TENNESSEE PHYSICIANS' QUALITY
VERIFICATION ORGANIZATION, LLC

1st

2nd

3rd

FAX:

Please complete the attached appointment application for health care organization privileges. A CV IS NOT ACCEPTABLE AS A SUBSTITUTE FOR COMPLETING THIS APPLICATION.

Some TPQVO client organizations will consider this a pre-application form until your eligibility is established. Upon establishment of eligibility, this application becomes official and the health care organization will begin processing this as an application for membership to its staff or network. If the health care organization determines you are not eligible, it will notify you directly.

The following items must be returned with your application or the verification process will not be started. This means there will be a delay in sending your application to the health care organization(s) to which you are applying until these items are received by TPQVO.

MAKE SURE YOU SUBMIT THE FOLLOWING:
(You do not need to resubmit if you believe TPQVO already has the information or document on file with the exception of item 3. and 12.)

1 . X A one-time Initial Application file set up/processing fee of $150 payable to TPQVO.
(You do not need to pay this fee if you have paid this fee in the past.)
2. X **A copy of your driver's license or U.S. Government-issued Passport**
3 X **NEW: A copy of the results from your most recent TB skin test**
4 X A copy of your current VISA/Alien Registration Card if not a U.S. Citizen
5 X A copy of each current license/certification
6 X A copy of your current face sheet of your current professional liability insurance policy
7 X A copy of your diploma (college), training certificates
8 X A copy of your certification
9. X A copy of your CPR, ACLS, ATLS, PALS certificates (if applicable)
10. X A copy of your DD-214 (Prior Military only)
11. X Your Resume/Curriculum Vitae (CV)
12. X CME Information for the past 2 years
13. X **Make sure you answer the questions, sign and date the application and the Authorization and Release. We cannot process your application until we receive this authorization.**

Please call TPQVO if you have any questions about this application for 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, LLC

INITIAL APPLICATION
FOR
ALLIED HEALTH PRACTITIONER APPOINTMENT

(PLEASE INDICATE YOUR PRACTITIONER CLASSIFICATION)

NAME: _____ TITLE:_____

- [ ] **Cardiovascular Perfusionist**
- [ ] **Certified Nurse Midwife**
- [ ] **Certified Registered Nurse Anesthetist**
- [ ] **Chiropractor**
- [ ] **Dental Assistant**
- [ ] **Nurse Practitioner**
- [ ] **Physician Assistant**
- [ ] **Non-Physician First Assistant**
  - [ ] **Physician Assistant**
  - [ ] **Registered Nurse First Assistant**
  - [ ] **Certified Surgical Assistant/Certified First Assist**
- [ ] **Surgical Technician**
  - [ ] **Registered Nurse/Operating Room**
- [ ] **Behavioral Health**
  - [ ] **Clinical Psychologist (PhD level)**
  - [ ] **Clinical Social Worker (Master's level)**
  - [ ] **Clinical Nurse Specialist (Master's level)**
  - [ ] **Other licensed, certified, or registered by the state behavioral health care specialist**
  - [ ] **Technologists**
  - [ ] **Therapists**
- [ ] **Optometrist**
- [ ] **Other** _____

1092 Chamberlain Avenue ♦ Suite B ♦ Chattanooga, TN 37404 ♦ (423) 495-1191 ♦ (423) 495-1190 FAX
tpqvo@tpqvo.com

APPLICATION FOR APPOINTMENT TO THE MEDICAL/PROFESSIONAL STAFF
ALLIED HEALTH PROFESSIONAL

(Please type or print legibly)

PERSONAL INFORMATION

First Name | Middle | Last Name | Suffix | Degree | Gender | Race/Ethnic Origin (**Optiona**l)

Social Security Number | Marital Status | Previous Name | Dates when this name was used | Birth Date | Birth Place

Languages Spoken/Read | US Citizen? ☐ Yes ☐ No | If no, alien registration number: _____

Home address (Required) | City | State | Zip | Telephone | Personal email

PRACTICE INFORMATION

Are you an independent practitioner or sponsored by a physician? ☐ Independent ☐ Physician-sponsored ☐ Other (Organization, Etc)

Sponsoring Physician/Employer

Practice Name | Office Contact

Primary Office Address | City | State | Zip | Telephone

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

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

Partner(s) | Office Contact Telephone

☐ Solo ☐ Group ☐ Partnership ☐ Corporation | Other (please specify) | Tax ID # | NPI (f/k/a UPIN)

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

Second Office (if applicable)

Secondary Office Address | City | State | Zip | Telephone

Secondary Office Practice Name | Office Contact

Office Contact Telephone | Fax Number

EDUCATION

List all undergraduate, Graduate and Postgraduate Education.

Institution Dates: From / To Degree conferred

Address

Institution Dates: From / To Degree conferred

Address

Institution Dates: From / To Degree conferred

Address

INTERNSHIP/PRACTICUM

List post-doctoral/fellowships/field placements.

Institution Program Director

Address

Dates: From To Degree/Certificate Earned

Institution Program Director

Address

Dates: From To Degree/Certificate Earned

MILITARY SERVICE

Military Reserves: ☐ Yes ☐ No Military Service Branch: _____

Date: Entry _____ Separation _____ Station where separated _____

Last Duty Assigned: _____ Type of Discharge _____

LICENSURE

List all current and past and specify the type of license. (If currently licensed in more than four states please supply the same information on a separate sheet and attach.)

State Type Number Date Issued Date Expires

State Type Number Date Issued Date Expires

State Type Number Date Issued Date Expires

State Type Number Date Issued Date Expires

DRUG ENFORCEMENT ADMINISTRATION INFORMATION (DEA)

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

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

PRACTICE HISTORY

*Please provide a chronological listing of clinical practice since training. If you need additional space, please use a separate sheet and attach to this application. "**See CV" or "See Attached" is not acceptable.** All time spans from graduation to present must be covered.*

Facility Dates: From / To

Address

Position/Category Reason for leaving

Facility Dates: From / To

Address

Position/Category Reason for leaving

Facility Dates: From / To

Address

Position/Category Reason for leaving

Facility Dates: From / To

Address

Position/Category Reason for leaving

Facility Dates: From / To

Address

Position/Category Reason for leaving

HOSPITAL STAFF AFFILIATIONS

List all past and present hospital staff affiliations in chronological order. If you need additional space, please use a separate sheet and attach.

Hospital Name(s) & Address (Please check box to indicate current Primary Facility)	Appointment Date	Resignation Date (if applicable)	Current Status
☐			
☐			
☐			
☐			
☐			
☐			

CERTIFICATION

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

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

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

List all professional memberships and societies, past and present. If additional space is required, please attach separate sheet of paper.

Name	Address	Currently a Member? (Y/N)

PEER REFERENCES

*List Medical References from three (3) peers from 1 physician and 2 peers in the same **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. 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 HISTORY QUESTIONS

Answer all questions since your last (re)appointment. If any answer is "yes", give a full explanation on a separate attachment.

Have any of the following ever been or are currently in the process, either on a voluntary or involuntary* basis: denied, revoked, suspended, reduced, limited, placed on probation, not renewed or relinquished for disciplinary reasons?	Yes	No
Health care professional registration/license in any state or district	☐	☐
State Controlled Substance Registration	☐	☐
Federal DEA Registration	☐	☐
Membership on any hospital medical/professional staff	☐	☐
Clinical privileges	☐	☐
Participation in the Medicare/Medicaid program	☐	☐
Membership in other health care organizations or plans (PPO, PHO, MSO, HMO, ASC)	☐	☐
Professional society membership	☐	☐
Board certification	☐	☐

*a voluntary relinquishment or voluntary non-renewal is for disciplinary reasons when the relinquishment or non-renewal is done to avoid an adverse action, preclude an investigation, or is done while the health care professional is under investigation related to professional conduct or competence.

Have you ever been terminated from any health care related job?	☐	☐
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?	☐	☐
Has your present professional liability insurance carrier excluded any specific procedures from your coverage or advised you that it intends to terminate, reduce, or otherwise restrict your coverage?	☐	☐
Have any professional liability suits ever been filed against you?	☐	☐
Have any professional liability suits filed against you resulted in a judgment against you or been terminated pursuant to a settlement in which you have paid damages to the plaintiff, with or without admitting liability?	☐	☐
Have you ever settled any professional liability claim against you prior to suit and admitted liability as a part of such settlement?	☐	☐
Do you now or have you in the past two years engaged in the illegal use of drugs?	☐	☐
Are you **unable** to perform any of the essential functions related to the medical /professional staff position and clinical privileges for which you are applying with or without accommodation according to accepted standards of professional performance and without posing a direct threat to patients?	☐	☐

PROFESSIONAL LIABILITY INSURANCE

*List all professional liability insurance carriers for the **past 5 years,** beginning with the most recent:*

Do you currently have malpractice insurance? ☐ **Yes** ☐ **No**

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

CONTINUING EDUCATION CREDITS (CEUs)

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

MEDICAL PROFESSIONAL STAFF MEMBERSHIP

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

_____

_____

_____

_____

SIGNATURE

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

THIS PAGE MUST BE PRINTED, SIGNED AND SENT/FAXED/EMAILED TO TPQVO. NOT ALL HEALTHCARE ORGANIZATIONS WILL ACCEPT A DIGITAL SIGNATURE

Signature: _____ Date: _____

Name _____

Send completed application to:

Print

TPQVO, LLC
1092 CHAMBERLAIN AVE., SUITE B
CHATTANOOGA, TN 37404
(423) 822-5500
(423) 495-1190 FAX

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, 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.

Name (Please print) _____ Date _____

THIS PAGE MUST BE PRINTED, SIGNED AND SENT/FAXED/EMAILED TO TPQVO. NOT ALL PRIMARY SOURCES WILL ACCEPT A DIGITAL SIGNATURE

Signature

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

TO: All Medical Professional Staff Members

As part of the process of applying for hospital admitting privileges to a TPQVO participating hospital/facility, the physician must complete the following acknowledgment at the time he or she is granted those privileges or before or at the time the physician admits his or her first patient to the hospital. This acknowledgment will remain in effect as long as the physician has admitting privileges to the hospital. These statement files are subject to audit by the PRO and other designees of the Director of CHAMPUS.

MEDICARE/CHAMPUS ACKNOWLEDGMENT STATEMENT
NOTICE TO PHYSICIANS

"Medicare/CHAMPUS payment to hospitals is based, in part, on each patient's principal diagnoses and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his/her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for the payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws."

_____ _____

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 _____

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.

THIS PAGE MUST BE PRINTED, SIGNED AND SENT/FAXED/EMAILED TO TPQVO. NOT ALL PRIMARY SOURCES WILL ACCEPT A DIGITAL SIGNATURE

_____ DATE: _____
SIGNATURE of Practitioner/Health Care Provider

_____
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.

101 Westpark Drive, Suite 300 - P.O. Box 1065 - Brentwood, Tennessee 37024-1065
615-377-1999 - 1-800-342-2239 - Fax# 615-377-9192