TPQVO
Your credentialing partner
www.tpqvo.com

Response May Be Email, Mail, or Fax
Fax: (423) 495-1189; (423) 495-1190
tpqvo@tpqvo.com

1st

2nd

3rd

FAX:

Dear

Please review the attached reappointment application for medical /professional staff membership and make changes/corrections and additions, if necessary. **The following items must be returned with your completed application (**please provide the document if checked**):**

_____ A **copy of your Driver's License or U.S. Government-issued Passport**

_____ A copy of your Tennessee and/or other state current **Medical License** or wallet card showing expiration date

__xx_ A copy of the face sheet of your **Professional Liability Insurance** policy

_____ A copy of your **ABMS** or **AOMS Board certification** (if applicable)

_XX_ A copy of your current **Federal DEA Certificate**

_____ **CME** information for the past 2 years (See CME requirements on Page 8)

_____ A signed **SVMIC Authorization to Release** (if applicable)

__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 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

Mobile Number | Answering Service | Fax Number | Office Contact e-mail

REQUIRED: Sequence of Telephone Numbers at which you can be reached (cellphones, home phones, etc.). Please include number if not otherwise provided on this application:

1. _____ 2. _____ 3. _____ 4. _____

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 # | YOUR (applicant's) NPI | Medicare # | Medicaid # | CLIA #

Call Coverage (all offices):

Do you provide call coverage 24 hours/day, 7 days a week and does this mechanism provide the ability to contact the covering medical professional? If yes, please provide the information requested below. ☐ Yes ☐ No

Physician sharing call (if outside your group) | Address | Office Telephone | After hours Telephone

Physician sharing call (if outside your group) | Address | Office Telephone | After hours Telephone

HOSPITAL AFFILIATIONS

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

Hospital Name(s) Please check box for current 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 past 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 Medical Licenses and DEA Certificate. (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 Board Certified? ☐ Yes ☐ No Have you been Recertified? ☐ Yes ☐ No

American 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 Malpractice Insurance policies held in the past 2 years. Attach a Copy of your Current Malpractice 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 Medical References from three (3) peers in the same 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.

In the past two years, Have any of the following ever 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
Medical license in any state or jurisdiction	☐	☐
Other professional registration/license	☐	☐
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	☐	☐
ECFMG 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 practitioner is under investigation related to professional conduct or competence.

In the past two years, have you been convicted of a criminal offense (other than minor traffic violations) or are you presently indicted for a felony?	☐	☐
In the past two years, 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?	☐	☐
In the past two years, have you been denied professional liability insurance?	☐	☐
In the past two years, 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?	☐	☐
In the past two years, have any professional liability suits been filed against you?	☐	☐
In the past two years, 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?	☐	☐
In the past two years, have you 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?	☐	☐
Do you have any physical or mental condition, or emotional impairment which would affect your ability to carry out your professional duties or to exercise the clinical privileges you have or will request, or would require an accommodation in order for you to exercise the requested privileges safely and competently?	☐	☐
Do you or a member of your family own, have an investment in, or otherwise have a direct or indirect interest in any clinical laboratory, diagnostic or testing center, hospital, surgicenter, or other business dealing with the provision of ancillary health services, equipment or supplies? If yes, complete the following:	☐	☐

Name of Organization: _____

Address: _____

Tax Identification Number: _____

Telephone Number: _____

Type and Size of Organization: _____

% of Business Invested by Applicant: _____

Nature of business interest: _____

HEALTH EXAMINATION

A health examination must be performed within the past 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 Number: _____

CONTINUING EDUCATION CREDITS (CMES)

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

Please observe the individual health care facility requirements listed on Page 8

HEALTH CARE FACILITY MEMBERSHIPS

Listed below are the TPQVO client facilities to which this reappointment application form will be sent and to which you authorize release of your credentialing information. Please feel free to write in additional health care facilities to which you are currently on staff and authorize release of this application and reappointment/recredentialing information.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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

HAMILTON COUNTY EMERGENCY RESPONSE PLAN PHYSICIAN VOLUNTEER PROGRAM

The Physician Volunteer Program offers assistance to local hospitals, the medical community and the public health department in a major emergency crisis situation such as natural disasters, accidental or intentional chemical releases, acts of terrorism, and other large public health threats. Please check "yes" if you are interested in volunteering or would like the Chattanooga-Hamilton County Health Department to contact you with more information about the program. ☐ Yes ☐ No

SIGNATURE/CERTIFICATION

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

_____ _____

Signature Date

_____

Name

TMA, the county medical societies and 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

PLEASE INDICATE IF YOU ALSO WISH TO BELONG TO YOUR LOCAL COUNTY MEDICAL SOCIETY & TENNESSEE MEDICAL ASSOCIATION (if you are not currently a member):

☐ YES ☐ NO

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.

CONTINUING MEDICAL 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 CME 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			

CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS

CHI Memorial Georgia	40 hours every 2 years
Kindred Hospital - Chattanooga	40 hours every 2 years
Memorial Health Care System (Memorial Hospital)	40 hours every 2 years IF RECENT GRADUATE PLEASE PROVIDE SURGERY LOG
Memorial Health Services	40 hours every 2 years IF RECENT GRADUATE PLEASE PROVIDE SURGERY LOG
Parkridge Medical Center, Inc	40 hours every 2 years IF RECENT GRADUATE PLEASE PROVIDE SURGERY LOG
Rhea Medical Center	40 hours every 2 years (with Certificates)
Siskin Rehabilitation Hospital	40 hours every 2 years (with Certificates)
Center For Sports Medicine and Orthopaedic Surgery	40 hours every 2 years (with Certificates)

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