



1st

2nd

3rd

FAX:

Please complete the attached appointment application for health care organization privileges. A CV IS NOT ACCEPTABLE AS A SUBSTITUTE FOR COMPLETING THIS APPLICATION.

Some TPQVO client organizations will consider this a pre-application form until your eligibility is established. Upon establishment of eligibility, this application becomes official and the health care organization will begin processing this as an application for membership to its staff or network. If the health care organization determines you are not eligible, it will notify you directly.

The following items must be returned with your application or the verification process will not be started. This means there will be a delay in sending your application to the health care organization(s) to which you are applying until these items are received by TPQVO.

MAKE SURE YOU SUBMIT THE FOLLOWING:

(You do not need to resubmit if you believe TPQVO already has the information or document on file with the exception of item 3. and 12.)

1. A one-time Initial Application file set up/processing fee of \$150 payable to TPQVO.
(You do not need to pay this fee if you have paid this fee in the past.)
2. A copy of your driver's license or U.S. Government-issued Passport
3. A copy of the results from your most recent TB skin test
4. A copy of your current VISA/Alien Registration Card if not a U.S. Citizen
5. A copy of each current license/certification
6. A copy of your current face sheet of your current professional liability insurance policy
7. A copy of your diploma (college), training certificates
8. A copy of your certification
9. A copy of your CPR, ACLS, ATLS, PALS certificates (if applicable)
10. A copy of your DD-214 (Prior Military only)
11. Your Resume/Curriculum Vitae (CV)
12. CME Information for the past 2 years
13. **Make sure you answer the questions, sign and date the application and the Authorization and Release. We cannot process your application until we receive this authorization.**
14. A signed **Consent and Release for Criminal Background Check form** (a new Erlanger Health System requirement)

Please call TPQVO if you have any questions about this application for appointment at (423) 495-1191 or (888) 779-0300. For your convenience, you may email your completed and signed application with attachments to tpqvo@tpqvo.com.

**INITIAL APPLICATION
FOR
ALLIED HEALTH PRACTITIONER APPOINTMENT**

(PLEASE INDICATE YOUR PRACTITIONER CLASSIFICATION)

NAME: _____ TITLE: _____

- Cardiovascular Perfusionist
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Chiropractor
- Dental Assistant
- Nurse Practitioner
- Physician Assistant
- Non-Physician First Assistant
 - Physician Assistant
 - Registered Nurse First Assistant
 - Certified Surgical Assistant/Certified First Assist
- Surgical Technician
 - Registered Nurse/Operating Room
- Behavioral Health
 - Clinical Psychologist (PhD level)
 - Clinical Social Worker (Master's level)
 - Clinical Nurse Specialist (Master's level)
 - Other licensed, certified, or registered by the state behavioral health care specialist
 - Technologists
 - Therapists
- Optometrist
- Other _____

**APPLICATION FOR APPOINTMENT TO THE MEDICAL/PROFESSIONAL STAFF
ALLIED HEALTH PROFESSIONAL**

(Please type or print legibly)

PERSONAL INFORMATION

First Name Middle Last Name Suffix Degree Gender Race/Ethnic Origin (Optional)

Social Security Number Marital Status Previous Name Dates when this name was used Birth Date Birth Place

US Citizen? Yes No If no, alien registration number: _____
Languages Spoken/Read _____

Home address City State Zip Telephone Your business email (required)

PRACTICE INFORMATION

Are you an independent practitioner or sponsored by a physician? Independent Physician-sponsored Other (Organization, Etc)

Sponsoring Physician/Employer _____

Practice Name Office Contact

Primary Office Address City State Zip Telephone

Billing Address (if different) City State Zip Telephone

Page Number Pager Code Answering Service Fax Number Office Contact email

Partner(s) Office Contact Telephone

Solo Group Partnership Corporation _____
Other (please specify) Tax ID # NPI (individual, not group)

Specialty(ies) Special Practice Area(s) /Subspecialty Medicare # Medicaid #

Second Office (if applicable)

Secondary Office Address City State Zip Telephone

Secondary Office Practice Name Office Contact

Office Contact Telephone Fax Number

EDUCATION

List all undergraduate, Graduate and Postgraduate Education.

Institution	Dates: From	To	Degree conferred
Address			
Institution	Dates: From	To	Degree conferred
Address			
Institution	Dates Attended		Degree conferred
Address			

INTERNSHIP/PRACTICUM

List post-doctoral/fellowships/field placements.

Institution	Program Director	
Address		
Dates: From	To	Degree/Certificate Earned
Institution	Program Director	
Address		
Dates: From	To	Degree/Certificate Earned

MILITARY SERVICE

Military Reserves: Yes No Military Service Branch: _____

Date: Entry _____ Separation _____ Station where separated _____

Last Duty Assigned: _____ Type of Discharge _____

LICENSURE

List all current and past and specify the type of license. (If currently licensed in more than four states please supply the same information on a separate sheet and attach.)

State	Type	Number	Date Issued	Date Expires

DRUG ENFORCEMENT ADMINISTRATION INFORMATION (DEA)

Please attach a copy of your current DEA registration to this application if applicable..

Federal DEA registration number: _____ Date Issued: _____ Date Expires: _____

PRACTICE HISTORY

Please provide a chronological listing of clinical practice since training. If you need additional space, please use a separate sheet and attach to this application. **"See CV" or "See Attached" is not acceptable.** All time spans from graduation to present must be covered.

Facility Dates: From/To

Address

Position/Category Reason for Leaving

Facility Dates: From/To

Address

Position/Category Reason for Leaving

Facility Dates: From/To

Address

Position/Category Reason for Leaving

Facility Dates: From/To

Address

Position/Category Reason for Leaving

HOSPITAL STAFF AFFILIATIONS

List all past and present hospital staff affiliations in chronological order. If you need additional space, please use a separate sheet and attach.

Hospital Name(s) & Address (Please check box to indicate current Primary Facility)	Appointment Date	Resignation Date (if applicable)	Current Status
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			

CERTIFICATION

Are you Board Certified? Yes No Have you been Recertified? Yes No

Board	Year Certified	Year Recertified	Year Expires	Cert #
Board	Year Certified	Year Recertified	Year Expires	Cert #

OTHER CERTIFICATIONS

Please check all current certifications that apply and attach a copy of your current certificate.

- | | | |
|---|--|--|
| <input type="checkbox"/> BASIC CPR CERTIFICATION
Expires: _____
Instructor: <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> ACLS CERTIFICATION
Expires: _____
Instructor: <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> ATLS CERTIFICATION
Expires: _____
Instructor: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> PALS CERTIFICATION
Expires: _____
Instructor: <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> NRP CERTIFICATION
Expires: _____
Instructor: <input type="checkbox"/> Yes <input type="checkbox"/> No | |

PROFESSIONAL MEMBERSHIPS

List all professional memberships and societies, past and present. If additional space is required, please attach separate sheet of paper.

Name	Address	Currently a Member? (Y/N)

PEER REFERENCES

List Medical References from three (3) peers from 1 physician and 2 peers in the same specialty and profession who can attest to your current clinical abilities, ethical character and ability to work cooperatively with others. These should be individuals who will provide specific written comments on these matters upon request. If your training was completed within the past three years, you may list your Program Director(s). If you have been out of training for more than three years, you must name individuals who have not been listed in any other part of the application.

_____	_____	_____
Name	Telephone	Fax Number

Address (please include suite or room number)	City/State/Zip	Email Address

Name	Telephone	Fax Number

Address (please include suite or room number)	City/State/Zip	Email Address

Name	Telephone	Fax Number

Address (please include suite or room number)	City/State/Zip	Email Address

PROFESSIONAL HISTORY QUESTIONS

Answer all questions since your last (re)appointment. If any answer is "yes", give a full explanation on a separate attachment.

Have any of the following ever been or are currently in the process, either on a voluntary or involuntary* basis: denied, revoked, suspended, reduced, limited, placed on probation, not renewed or relinquished for disciplinary reasons?

	Yes	No
Health care professional registration/license in any state or district	<input type="checkbox"/>	<input type="checkbox"/>
State Controlled Substance Registration	<input type="checkbox"/>	<input type="checkbox"/>
Federal DEA Registration	<input type="checkbox"/>	<input type="checkbox"/>
Membership on any hospital medical/professional staff	<input type="checkbox"/>	<input type="checkbox"/>
Clinical privileges	<input type="checkbox"/>	<input type="checkbox"/>
Participation in the Medicare/Medicaid program	<input type="checkbox"/>	<input type="checkbox"/>
Membership in other health care organizations or plans (PPO, PHO, MSO, HMO, ASC)	<input type="checkbox"/>	<input type="checkbox"/>
Professional society membership	<input type="checkbox"/>	<input type="checkbox"/>
Board certification	<input type="checkbox"/>	<input type="checkbox"/>

* a voluntary relinquishment or voluntary non-renewal is for disciplinary reasons when the relinquishment or non-renewal is done to avoid an adverse action, preclude an investigation, or is done while the health care professional is under investigation related to professional conduct or competence.

Have you ever been terminated from any health care related job?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been convicted of a felony or are you presently indicted for a felony?	<input type="checkbox"/>	<input type="checkbox"/>
Has any claim of sexual harassment or violation of civil rights ever been made against you that resulted in your receiving or incurring any warning, disciplinary action, or civil liability?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been denied professional liability insurance?	<input type="checkbox"/>	<input type="checkbox"/>
Has your present professional liability insurance carrier excluded any specific procedures from your coverage or advised you that it intends to terminate, reduce, or otherwise restrict your coverage?	<input type="checkbox"/>	<input type="checkbox"/>
Have any professional liability suits ever been filed against you?	<input type="checkbox"/>	<input type="checkbox"/>
Have any professional liability suits filed against you resulted in a judgment against you or been terminated pursuant to a settlement in which you have paid damages to the plaintiff, with or without admitting liability?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever settled any professional liability claim against you prior to suit and admitted liability as a part of such settlement?	<input type="checkbox"/>	<input type="checkbox"/>
Do you now or have you in the past two years engaged in the illegal use of drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Are you unable to perform any of the essential functions related to the medical /professional staff position and clinical privileges for which you are applying with or without accommodation according to accepted standards of professional performance and without posing a direct threat to patients?	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH EXAMINATION

Some TPQVO Clients* require that a health examination be performed within the last two years. Please provide the name of the physician who performed the examination. (The examining physician may not be a practice associate.)

Examination Date: _____ Examining Physician: _____

Physician's Address: _____

Telephone: _____ Fax: _____

* Please check with the organization to which you are applying whether a health examination is required.

PROFESSIONAL LIABILITY INSURANCE

Do you currently have malpractice insurance? Yes No

List all professional liability insurance carriers for the past 5 years, beginning with the most recent:

Carrier	Limits	Occ/Claims	Policy number	Dates
Address				
Carrier	Limits	Occ/Claims	Policy number	Dates
Address				
Carrier	Limits	Occ/Claims	Policy number	Dates
Address				

MEDICAL PROFESSIONAL STAFF MEMBERSHIP

Please check which health care facilities for which you are applying for staff privileges or membership and to whom you wish this application form mailed.

- | | |
|---|---|
| <input type="checkbox"/> Center for Sports Medicine and Orthopaedic Surgery | <input type="checkbox"/> Parkridge Medical Center, Inc (Parkridge East, Parkridge Valley, Parkridge Medical Center, Parkridge West Hospital fka Grandview Medical Center) |
| <input type="checkbox"/> CHI Memorial Hospital Georgia (Ft Oglethorpe) | <input type="checkbox"/> Rhea Medical Center |
| <input type="checkbox"/> Erlanger Medical Center | <input type="checkbox"/> Siskin Hospital for Physical Rehabilitation |
| <input type="checkbox"/> Memorial Health System (Memorial and North Park Hospitals) | |
| <input type="checkbox"/> | |

SIGNATURE

I certify the information in this application is true and complete.

Signature: _____

Date: _____

Name _____

Send completed application to:

TPQVO, LLC
1092 Chamberlain Ave, Suite B
Chattanooga, TN 37404
(423) 495-1191
(423) 495-1190 FAX
tpqvo@tpqvo.com

Participating facilities do not discriminate on the basis of race, color, sex, religion, age, national origin or handicap.

AUTHORIZATION AND RELEASE OF APPLICANT

PLEASE READ CAREFULLY BEFORE SIGNING

I understand and acknowledge that, as an applicant for medical/professional staff at the hospital or ambulatory care center, state and county medical society membership, or affiliation with a health care network or plan (hereafter referred to as "Organizations") indicated in this Application, it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, judgment, health status, character, ethics and any other criteria adopted by Organizations for medical/professional staff membership or medical and/or surgical privileges or affiliation.

I further acknowledge that I am responsible for knowing the contents of the bylaws, rules and regulations of the Organizations and their medical/professional staffs and agree to be bound by them if granted membership and/or privileges or affiliation.

I further understand and acknowledge that the Tennessee Physicians' Quality Verification Organization, LLC ("TPQVO") acting as a contractor for the Organizations will investigate the information in this Application. By submitting this Application, I agree and consent to such investigation activities of TPQVO and Organizations as follows:

Authorization of Investigation and Release of Information Concerning Application for Appointment. I authorize all individuals, institutions and entities, including but not limited to administrators and members of the medical/professional staffs of other facilities, organizations or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who have knowledge concerning information requested in this Application, who have knowledge concerning information requested in this Application, to consult with and release relevant information to TPQVO and Organizations, their medical/professional staffs, credentialing committees and agents.

Release from Liability. I hereby release from liability Organizations, TPQVO and their respective agents, and all other individuals, institutions and entities providing information in accordance with the authorizations contained herein for their acts performed in good faith and without malice in connection with the investigation of this Application for Appointment. This release shall be cumulative and in addition to any other applicable immunities provided by law for medical care review activities.

Use of Information. I acknowledge that part of the information to be provided by me is for identification purposes only and will not be used to form the basis of decisions regarding medical/professional staff membership or credentialed status.

I understand and agree that the authorizations I have provided are irrevocable so long as I am an applicant for or have medical/professional staff privileges at or am affiliated with any Organizations participating in TPQVO's central verification service.

I acknowledge that the investigation of information in this Application by the Organizations, TPQVO and their agents is done to achieve, maintain and improve quality patient care.

I agree to provide continuous care for each of my patients and recognize my responsibilities therein.

I consent to an inspection of my records and agree to an interview if requested.

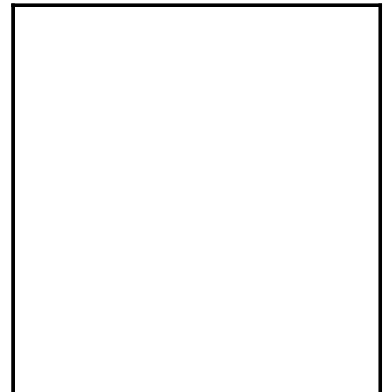
All information provided by me in the Application is true and complete to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the Application may constitute grounds for denial of appointment or for summary dismissal from the medical/professional staff. I understand and acknowledge that the Organizations shall be solely responsible for all decisions concerning medical/professional staff membership and the granting of medical and/or surgical privileges or credentialed status. Medical/professional staff membership are determined independently. I further understand and acknowledge that TPQVO has no responsibility or liability with respect to medical/professional staff membership or credentialing decisions by Organizations.

I further acknowledge that I have read and understand the foregoing Authorization and Release.

Name (Please print) _____ Date _____

Signature _____

A photocopy of this Authorization and Release shall be as effective as the original.



CONSENT AND RELEASE FOR CRIMINAL BACKGROUND CHECK

I am receiving this consent and release because the healthcare organization to which I have applied for medical staff membership or continuation of my membership requires a criminal background check as part of the medical staff screening process and that the Tennessee Physicians' Quality Verification Organization, LLC (TPQVO) is processing this check on behalf of the healthcare organization either directly or through a third party criminal background screening service.

In connection with my application for medical staff membership or my continued medical staff membership, I have been advised and I hereby consent and authorize TPQVO and its agent, at any time during my application process to conduct an investigative consumer report that may include, but not be limited to, a criminal record check. I do hereby consent and authorize TPQVO and its agent to use any information provided on this form or during the application process in performing the investigative consumer report. I have been informed that I have the right to review and challenge any negative information that would adversely affect me or adversely affect a decision to extend membership. I agree to release, indemnify and hold harmless TPQVO and any consumer reporting agency used by TPQVO with regard to any information reported by the consumer reporting agency.

I have also been informed that I have the right to review and challenge any negative information that would adversely affect a decision by the healthcare organization client to extend or continue medical staff membership. In addition, I have been informed that I will have a reasonable opportunity to clear up any mistaken information reported within a reasonable time. Under the Fair Credit Reporting Act, I have been advised that upon request I will be provided the name, address and telephone number of the reporting agency as well as the nature, substance and source of all information. In addition, upon timely written request to TPQVO the name, address and telephone number of the consumer reporting agency and the nature and scope of the investigative report will be disclosed to me.

I acknowledge that facsimile, copy or email of this document shall have the same validity, force and effect as the original. I hereby certify that all information provided in this background check disclosure notice, my application for membership or reapplication for membership to healthcare organization medical staffs or panels, and authorization form is true, correct and complete. If any information proves to be incorrect or incomplete, I understand that grounds for termination of current membership or cancellation of any and all offers of medical staff membership are at the discretion of TPQVO clients using this information.

New York Applicants Only: I acknowledge receipt of a copy of Article 23-A of New York Correction Law.

NOTICE TO CALIFORNIA CANDIDATES

You have a right to obtain a copy of any consumer report or investigative consumer report obtained by TPQVO by checking the box provided below. The report will be provided to you within three (3) business days after we receive the requested reports related to the matter investigated.

I request to receive a free copy of this report by checking this box.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by GIS during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at GIS in person or by mail. You may also receive a summary of the file by telephone. The agency is required to have personnel available to explain your file to you and the agency must explain to you any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.

Signature

Printed Name

Date

Please list addresses at which you lived for past 7 years:

From ___/___ to ___/___

From ___/___ to ___/___

From ___/___ to ___/___

A summary of rights under the Fair Credit Reporting Act can be found at found online at <http://www.ftc.gov/bcp/edu/pubs/consumer/credit/cre35.pdf>

CONTINUING EDUCATION

Name: _____

Date: _____

Please attach a copy of each certificate received confirming CE hours listed below

Category	Meeting or Activity	Date and Place	Credit Hours
Category I (Accredited Sponsorship)			
Category II (Non-accredited sponsorship)			
Category III (Teaching)			
Category IV (Papers, books, publications and exhibits)			
Category V (Non-supervised individual CE Activities)			
Category VI (other meritorious learning experiences)			

TO: All Medical Professional Staff Members

As part of the process of applying for hospital admitting privileges to a TPQVO participating hospital/facility, the physician must complete the following acknowledgment at the time he or she is granted those privileges or before or at the time the physician admits his or her first patient to the hospital. This acknowledgment will remain in effect as long as the physician has admitting privileges to the hospital. These statement files are subject to audit by the PRO and other designees of the Director of CHAMPUS.

MEDICARE/CHAMPUS ACKNOWLEDGMENT STATEMENT
NOTICE TO PHYSICIANS

"Medicare/CHAMPUS payment to hospitals is based, in part, on each patient's principal diagnoses and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his/her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for the payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws."

Signature of Physician

Date

Name (Please Print)

(For Facility's Use: Do Not Complete)

Facility Name _____

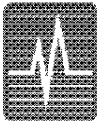
Provider Number _____

PRO Contact Name _____

PRO Contact Telephone Number _____

Physician's Full Name _____

NPI _____



SVMIC[®]
State Volunteer Mutual Insurance Company

101 Westpark Drive, Suite 300
Brentwood, TN 37027-5031
Phone 615.377.1999
www.svmic.com



AUTHORIZATION AND RELEASE FORM

From: _____ Medical License Number: _____ State _____

RELEASE OF INFORMATION TO:
(Complete Address)

TENNESSEE PHYSICIANS' QUALITY VERIFICATION ORGANIZATION, LLC
1092 CHAMBERLAIN AVE, SUITE B
CHATTANOOGA, TN 37404

State Volunteer Mutual Insurance Company ("SVMIC") is the carrier of my medical professional liability insurance, and as such SVMIC maintains certain information regarding my medical practice -- specifically the history of any malpractice claims against me. I understand that this information is extremely sensitive and confidential. I acknowledge that SVMIC is protective of this information and will only release it upon my express and unambiguous consent and direction. I have decided, for reasons related to my practice, that certain information from SVMIC be provided as requested. I authorize SVMIC to provide to the above person or organization information relating to many professional liability claims activity against me that has been reported and covered by SVMIC, but specifically limited to: a) Claims that have resulted in paid losses (settlements), and/or b) Lawsuits (open or closed).

I HEREBY RELEASE SVMIC, ITS OFFICERS DIRECTORS, EMPLOYEES AND AGENTS FROM ANY CLAIMS, LIABILITIES, ACTIONS DAMAGES OR OTHERWISE, FOR THE RELEASE OF SUCH INFORMATION IF SUCH RELEASED INFORMATION IS DELIVERED IN GOOD FAITH AND WITHOUT MALICE. I ALSO ACKNOWLEDGE THAT MISTAKES MAY OCCUR IN THE PROVISION OF SUCH INFORMATION, AND WITHOUT LIMITING THE FOREGOING, I SPECIFICALLY RELEASE SVMIC, ITS OFFICERS DIRECTORS EMPLOYEES AND AGENTS FROM ANY CLAIMS DUE TO INCORRECT, MISDELIVERED, OR OTHERWISE INAPPLICABLE INFORMATION IF SUCH ERRORS OCCURRED IN GOOD FAITH, AND UPON DISCOVERY, SVMIC TAKES REASONABLE CORRECTIVE ACTIONS.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL SPECIFICALLY REVOKED BY ME IN WRITING.

Signature of Insured

Date

Print Name

Policy Number _____

For Extender Employees - Please Provide Name of Employer _____