TPQVO
*Your credentialing partner*
www.tpqvo.com

1st Request

2nd Request

3rd Request

FAX:

Dear

Please complete the attached application for medical /professional appointment or health plan network membership or affiliation.

**Some health care organizations will consider this a pre-application form until your eligibility is established. Upon establishing 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:**

__X__ **A copy of your driver's license or U.S. Government-issued Passport** and your alien registration card, if applicable
__X__ A copy of your **Medical** or **Dental Degree**
__X__ A copy of your **ECFMG Certificate** (if applicable)
__X__ A copy of your Current **VISA/Alien Registration Card** if not a U.S. Citizen
__X__ A copy of your **Certificate of Completion** from your **Internship Program**
__X__ A copy of C**ertificate of Completion** from **Residency** Program
__X__ A copy of your Tennessee or other state current **Medical License** or wallet card showing expiration date
__X__ Your **Curriculum Vitae** or **Biography**
__X__ A copy of the face sheet or your **Professional Liability Insurance** policy (Past 5 Years)
__X__ A copy of your **ABMS** or **AOMS Board certification** (if applicable)
__X__ A copy of your current **Federal DEA Certificate**
__X__ A signed **SVMIC Authorization to Release if applicable**
__X__ A copy of **Military Discharge** (DD214) (if applicable)
____ **Continuing Medical Education** hours in the past two years (if applicable)

## NOTE: PLEASE BE SURE TO SIGN AND DATE THE ATTACHED AUTHORIZATION AND RELEASE FORM AS WELL AS THE APPLICATION.

1092 Chamberlain Avenue ¨ Suite B ¨ Chattanooga, TN 37404 ¨ (423) 495-1191 ¨ (423) 531-2531 FAX
*tpqvo@tpqvo.com*

TPQVO
*Your credentialing partner*
www.tpqvo.com

# UNIVERSAL
# INITIAL APPLICATION

**FOR APPOINTMENT TO MEDICAL/PROFESSIONAL STAFF**

NAME:_____
Please print your full name

DATE: _____

I hereby apply to the following Specialty (check below)

- ☐ Allergy
- ☐ Anesthesiology
- ☐ Dentistry
- ☐ Dermatology
- ☐ Endocrinology
- ☐ Emergency Medicine
- ☐ Family/General Practice
- ☐ Gastroenterology
- ☐ Hematology/Oncology
- ☐ Infectious Disease
- ☐ Internal Medicine
- ☐ Nephrology
- ☐ Obstetrics & Gynecology
- ☐ Ophthalmology
- ☐ Oral & Maxillofacial Surgery
- ☐ Orthopedic Surgery
- ☐ Otolaryngology
- ☐ Neurology
- ☐ Neurosurgery
- ☐ Pathology
- ☐ Pediatrics
- ☐ Pediatric Surgery
- ☐ Physical Medicine
- ☐ Plastic Surgery
- ☐ Podiatry
- ☐ Pulmonary Medicine
- ☐ Psychiatry
- ☐ Radiology
- ☐ Radiation Oncology
- ☐ Rheumatology
- ☐ Surgery
- ☐ Urology
- ☐ Other _____

Will you be treating children under the age of 13 years old? ☐ Yes ☐ No

# APPLICATION FOR MEDICAL/PROFESSIONAL STAFF, HEALTH PLAN OR MEMBERSHIP
(Please type or print legibly)

## PERSONAL INFORMATION

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

Social Security Number | Marital Status | Previous Name | Dates when this name was used | Spouse's Name

Birth Date | Birth Place (City, State, Country) | US Citizen? ☐ Yes ☐ No | If no, alien registration number:

Home address | City | State | Zip | Telephone | Personal email

## PRACTICE INFORMATION

Practice Name | Office Contact

Primary Office Address (include suite number) | City | State | Zip | Telephone

Billing Address (if different) | City | State | Zip | Telephone

Pager | Pager Code | Answering Service | Fax Number | Your business email (required) | Office Contact email

Partner(s) You may attach a list | Office Contact Telephone

☐ Solo ☐ Group ☐ Partnership ☐ Corporation | Other (please specify) | Tax ID # | Your NPI-REQUIRED

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

Do you provide 24 hour call coverage, including weekends? ☐ Yes ☐ No

Call Coverage (all offices): If in group, attach a list of physicians providing call coverage

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 (include suite number) | 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:

Complete Street Mailing Address (street, suite, city, state):

Institution: | Dates Attended | Degree conferred:

Complete Street Mailing Address (street, suite, city, state):

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

Complete Street Mailing Address (street, suite, city, state):

## RESIDENCIES

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

Institution | Current Program Director

Complete Street Mailing Address (street, suite, city, state): | Telephone/ Fax Number

Completed? ☐ Yes ☐ No

Specialty | Dates: From To

RESIDENCIES, CONTINUED

Institution _____ Current Program Director _____

Complete Street Mailing Address (street, suite, city, state): _____

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

## FELLOWSHIPS

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

Institution _____ Current Program Director _____

Complete Street Mailing Address (street, suite, city, state): _____

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

Institution _____ Current Program Director _____

Complete Street Mailing Address (street, suite, city, state): _____

Specialty _____ Dates: From _____ To _____ Completed? ☐ Yes ☐ 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 _____

Complete Street Mailing Address (street, suite, city, state): _____ Type of Appointment _____

Institution _____ Dates: From _____ To _____ Type of Appointment _____

Complete Street Mailing Address (street, suite, city, state): _____ Department Chair _____

## 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. Do not list hospital affiliation unless you were employed by the hospital.

| NAME OF PRACTICE | COMPLETE STREET MAILING ADDRESS | **FROM mm/yy** | **TO mm/yy** |
|---|---|---|---|
| | | | |
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## HOSPITAL STAFF

Please list all present and past hospital affiliations in chronological order from recent to past. Do not list hospitals that are part of your residency or training. If additional room is needed, please continue on a separate sheet and attach to this application.

| Hospital Name(s) and complete location. Please indicate current Primary Facility by checking box. | | Appointment Date mm/yy | Resignation Date mm/yy | Current Status |
|---|---|---|---|---|
| | ☐ | | | |
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## LICENSURE

Please list all current and past and specify the type, i.e., MD, DO, DDS, DPM, etc. (If currently licensed in more than five 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: _____

State: _____ Type: _____ Number: _____ Date Issued: _____ Date Expires: _____

## DRUG ENFORCEMENT ADMINISTRATION INFORMATION (DEA)

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

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

## BOARD CERTIFICATION

Are you certified by a member board of the ABMS, AOA, ABPS or ABOMBS? ☐ Yes ☐ No Have you been Recertified? ☐ Yes ☐ No

| Board | Year Certified | Year Recertified Year Expires | Cert # |
|---|---|---|---|
| Board | Year Certified | Year Recertified Year Expires | Cert # |
| Board | Year Certified | Year Recertified Year Expires | Cert # |

## OTHER CERTIFICATIONS

Please check all 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

Please 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

Please list the names and addresses of at least three (3) professional references who have first-hand knowledge of your current professional competence during the past 3 years in the clinical area in which you are seeking privileges. A professional reference cannot include your residency or fellowship director. An application submitted without complete information will be returned to the applicant and not processed.

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 LIABILITY INSURANCE

Do you currently have malpractice insurance? ☐ Yes ☐ No

Please list all professional liability insurance carriers for the past 5 years beginning with the most recent.

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

Complete Street Mailing Address _____

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

Complete Street Mailing Address _____

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

Complete Street Mailing 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?

| | 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 any healthcare training program (medical school, residency, fellowship, etc) | ☐ | ☐ |
| 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.

| | | |
|---|---|---|
| Have you ever been convicted of a felony 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 or has your coverage ever been canceled? | ☐ | ☐ |
| 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? | ☐ | ☐ |
| Are you currently engaged in the illegal use of drugs? | ☐ | ☐ |
| 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? | ☐ | ☐ |
| 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: _____

## 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

## 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 _____

Email, fax or mail completed application to:

TPQVO, LLC
1092 Chamberlain Ave., Suite B
Chattanooga, TN 37404
(423) 531-2531 FAX
Toll-Free FAX (877) 309-0932
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.

(Attach Photo Here)

# CONTINUING MEDICAL 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 1 (Accredited Sponsorship) | | | |
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| | | | |
| | | | |
| | | | |
| Category II (Non-accredited sponsorship) | | | |
| | | | |
| | | | |
| Category III (Medical Teaching) | | | |
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| | | | |
| Category IV (Papers, books, publications and exhibits) | | | |
| | | | |
| | | | |
| Category V (Non-supervised individual CME 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 diagnosis and secondary diagnosis and the major procedures performed on the patient, as attested to by the 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 _____

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.

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.

_____
Print Name

_____ _____
Signature of Insured Date

Policy Number _____

For Extender Employees - Please Provide Name of Employer _____

Last revised on 10/30/2024

Submit Reset