TPQVO
Your credentialing partner
www.tpqvo.com

1st

2nd

3rd

FAX:

Dear _____

Please review the attached reappointment application for health care organization and make changes/corrections if necessary. **The following items must be returned with your completed application:**

__X__ **A copy of your Driver's License or U.S. Government-issued Passport**
_____ A copy of your TB Test Result from the past 2 years
_____ A copy of each current license/certification showing expiration date
_xx__ A copy of the current face sheet of your **Professional Liability Insurance** policy
_____ A copy of your **certification** (if applicable)
_XX_ A copy of your current **Federal DEA Certificate** (if applicable)
_____ **A copy of your CPR, ACLS, ATLS, PALS certificates**
_____ A statement from your examining physician
_____ Your current Resume/Curriculum Vitae (CV)
__X__ CEU Information (Continuing Education Units) for the past 2 years

__X_ **Completed Reappointment Application**

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 reappointment at (423) 495-1191.

For your convenience, you may email your completed and signed application with attachments to tpqvo@tpqvo.com.

REAPPOINTMENT APPLICATION FOR MEDICAL/PROFESSIONAL STAFF ALLIED HEALTH MEMBERSHIP

Please Type or Print Legibly. If this form is pre-filled, please mark out incorrect responses and provide updated information.

PERSONAL INFORMATION

First Name | Middle | Last Name | Suffix | Degree | Gender

Marital Status | Previous Name | Spouse's Name

Social Security # | Birth Date | Birth Place | Other language(s) spoken | Race/Ethnic Origin (optional)

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

PRACTICE INFORMATION

Primary Office Address | City | State | Zip | Telephone

Secondary Office Address | City | State | Zip | Telephone

Pager | Pager Code | Answering Service | Fax Number | Office Contact email

Practice Name | Affiliation Date | Office Contact

Partner(s) | Office Contact Telephone

☐ Solo ☐ Group ☐ Partnership ☐ Corporation _____ Other (please specify)

Specialty(ies) | Special Practice Area(s) /Subspecialty

Tax ID # | /NPI | Medicare # | Medicaid # | CLIA #

Are you an Independent Allied Health Affiliate, or are you sponsored by a physician?

☐ Independent ☐ Physician-sponsored ☐ Other(Agency,Organization,Etc)

SPONSOR NAME | Address | Office Telephone | After hours Telephone

SPONSOR NAME | Address | Office Telephone | After hours Telephone

HOSPITAL AFFILIATIONS

Please list all current and past affiliations in the past 2 years.

Hospital Name(s) & Address Please check box for primary admitting facility		Appointment Date	Resignation Date (if applicable)	Current Status	Request change in status?
	☐				
	☐				
	☐				
	☐				
	☐				
	☐				
	☐				

FELLOWSHIPS/TEACHING

Please list all Fellowships and Teaching Appointments in the last two years.

Institution _____ Department _____

Address _____ City _____ State _____ Zip _____ Dates: From / To _____

Program Director _____ Teaching Position _____ Full time? (Y/N)

LICENSURE

Please attach a copy of All Current Professional Licenses and DEA Certificate(s). (Please attach sheet with additional licensing information)

Primary State License # _____ Expiration Date _____ Other Current State License(s) and expiration date(s) _____

State licenses and expiration dates continued _____ DEA Number(s) _____ Expiration Date(s) _____

CERTIFICATION

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

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

Other Board _____ Year Certified _____ Year Recertified _____ Year Expires _____ Cert # _____

Other 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

LIABILITY INSURANCE

Please list all Professional Insurance policies held in the past 2 years. Attach a Copy of your Current Professional Insurance Policy face sheet showing the name of Carrier, policy Number, Amounts of Coverage, and Policy Expiration Date.

Do you currently have malpractice insurance? ☐ Yes ☐ No

Carrier Name _____ $ Per Occurrence/$ Per Annum _____ Policy # _____ Expiration Date _____

Carrier Address _____ City _____ State _____ Zip _____

Carrier Name _____ $ Per Occurrence/$ Per Annum _____ Policy # _____ Expiration Date _____

Carrier Address _____ City _____ State _____ Zip _____

PEER REFERENCES

List names and addresses of three (3) peers in the same profession and specialty 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. You must name individuals who have not been listed in any other part of the application.

Name _____ Telephone _____ Fax Number _____

Address _____ City/State/Zip _____ Email Address _____

Name _____ Telephone _____ Fax Number _____

Address _____ City/State/Zip _____ Email Address _____

Name _____ Telephone _____ Fax Number _____

Address _____ 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 in the past two years been or are currently under investigation, 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 license/registration 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.

Have you in the past two years been terminated from any health care related job?	☐	☐
Have you in the past two years 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 in the past two years been made against you that resulted in your receiving or incurring any warning, disciplinary action, or civil liability?	☐	☐
Have you in the past two years 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 in the past two years 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?	☐	☐

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 or a relative.)

Examination Date: _____ Examining Physician: _____

Physician's Address: _____

Telephone: _____ Fax: _____

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

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

HEALTH CARE FACILITY MEMBERSHIPS

Please review the list of health care facilities for which TPQVO will process your reappointment and to whom you authorize release of the reappointment and credentialing information. If you are on another health care facilities that is not listed, please write it in.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

If you no longer wish to continue your membership at a health care facility listed above or would like to apply to another facility, you will need to contact that facility directly.

SIGNATURE/CERTIFICATION

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

_____ _____

Signature: Date:

_____

Name

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

PLEASE RETURN UPDATED APPLICATION AND ATTACHMENTS TO:

TPQVO, LLC
1092 CHAMBERLAIN AVE., SUITE B
CHATTANOOGA, TN 37404
(423) 495-1191
tpqvo@tpqvo.com

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.

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 _____

Last revised on 03/17/2025

CONTINUING EDUCATION

I attest that all information provided on this page is true and accurate. I understand that the information provided may be subject to review at which point I will provide proof of attendance of all CE events.

Signature _____ Name (please print) _____ Date _____

Category	Meeting or Activity	Date and Place	Credit Hours
Category 1 (Accredited Sponsorship)			
Category II (Non-accredited sponsorship)			
Category III (Medical Teaching)			
Category IV (Papers, books, publications and exhibits)			
Category V (Non-supervised individual CME Activities			
Category VI (other meritorious learning experiences			