



1st

2nd

3rd

FAX:

Application for

Dear

Please complete the attached application for medical /professional appointment or health plan network membership (Health Care facility/Agency/Employer).

Some health care 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 completed application:

- A one-time Initial Application setup/processing fee of **\$125.00**
- A copy of your most recent TB skin test result** (positive results will be handled by the individual hospital)
- A copy of your driver's license or U.S. government-issued Passport**
- A copy of your current VISA/Alien Registration Card if not a U.S. Citizen
- A copy of your Medical or Dental Degree**
- A copy of your **ECFMG Certificate** (if applicable)
- A copy of your **Certificate of Completion** from your **Internship Program**
- A copy of **Certificate of Completion** from **Residency Program**
- A copy of your Tennessee or other state current **Medical License** or wallet card showing expiration date
- Your **Curriculum Vitae** or **Biography**
- A copy of the face sheet or your **Professional Liability Insurance** policy (Past 5 Years)
- A copy of your **ABMS or AOMS Board certification** (if applicable)
- A copy of your current **Federal DEA Certificate**
- A signed **SVMIC Authorization to Release if applicable**
- A signed **Consent and Release for Criminal Background Check** form (Erlanger Health System requirement)
- A copy of **Military Discharge** (DD214) (if applicable)
- Continuing Medical Education** hours for the past two years (if applicable--see facility requirements)

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 or (888) 779-0300.

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

**TENNESSEE PHYSICIANS'
QUALITY VERIFICATION ORGANIZATION**

UNIVERSAL APPLICATION

APPOINTMENT TO MEDICAL/PROFESSIONAL STAFF, HEALTH PLAN,

AND/OR

MEDICAL SOCIETY MEMBERSHIP

NAME: _____

DATE: _____

For what purpose do you intend to use your privileges?

- Establish a practice in _____ (area)
- As a practice associate with _____ (practice)
- As a contract physician with _____ (company)
- Other (please explain) _____

I hereby apply to the following Specialty (check below)

- | | | |
|--|--|---|
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Obstetrics & Gynecology | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Dentistry | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Physical Medicine |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Orthopedic Surgery | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Family/General Practice | <input type="checkbox"/> Pathology | <input type="checkbox"/> Radiation Oncology |
| <input type="checkbox"/> Medicine | <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Oral & Maxillofacial
Surgery | <input type="checkbox"/> Podiatry | <input type="checkbox"/> Other _____ |

APPLICATION FOR APPOINTMENT TO THE MEDICAL/PROFESSIONAL STAFF

(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		Spouse's Name	
Birth Date	Birth Place	US Citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, alien registration number: _____		
Home address	State	Zip	Telephone	Personal email		

PRACTICE INFORMATION

Practice Name	Credentialing Contact			
Primary Office Address	City	State	Zip	Telephone
Billing Address (if different)	City	State	Zip	Telephone
Pager Number	Pager Code	Answering Service	Fax Number	Credentialing Contact email
Partner(s) You may attach brochure or list.	Credentialing Contact Telephone			
<input type="checkbox"/> Solo <input type="checkbox"/> Group <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation	Other (please specify)	Tax ID #	NPI	
Specialty(ies)	Special Practice Area(s) /Subspecialty	Medicare #	Medicaid #	

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? 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

Languages Spoken/Read: Applicant : _____ Staff _____

Do you employ nurse practitioners, physicians assistants or other allied health practitioners? Yes No

Are you accepting new patients? Yes No

Do you accept Medicare assignment? Yes No

Does this office meet ADA accessibility standards? Yes No

Does this office have a CLIA certified lab? Yes No

If yes, certification number: _____ Expiration Date: _____

Reference Lab: _____

Second Office (if applicable)

Secondary Office Address _____ City _____ State _____ Zip _____ Telephone _____

Secondary Office Practice Name _____ Office Manager _____

Office Manager Telephone _____ Fax Number _____

Does this office meet ADA accessibility requirements? Yes No
 Does this office have a CLIA certified lab? Yes No

If so, please provide certification number: _____

Expiration date: _____

Reference lab: _____

Office Hours: (You may attach a list or brochure in lieu of completing chart)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Primary Office							
Second Office							
Third Office							
Fourth Office							

MILITARY SERVICE

Military Reserves: Yes No

Military Service Branch: _____

Date: Entry _____ Separation _____ Station where separated _____

Last Duty Assigned: _____ Type of Discharge _____

MEDICAL EDUCATION

Please note: "See CV" or "see attached" are not acceptable.

Institution: _____ Dates Attended _____ Degree conferred: _____

Address: _____

Institution: _____ Dates Attended _____ Degree conferred: _____

Address: _____

ECFMG Number (if applicable): _____ Issue Date: _____

INTERNSHIP

If more than one internship was begun or completed, please supply the same information on a separate sheet and attach.

Institution _____ Type of internship _____ Specialty _____ Dates: From _____ To _____

Address _____

RESIDENCIES

If more than two residencies were begun or completed, please supply the same information on a separate sheet and attach.

Institution _____ Chairman/Chief of service _____

Address _____

Specialty _____ Dates: From _____ To _____ Completed? Yes No

RESIDENCIES, CONTINUED

Institution	Chairman/Chief of service
Address	
Specialty	Dates: From _____ To _____
Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

FELLOWSHIPS

If more than two fellowships were begun or completed, please supply the same information on a separate sheet and attach.

Institution	Chairman/Chief of service
Address	
Specialty	Dates: From _____ To _____
Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Institution	Chairman/Chief of service
Address	
Specialty	Dates: From _____ To _____
Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

TEACHING APPOINTMENTS

Please list teaching or university appointments held. If additional appointments, provide additional information as an attachment.

Institution	Dates: From _____ To _____	Department Chair
Address		Type of Appointment
Institution	Dates: From _____ To _____	Department Chair
Address		Type of Appointment

PRACTICE HISTORY

Please provide a chronological listing of medical practice since medical training. If you need additional space, please use a separate sheet and attach to this application. **See CV is not acceptable.** Provide a written explanation of any gaps in dates between education and/or practice affiliations exceeding 30 days.

NAME OF PRACTICE	ADDRESS	Start Date	End Date

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, including state and county medical societies, with dates. 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 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. 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	
Name	Telephone	Fax number
Address (please include suite or room number)	City/State/Zip	
Name	Telephone	Fax number
Address (please include suite or room number)	City/State/Zip	

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				

PROFESSIONAL HISTORY QUESTIONS

Answer all questions. If any answer is "yes", give a full explanation on a separate attachment.

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?

Medical license in any state or district

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Other professional registration/license

<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"/>
--------------------------	--------------------------

ECFMG 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 practitioner is under investigation related to professional conduct or competence.

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 or has your coverage ever been canceled?

<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"/>
--------------------------	--------------------------

Are you currently engaged in the illegal use of drugs?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you have any physical or mental condition 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?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

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:

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Name of Organization: _____

Address: _____

Tax Identification Number: _____

Telephone Number: _____

Type and Size of Organization: _____

% of Business Invested by Applicant: _____

Nature of business interest: _____

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 CME documentation requirements listed later in this application

HEALTH EXAMINATION

A health examination must 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 relative.)

Examination Date: _____ Examining Physician: _____

Address: _____ Telephone: _____ Fax: _____

MEDICAL PROFESSIONAL STAFF MEMBERSHIP

Please check the health care facilities for which you are applying for staff privileges or membership and to which you authorize the release of this application and credentials information.

- | | |
|--|--|
| <input type="checkbox"/> Erlanger Health System (Erlanger Hospital) | <input type="checkbox"/> Parkridge Medical Center, Inc
(Parkridge East, Parkridge Valley, Parkridge Medical Center) |
| <input type="checkbox"/> Healthsouth Chattanooga Rehabilitation Hospital | <input type="checkbox"/> Rhea Medical Center (Dayton, TN) |
| <input type="checkbox"/> Hutcheson Medical Center | <input type="checkbox"/> Siskin Hospital for Physical Rehabilitation |
| <input type="checkbox"/> Kindred Hospital of Chattanooga | <input type="checkbox"/> The Surgery Center of Chattanooga (formerly
Healthsouth Surgery Center) |
| <input type="checkbox"/> Memorial Health System (Memorial Hospital) | |
| <input type="checkbox"/> Memorial Mission Surgery Center | |

Participating health plans send us a list of physicians to be credentialed for their individual plans. You must contact them 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

MEDICAL SOCIETY MEMBERSHIP

Do you wish to become a member of the Medical Society and to use this application form as your application to the state and county medical society? (Only answer if you are not currently a member)

Yes No

SIGNATURE AND CERTIFICATION

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

Date:

Signature:

Name

Send completed application to:

**TPQVO, LLC
1092 CHAMBERLAIN AVE., SUITE B
CHATTANOOGA, TN 37404
(423) 495-1191
(423) 822-5500 FAX
tpqvo@tpqvo.com**

The Tennessee Medical Association, county medical societies and 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 and state and county medical society membership (hereafter referred to as "Facilities") indicated in this Application for Appointment 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 Facilities for medical/professional staff membership or medical and/or surgical privileges.

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

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

Release from Liability. I hereby release from liability Facilities, 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.

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 any Facilities participating in TPQVO's central verification service.

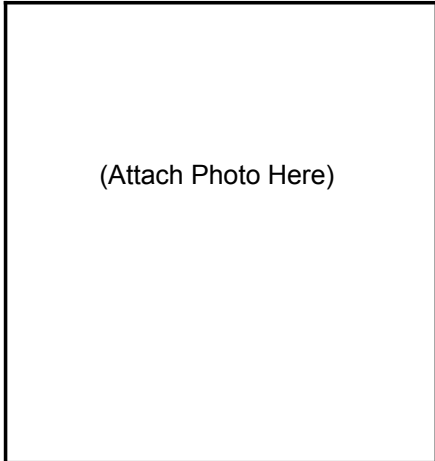
I acknowledge that the investigation of information in this Application by the Facilities, TPQVO and their agents is done to achieve, maintain and improve quality patient care.

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

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

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 Facilities shall be solely responsible for all decisions concerning medical/professional staff membership and the granting of medical and/or surgical privileges. 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 decisions by Facilities.

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



Name (Please print) _____

Signature _____ Date _____

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."

Signature of Physician

Date

(For Facility's Use: Do Not Complete)

Facility Name _____

Provider Number _____

PRO Contact Name _____

PRO Contact Telephone Number _____

Physician's Full Name _____

NPI _____

CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS

Chattanooga-Hamilton County Health Department	40 hours of category 1 CME every 2 years Physicians: at least 1 hr regarding prescribing practices Dentists: at least 2 hrs regarding chemical dependency
Erlanger Medical Center	40 hours every 2 years (with Certificates) A procedure log is required for all physicians and should include at a minimum the last two years of your practice
HealthSouth Chattanooga Rehabilitation Hospital	40 hours every 2 years (with Certificates)
Hutcheson Medical Center	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)
The Surgery Center of Chattanooga (fka Healthsouth Surgery Center of Chattanooga)	40 hours every 2 years (with Certificates)

STATE VOLUNTEER MUTUAL INSURANCE COMPANY
AUTHORIZATION AND RELEASE FORM

From: _____ License # _____ State _____

RELEASE OF INFORMATION TO: TENNESSEE PHYSICIANS' QUALITY VERIFICATION ORGANIZATION
(Complete Address) 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, and 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 *reports of any medical professional liability claims activity against me on record with SVMIC, but specifically limited to: 1) claims that have resulted in paid losses (settlements), and/or 2) 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 Practitioner/Health Care Provider

DATE: _____

PRINTED NAME of Practitioner/Health Care Provider

Policy # _____ REQUIRED Account # _____

Extender Employees/ALLIED HEALTH PROVIDERS:

YOU MUST PROVIDE THE NAME OF INSURED ON THE CURRENT POLICY THAT PROVIDES YOUR COVERAGE OR THE PRIOR POLICY HOLDER IF YOU ARE NO LONGER INSURED BY THIS COMPANY. INCOMPLETE FORM MAY CAUSE DELAY IN COMPLETION OF THE REQUEST.

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>