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:

1. __X__ **A copy of your driver's license or U.S. Government-issued Passport** (this is a new Joint Commissioner requirement)
2. __X__ A copy of your current VISA/Alien Registration Card if not a U.S. Citizen
3. __X__ A copy of each current license/certification
4. __X__ A copy of your current face sheet of your professional liability insurance policy (Past 5 years)
5. __X__ A copy of your diploma (college), training certificates (Transcripts)
6. __X__ A copy of your certification
7. __X__ A copy of your CPR, ACLS, ATLS, PALS certificates (if applicable)
8. __X__ A copy of your DD-214 (Prior Military only)
9. __X__ Your Resume/Curriculum Vitae (CV)
10. __X__ Continuing Education Information for the past 2 years
11. __X__ **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.

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

TPQVO
Your credentialing partner
www.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

Languages Spoken/Read

US Citizen? ☐ Yes ☐ No If no, alien registration number: ____________________

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

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EDUCATION

List all undergraduate, Graduate and Postgraduate Education.

Institution Dates: From To Degree conferred

Address Program Director Email Phone Fax

Institution Dates: From To Degree conferred

Address Program Director Email Phone Fax

Institution Dates: From To Degree conferred

Address Program Director Email Phone Fax

INTERNSHIP/PRACTICUM

List post-doctoral/fellowships/field placements.

Institution Program Director Phone

Address Email Fax

Degree/Certificate Earned

Dates: From To

Institution Program Director Phone

Address Email Fax

Degree/Certificate Earned

Dates: From To

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
State	Type	Number	Date Issued	Date Expires
State	Type	Number	Date Issued	Date Expires
State	Type	Number	Date Issued	Date Expires

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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
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			

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____

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.

☐ BASIC CPR CERTIFICATION
Expires: ____________
Instructor: ☐ Yes ☐ No

☐ ACLS CERTIFICATION
Expires: ____________
Instructor: ☐ Yes ☐ No

☐ ATLS CERTIFICATION
Expires: ____________
Instructor: ☐ Yes ☐ No

☐ PALS CERTIFICATION
Expires: ____________
Instructor: ☐ Yes ☐ No

☐ NRP CERTIFICATION
Expires: ____________
Instructor: ☐ Yes ☐ 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

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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	☐	☐
State Controlled Substance Registration	☐	☐
Federal DEA Registration	☐	☐
Membership on any hospital medical/professional staff	☐	☐
Clinical privileges	☐	☐
Participation in the Medicare/Medicaid program	☐	☐
Membership in other health care organizations or plans (PPO, PHO, MSO, HMO, ASC)	☐	☐
Professional society membership	☐	☐
Board certification	☐	☐

* 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.

	Yes	No
Have you ever been terminated from any health care related job?	☐	☐
Have you ever been convicted of a criminal offense (other than minor traffic violations) or are you presently indicted for a felony?	☐	☐
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?	☐	☐
Have you ever been denied professional liability insurance?	☐	☐
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?	☐	☐
Have any professional liability suits ever been filed against you?	☐	☐
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?	☐	☐
Have you ever settled any professional liability claim against you prior to suit and admitted liability as a part of such settlement?	☐	☐
Do you now or have you in the past two years engaged in the illegal use of drugs?	☐	☐
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?	☐	☐

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

CONTINUING EDUCATION CREDITS (CEUs)

Do you attest that you have attended CME programs in the past 2 years that relate to your area of practice, and that you will be able to provide proof of attendance and program content upon request? ☐ YES ☐ NO

MEDICAL PROFESSIONAL STAFF MEMBERSHIP

Please indicate the TPQVO client health care facilities for which you are applying for staff privileges or membership and to whom you authorize release of your application and credentialing information. Please note: Lakeside Behavioral Health membership is by invitation only.

SIGNATURE

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

By typing your name below, you acknowledge that it serves as a legal equivalent to your handwritten signature, signifying your agreement to the terms and conditions outlined above.

Date:

Name

Signature

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.

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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.

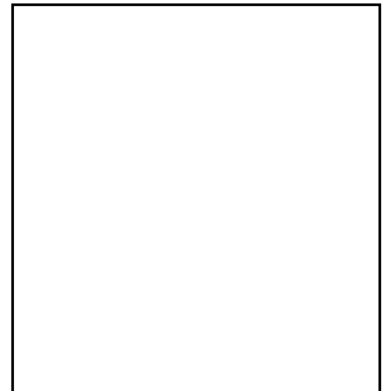
I further acknowledge that I have read and understand the foregoing Authorization and Release.

By typing your name below, you acknowledge that it serves as a legal equivalent to your handwritten signature, signifying your agreement to the terms and conditions outlined above.

Name (Please print) ______________________________ Date __________

____
Signature

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



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."

By typing your name below, you acknowledge that it serves as a legal equivalent to your handwritten signature, signifying your agreement to the terms and conditions outlined above.

____
Name

______________________________ ______________
Signature of Physician/Practitioner Date

(For Facility's Use: Do Not Complete)

Facility Name ______________________________

Provider Number ______________________________

PRO Contact Name ______________________________

PRO Contact Telephone Number ______________________________

Physician's Full Name ______________________________

NPI ______________________________