician (Physicians other than primary care physicians in their designated clinical practice)						
<input type="checkbox"/>	Allied Health Professional (Licensed, certified, or registered non-physician Practitioners of direct patient care services)						
<input type="checkbox"/>	Dual Role (Serve as both a Primary Care Physician as well as a Specialist)						
Directory Listing							
Should this office be listed in the directory?				Should this office receive correspondence?			
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Please indicate, in preference order, how you wish to be listed in the directory.							
Primary Specialty:				Secondary Specialty:			

After-Hours Coverage						
Do you provide 24-hour coverage?				Describe Coverage		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA				
Do you have an answering service/machine?				Is your answering service/machine available at all times when you are not in the office?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
List below other after-hours arrangements or special instructions to patients for after-hours care needs:						

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

Workers' Compensation Information			
Do you accept Workers' Compensation Patients?	<input type="checkbox"/> Yes		<input type="checkbox"/> No
If yes, please provide the following information:	a. Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an 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

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
	()	()	

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

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

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

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

Telephone # (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)		

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

State	License #	Issue Date	Expiration Date	States (Please check)	Is/was license restricted?	Reason License is/was Inactive or Restricted
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the scope of your practice require the supervision of another practitioner?				<input type="checkbox"/> Yes		<input type="checkbox"/> No
If Yes, please list name of each supervising practitioner:				Practitioner Name:		

6. Certifications/Registrations

. Check here if entire section is not applicable to applicant

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

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

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

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

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

Other Certificate(s)/Formal Training (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 Practitioner (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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.)				

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

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

9. Additional Affiliations:

(Photocopy this page for additional affiliations)

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

Name of Affiliation/Hospital/Healthcare Entity			Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.)		
Street Address			City	State	
Telephone Number			Fax Number		
()			()		

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

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

Reason for leaving, if applicable

Name of Affiliation/Hospital/Healthcare Entity		Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.)			
Street Address		City	State		
Telephone Number		Fax Number			
()		()			

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

Reason for leaving, if applicable

10. Work History/Experience:

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

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

Reason for leaving, if applicable

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

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

Reason for leaving, if applicable

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

Reason for leaving, if applicable

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

Reason for leaving, if applicable

11. Time Gaps

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

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

Section	Dates	Explanation
---------	-------	-------------

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

Medical/Professional Education	From: To:	
	From: To:	
	From: To:	
Professional Training	From: To:	
	From: To:	
	From: To:	
Hospital/Health Care Entity 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 as noted on Page 1 for the CME/CEU sessions you have completed in last two (2) years (if required by Credentialing Entity).

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.

Check here if not applicable

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

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

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

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

Coverage Effective Date	Coverage Termination Date	Amount of Coverage		If Umbrella/Excess coverage, amount of coverage
		\$	million/occurrence	\$
		\$	million/aggregate	
Policy Number	Type of Coverage		Do you have prior acts coverage?	
	<input type="checkbox"/> Claims Made	<input type="checkbox"/> Occurrence	<input type="checkbox"/> No	<input type="checkbox"/> Yes

15. Professional Liability Insurance Coverage Disclosure:

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

A. Has your professional liability insurance coverage every 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 and sign and date this form:

- Information for each professional liability action you have had taken against you, including those pending.
- Information for each settlement, or decision for the plaintiff that has ever occurred on our behalf.
- Practitioner Signature and Date

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.

<input type="checkbox"/> <input type="checkbox"/>	Check here if entire section is not applicable to applicant (and sign below even if no suits or settlements). Check here if no professional liability actions/claims filed (and sign below even if no suits or settlements).
--	---

1. Case Number	2. Carrier Name		
3. Name of Plaintiff	4. Date of Incident		
5. Date Filed	6. Date Closed		
7. What was/is your status in the case?	8. What is the status of the case?		
<input type="checkbox"/> Primary Defendant <input type="checkbox"/> Co-Defendant <input type="checkbox"/> Other, please explain:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"> <input type="checkbox"/> Dropped <input type="checkbox"/> Settled Out of Court <input type="checkbox"/> Under Appeal </td> <td style="width: 33%;"> <input type="checkbox"/> Found for Defendant <input type="checkbox"/> Pending <input type="checkbox"/> Dismissed Without Payment <input type="checkbox"/> Found for Plaintiff </td> </tr> </table>	<input type="checkbox"/> Dropped <input type="checkbox"/> Settled Out of Court <input type="checkbox"/> Under Appeal	<input type="checkbox"/> Found for Defendant <input type="checkbox"/> Pending <input type="checkbox"/> Dismissed Without Payment <input type="checkbox"/> Found for Plaintiff
<input type="checkbox"/> Dropped <input type="checkbox"/> Settled Out of Court <input type="checkbox"/> Under Appeal	<input type="checkbox"/> Found for Defendant <input type="checkbox"/> Pending <input type="checkbox"/> Dismissed Without Payment <input type="checkbox"/> Found for Plaintiff		
9. Amount of Any Settlement or Award?	10. Date of any Settlement or Award		

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

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

Practitioner Signature (REQUIRED)	Date (REQUIRED)

16. Practice Disclosure Information

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

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

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

P. Have you had any charges of unprofessional conduct brought against you?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Q. Have you had any charges of fraud brought against you?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
R. Have you received any confirmed Quality Citations from a Peer Review Organization (PRO) in the last two (2) years? If you answered yes, on a separate sheet, indicate the address of the PRO that cited you, the circumstances of the citation and the number of points you were fined.	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Health Status

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

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

Health Care Entity:

WEST VIRGINIA PRACTITIONER
ATTESTATION/AUTHORIZATION AND RELEASE OF INFORMATION

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

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

Print Name Here: _____

Signature: _____

Date: _____

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

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

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

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

ADDENDUM

VERIFICATION OF PROFESSIONAL LIABILITY

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

(Enter Current Professional Liability Insurance Carrier Name)

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

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

(Entity Specific)

_____ is to hereinafter be
(Entity Specific)

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

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

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

Practitioner's Signature Date

Printed Name

Policy Number

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

State of West Virginia Recredentialing Form

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

Attach additional sheets where necessary.

(Indicate clearly the practitioner name and section on each attachment)

Type or print clearly in black ink.

Sign and date the application.

Date of Last Credentialing (may be obtained from Entity if not provided)	
Practitioner's Name	Date
Social Security Number	Date of Birth
Credentialing Entity Name	

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

- Copy of current State License(s) For purposes of this application, State License shall include licensure from all 50 states, the District of Columbia, and U.S. Territories.
- Copy of current DEA Registration (if applicable)
- Copy of current State Controlled Dangerous Substance (CDS) Certificate (if applicable)
- Copy of current professional liability insurance policy face sheet, showing expiration dates, limits, and practitioner's name
- Copy of Board Certification Certificate(s) (if applicable), or other National Certification Certificates **(if changed since date of last credentialing)**
- Copies of CME/CEU session certificates (if required by Credentialing Entity)
- Signature requirements per each entity
- Professional Peer References (if required by Credentialing Entity)

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

State of West Virginia

Recredentialing Form

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

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

1. Applicant Information (Entire section must be completed)							
Last Name (as shown on state license)	First Name	Middle Name	Maiden Name	Suffix (e.g., Jr., Sr., etc.)			
Degree (e.g., MD, DO, DDS, DPM, PA-C, RN)							
Other Name(s) Also Known By							
Name(s)	Name:				Name:		
Date Name Used	From:		To:		From:		To:
Area(s) of Specialty (please be specific and list any primary focus)							
Specialty:				Sub-specialty:			
Current Home Address			City	State		Zip Code	
Home Telephone			Is this # unlisted?		Home Fax		
() -			[] Yes	[] No	() -		
If citizenship status or VISA status has changed, please indicate below and attach an explanation as well as pertinent documentation.							
[]			Citizenship/VISA status has changed.				
Language(s) Spoken (other than English)							

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

2. Office Practice Information: (Complete only for information changed since last date of credentialing)								
<input type="checkbox"/>		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.)								
<input type="checkbox"/>		Primary Office Site #1			<input type="checkbox"/>		Additional Office Site #2	
Group/Practice Name								
Type of Practice		<input type="checkbox"/> Individual Partnership <input type="checkbox"/> Group <input type="checkbox"/> Corporation		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Hospital Based Teaching or Research Other (specify):		
Address (Building, Street, Suite #)					City			
State		Zip Code			County			
Telephone Number		Fax Number			Answering Service/After-Hours Number			
() -		() -			() -			
Alternate Telephone Number		Cell Phone Number			Beeper/Pager Number			
() -		() -			() -			
E-Mail Address					Long Range Beeper Number			
					() -			
Medicare Number		UPIN Number			Medicaid Number			
Are you currently accepting new patients?				Have you closed your practice to any plans or programs?				
<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, explain:	
Handicap Accessible?				Public Transit Available?				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA		
Does the office have other services available for disabled? (TTY, ASL, Mental/physical impairments, etc.)				If yes, list below what services are available				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA						
Office Manager's Name		Nurse Manager's Name			Credentialing Contact			
Office Hours		<input type="checkbox"/> Check if not applicable		<input type="checkbox"/> Check if practitioner is not available to see patient during hours indicated				
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday		
AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM		
Services Provided (Please check below if these services are available)								
<input type="checkbox"/> Lab Services		<input type="checkbox"/> On-Site		Reference Lab Name:		CLIA Number and Type of Certification:		
<input type="checkbox"/> Radiology Services		<input type="checkbox"/> EKG		<input type="checkbox"/> Sigmoidoscopy		<input type="checkbox"/> Audiology Services		
<input type="checkbox"/> Treadmill								
<input type="checkbox"/> Other (Please list):								
<input type="checkbox"/> List any special diagnostic or treatment procedures performed in your office:								

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	
Billing Office Phone Number			Billing Manager's Name			
() -						
Tax ID Number (must match W-9)			Name affiliated with Tax ID Number (must match W-9)			
Business Interests						
Do you or your business entity own, operate, have an interest in, or participate in any medical enterprise or business?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, provide details on separate sheet.		
Do you have a financial relationship with a hospital, clinical lab, nursing home, pharmacy, radiology lab, emergency room, or any other medical related organization?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, provide details on separate sheet.		
Practice Classification						
<input type="checkbox"/> Primary Care Physician (Family Practitioners, Internists, or Pediatricians who deliver primary health care services) <input type="checkbox"/> Specialist Physician (Physicians other than primary care physicians in their designated clinical practice) <input type="checkbox"/> Allied Health Professional (Licensed, certified, or registered non-physician practitioners of direct patient care services) <input type="checkbox"/> Dual Role (Serve as both a Primary Care Physician as well as a Specialist)						
Directory Listing						
Should this office be listed in the directory?			Should this office receive correspondence?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Please indicate, in preference order, how you wish to be listed in the directory.						
Primary Specialty:			Secondary Specialty:			
After-Hours Coverage						
Do you provide 24-hour coverage?			Describe Coverage			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA				
Do you have an answering service/machine?			Is your answering service/machine available at all times when you are not in the office?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA

List below other after-hours arrangements or special instructions to patients for after-hours care needs:			
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:			
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	a. Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy?
	<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.

NOTE: Section 3 (Medical/Professional Education) and Section 4 (Professional Training) have been intentionally omitted. If additional formal education/training has been obtained since the date of last credentialing, please complete Sections 3 and 4 from the Credentialing application as appropriate and attach.

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

3. Medical/Professional Education:			
Please provide the following information for your medical school of graduation.			
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

NOTE: The remainder of Section 3 (Medical/Professional Education) and Section 4 (Professional Training) have been intentionally omitted. If additional formal education/training has been obtained since the date of last credentialing, please complete Sections 3 and 4 from the Credentialing application as appropriate and attach.

5. State License(s): List all current professional licenses (Submit copy of current licenses)						
State	License #	Issue Date	Expiration Date	Status (Please check)	Is/was license restricted?	Reason License is/was Inactive or Restricted
				<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 (Submit copy of current DEA Certificate)						
<input type="checkbox"/> Not applicable						
Certificate #		Expiration Date		Unlimited?		
				<input type="checkbox"/> Yes	<input type="checkbox"/> No	If no, explain:
State DEA or CDS Certificate(s) (Submit copy of current State Controlled Dangerous Substance Certificates, if Applicable)						
<input type="checkbox"/> Not applicable						
Certificate #		Expiration Date		Unlimited?		
				<input type="checkbox"/> Yes	<input type="checkbox"/> No	If no, explain :
Other Certificate(s)/Formal Training (Please check below if currently certified. Submit copy(s))						
<input type="checkbox"/>	Basic Life Support (BLS)	<input type="checkbox"/>	Anesthesia Permit			
<input type="checkbox"/>	Advanced Cardiac Life Support (ACLS)	<input type="checkbox"/>	Health Care Practitioner (Core C)			
<input type="checkbox"/>	Pediatric Advanced Life Support (PALS)	<input type="checkbox"/>	Neonatal Resuscitation Program (NRP)			
<input type="checkbox"/>	Advanced Trauma Life Support (ATLS)	<input type="checkbox"/>	Therapeutics Classification Number (Optometrists only)			
<input type="checkbox"/>	Neonatal Advanced Life Support (NALS)	<input type="checkbox"/>	Other (please list below or on a separate sheet and include descriptions):			

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

7. Specialty Board Certification: Complete for information changed SINCE DATE OF LAST CREDENTIALING. Submit copies of board certifications and/or qualification confirmation letter.			
<input type="checkbox"/>	Check here if entire section is not applicable to applicant or if no changes since last credentialing date.		
Are you board certified? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If not certified, please indicate your status in the certifying process:	<input type="checkbox"/> Failed to pass specialty board examination <ul style="list-style-type: none"> ● How many times have you taken the exam but failed to pass? _____ ● Last date(s) exam was taken: _____ <input type="checkbox"/> Date(s) board examination was taken/retaken and date board exam is scheduled, if applicable: <ul style="list-style-type: none"> ● Date(s) taken/retaken: _____ ● Date scheduled, if applicable: _____ <input type="checkbox"/> Not eligible to take specialty boards <input type="checkbox"/> Not planning to take specialty boards <input type="checkbox"/> Admissible with exam pending		

NOTE: Section 8 (Professional Peer References) has been intentionally omitted; however, may be required by specific entity in which case Section 8 from Credentialing application may be required as indicated on Page 1.

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

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

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

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

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

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

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

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

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

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

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

Please supply the following and sign and date this form:

- 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.
- Information for each settlement, or decision for the plaintiff that has occurred on your behalf SINCE LAST DATE OF CREDENTIALING.
- Practitioner Signature and Date

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 (and sign below even if no suits or settlements).
[]	Check here if no professional liability actions/claims filed (and sign below even if no suits or settlements).

1. Case Number	2. Carrier Name								
3. Name of Plaintiff	4. Date of Incident								
5. Date Filed	6. Date Closed								
7. What was/is your status in the case?	8. What is the status of the case?								
<input type="checkbox"/> Primary Defendant <input type="checkbox"/> Co-Defendant <input type="checkbox"/> Other, please explain:	<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Dropped</td> <td style="width: 33%;"><input type="checkbox"/> Found for Defendant</td> </tr> <tr> <td><input type="checkbox"/> Pending</td> <td><input type="checkbox"/> Dismissed Without Payment</td> </tr> <tr> <td><input type="checkbox"/> Settled Out of Court</td> <td><input type="checkbox"/> Found for Plaintiff</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Under Appeal</td> </tr> </table>	<input type="checkbox"/> Dropped	<input type="checkbox"/> Found for Defendant	<input type="checkbox"/> Pending	<input type="checkbox"/> Dismissed Without Payment	<input type="checkbox"/> Settled Out of Court	<input type="checkbox"/> Found for Plaintiff		<input type="checkbox"/> Under Appeal
<input type="checkbox"/> Dropped	<input type="checkbox"/> Found for Defendant								
<input type="checkbox"/> Pending	<input type="checkbox"/> Dismissed Without Payment								
<input type="checkbox"/> Settled Out of Court	<input type="checkbox"/> Found for Plaintiff								
	<input type="checkbox"/> Under Appeal								
9. Amount of any Settlement or Award?	10. Date of any Settlement or Award								

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

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

Practitioner Signature (REQUIRED)	Date (REQUIRED)

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

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

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

N. Has your request for any specific clinical privileges or scope of practice ever been denied (as a result of disciplinary action) or granted with stated limitations or conditions (aside from ordinary initial probationary requirements of proctorship)? Are such proceedings currently pending?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
O. Do you have any knowledge of any civil actions pending against you by any hospital, law enforcement agency, professional group or society?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
P. Have you had any charges of unprofessional conduct brought against you?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Q. Have you had any charges of fraud brought against you?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
R. Have you received any confirmed Quality Citations from a Peer Review Organization (PRO) in the last two (2) years? If you answered yes, on a separate sheet, indicate the address of the PRO that cited you, the circumstances of the citation and the number of points you were fined.	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Health Status			
<p>Note: Your application will be processed in the usual manner regardless of how you answer questions A and B. If you have answered "No" to question A or B, please explain completely on a separate sheet. If you are found to be qualified, a representative will contact you to determine what accommodations are necessary and feasible to allow you to practice safely.</p>			
A. Are you physically and mentally able to perform all the essential functions or services necessary to exercise the privileges or services applied for with or without a reasonable accommodation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
B. Are you able to perform these functions without significant risk of injury to yourself or others	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
C. Do you illegally use drugs? Have you used illegal drugs within the last two years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
D. Do you currently take any medications that may affect your ability to perform the clinical privileges or scope of practice requested competently and safely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Health Care Entity

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

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

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

Print Name Here _____

Signature: _____

Date: _____

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

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

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

ADDENDUM

VERIFICATION OF PROFESSIONAL LIABILITY

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

(Enter Current Professional Liability Insurance Carrier Name)

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

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

_____ is to hereinafter be a
(Entity Specific)

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

I will notify _____ of any changes
(Entity Specific)

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

Practitioner's Signature

Date

Printed Name

Policy Number

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