

1st

2nd

3rd

Re:Application for _____ (Health Care facility/Agency/Employer)

Dear Doctor:

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 **\$100.00**
- A copy of your driver's license or U.S. government-issued Passport** (this is Joint Commission requirement)
- 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 copy of **Military Discharge (DD214)** (if applicable)
- Continuing Medical Education** hours for the past two years (if applicable)

NOTE: BE SURE TO SIGN AND DATE THE ATTACHED AUTHORIZATION AND RELEASE OF INFORMATION FORM. WE CANNOT PROCESS YOUR APPLICATION WITHOUT YOUR SIGNATURE ON THIS FORM.

**TENNESSEE PHYSICIANS'
QUALITY VERIFICATION ORGANIZATION**

**UNIVERSAL
INITIAL APPLICATION**

APPOINTMENT TO MEDICAL/PROFESSIONAL STAFF, HEALTH PLAN,

AND/OR

MEDICAL SOCIETY MEMBERSHIP

NAME: _____

DATE: _____

I hereby apply to the following Specialty (check below)

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Physical Medicine |
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Obstetrics & Gynecology | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> Dentistry | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Podiatry |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Oral & Maxillofacial Surgery | <input type="checkbox"/> Pulmonary Medicine |
| <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Orthopedic Surgery | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Family/General Practice | <input type="checkbox"/> Neurology | <input type="checkbox"/> Radiation Oncology |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Hematology/Oncology | <input type="checkbox"/> Pathology | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Pediatric Surgery | <input type="checkbox"/> 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	US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, alien registration number: _____			
Home address		City	State	Zip	Telephone

PRACTICE INFORMATION

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	e-mail	
Partner(s) You may attach a list					Office Contact Telephone
<input type="checkbox"/> Solo <input type="checkbox"/> Group <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation		Other (please specify)	Tax ID #	NPI (f/k/a UPIN)	
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 _____ 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 _____	Type of Appointment
Address		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.

NAME OF PRACTICE	ADDRESS	START	END

OTHER CERTIFICATIONS

Please check Yes or No for each Certification Listed. If "Yes" is checked, attach Certificate

BASIC CPR CERTIFICATION

Certified: Yes No

Expires: _____

Instructor: Yes No

ACLS CERTIFICATION

Certified: Yes No

Expires: _____

Instructor: Yes No

ATLS CERTIFICATION

Certified: Yes No

Expires: _____

Instructor: Yes No

PALS CERTIFICATION

Certified: Yes No

Expires: _____

Instructor: Yes No

NRP CERTIFICATION

Certified: Yes No

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

Please list the names and addresses of at least three (3) professional references, only one of whom may be a partner or professional associate, who have first-hand knowledge of your current professional competence in the clinical area in which you are seeking privileges. One reference must be the chief of staff or department chairman of your most active current hospital affiliation. A professional reference cannot include your residency or fellowship director.

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.**

	Yes	No
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 jurisdiction	<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"/>
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?	<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

MEDICAL PROFESSIONAL STAFF MEMBERSHIP

Please list below the TPQVO client health care facilities for which you are applying for staff privileges or membership and to which you authorize release of credentialing information and this application.

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?

Yes No

CERTIFICATION AND SIGNATURE

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

Date: _____

Signature: _____

Name _____

Send or fax completed application to:

TPQVO, LLC
1092 CHAMBERLAIN AVE., STE. B
CHATTANOOGA, TN 37404
(423) 495-1191
Toll-free (888) 779-0300
(423) 495-1190 FAX
Toll-Free FAX (877) 309-0933 or
(877) 309-0932

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, 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 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 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.

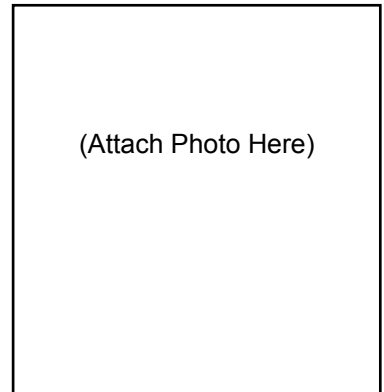
I acknowledge that the investigation of information in this Application by the Organizations, TPQVO and their agents is done to achieve, maintain and improve quality patient care.

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 of the Organization(s). 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 by each Organization. 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 _____

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 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."

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: _____ Medical License # (MD) _____ State: _____

RELEASE OF INFORMATION TO: TENNESSEE PHYSICIANS' QUALITY VERIFICATION ORGANIZATION
1092 CHAMBERLAIN AVENUE, 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 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.