State of West Virginia
Credentialing Form

Please complete each section thoroughly.

Attach additional sheets where necessary.

(Indicate clearly the practitioner name and section on each attachment)

Type or print clearly in black ink.

Sign and date the application.

Practitioner's Name	**Date**
Social Security Number	**Date of Birth**
Credentialing Entity Name	

YOU MUST INCLUDE THE FOLLOWING WITH THIS COMPLETED APPLICATION

(Use this checklist as a guide)

- ☐ Copy of ALL current State License(s): For purposes of this application, State License shall include licensure from all 50 states, the District of Columbia, and U.S. Territories.
- ☐ Copy of current DEA Registration (if applicable)
- ☐ Copy of current State Controlled Dangerous Substance (CDS) Certificate (if applicable)
- ☐ Copy of current professional liability insurance policy face sheet, showing expiration dates, limits, and Practitioner's name
- ☐ Copy of Board Certification Certificate(s) (if applicable), or other National Certification Certificates
- ☐ Copy of certificate(s) or letter(s) certifying formal post-graduate training
- ☐ Copy of Curriculum Vitae/Resume (Include work history)
  (Not accepted as a substitute for completion of application.)
- ☐ Copy of ECFMG Certificate (if applicable)
- ☐ Copy of W-9 for verification of each tax identification number used (required for payers only)
- ☐ Copy of Visa or work permit (if not a U.S. citizen)
- ☐ Copies of CME/CEU session certificates (if required by Credentialing Entity)
- ☐ Signature requirements per each entity
- ☐ Professional Peer References (if required by Credentialing Entity)

CREDENTIALING ENTITIES MAY SUPPLEMENT THIS CHECKLIST OF REQUIRED ITEMS AS NEEDED TO MEET CREDENTIALING REQUIREMENTS.

State of West Virginia
Credentialing Form

Responses must be legible. Any response, which cannot be completed in the space provided, may be included on supplementary sheets of paper and attached. DO NOT LEAVE ANY FIELDS BLANK. If an item is not applicable, indicate N/A. Please note you will be held responsible for all information or omissions in this application, regardless of whether such statements were prepared by you, an employee, agent or representative. For time gaps greater than three (3) months provide information in Section 11. After completion of the application, you may photocopy and then submit with a signed attestation to each entity to which you wish to apply.

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

1. Applicant Information

Last Name (as shown on state license)	First Name	Middle Name	Maiden Name	Suffix (e.g., Jr., Sr., etc.)

Degree (e.g., MD, DO, DDS, DPM, PA-C, RN)	Gender	Birth Date	Birthplace
	Male ☐ Female ☐		

Other Name(s) Also Known By

Name(s)	Name:		Name:	
Date Name Used	From:	To:	From:	To:

Area(s) of Specialty (please be specific and list any primary focus)

Specialty:	Sub-specialty:

Citizenship

Are you a US Citizen?	☐ Yes ☐ No
Please provide the following information if you are not a US Citizen:	If no, what is your citizenship?
	If no, what is status of your Visa?
	If no, do you hold a permanent work permit?
	Type of Visa: / Expiration of Visa:

Social Security #	National Provider ID # (if available)	ECFMG # (if applicable, attach copy)	ECFMG Certificate Date

Current Home Address	City	State	Zip Code

Home Telephone	Is this # unlisted?	Home Fax
( ) -	☐ Yes ☐ No	( ) -

Language(s) Spoken (other than English)

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2. Office Practice Information

If you have more than one office site or more than one billing address or entity, please make a photocopy of this section before completing it and provide information for each site or billing entity (i.e., multiple tax identifiers), as needed. Indicate below whether the office is the primary or an additional site. (NOTE: Only one primary site should be designated.)

☐ Primary Office Site # 1	☐ Additional Office Site #

Group/Practice Name	
Type of Practice	☐ Individual ☐ Partnership ☐ Group ☐ Corporation ☐ Hospital Based ☐ Teaching or Research ☐ Other (specify):

Address (Building, Street, Suite #)	**City**

State	**Zip Code**	**County**

Telephone Number	**Fax Number**	**Answering Service/After-Hours Number**
( ) -	( ) -	( ) -

Alternate Telephone Number	**Cell Phone Number**	**Beeper/Pager Number**
( ) -	( ) -	( ) -

E-Mail Address	**Long Range Beeper Number**
	( ) -

Medicare Number	**UPIN Number**	**Medicaid Number**

Are you currently accepting new patients?	**Have you closed your practice to any plans or programs?**
☐ Yes ☐ By referral only ☐ No ☐ NA	☐ Yes ☐ No ☐ NA If Yes, please list:

Handicap Accessible?	**Public Transit Available?**
☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA

Does the office have other services available for disabled? (TTY, ASI, Mental/physical impairments, etc.)	**If yes, list below what services are available**
☐ Yes ☐ No ☐ NA	

Office Manager's Name	**Nurse Manager's Name**	**Credentialing Contact**
☐ N/A	☐ N/A	Name ☐ N/A Phone #

Office Hours _____

☐ **Check if not applicable** ☐ **Check if practitioner is not available to see patient during hours indicated**

Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

Services Provided
(Please check below if these services are available)

☐ Lab Services	☐ On-Site	Reference Lab Name:	CLIA Number and Type of Certification:	
☐ Radiology Services	☐ EKG	☐ Sigmoidoscopy	☐ Audiology Services	☐ Treadmill
☐ Other (Please list):				
☐ List any special diagnostic or treatment procedures performed in your office:				

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Patient Population	
Do you limit the age of patients you treat?	**If yes, what ages do you treat?**
☐ Yes ☐ No	Minimum: Maximum:

Remittance/Billing Information (NOTE: Must match box 33 on HCFA/CMS 1500)			
Are all services payable to one practice or group name/address?	☐ Yes ☐ No		
Group/Practice Name (Check Payable To):			
Address (Building, Street, Suite #)	**City**	**State**	**Zip Code**

Billing Office Phone Number	**Billing Manager's Name**
( ) -	
Tax ID Number (must match W-9)	**Name affiliated with Tax ID Number (must match W-9)**

Business Interests	
Do you or your business entity own, operate, have an interest in, or participate in any medical enterprise or business?	☐ Yes ☐ No If yes, provide details on separate sheet.
Do you have a financial relationship with a hospital, clinical lab, nursing home, pharmacy, radiology lab, emergency room, or any other medical related organization?	☐ Yes ☐ No If yes, provide details on separate sheet.

Practice Classification

☐ Primary Care Physician (Family Practitioners, Internists, or Pediatricians who deliver primary health care services)

☐ Specialist Physician (Physicians other than primary care physicians in their designated clinical practice)

☐ Allied Health Professional (Licensed, certified, or registered non-physician Practitioners of direct patient care services)

☐ Dual Role (Serve as both a Primary Care Physician as well as a Specialist)

Directory Listing	
Should this office be listed in the directory?	**Should this office receive correspondence?**
☐ Yes ☐ No	☐ Yes ☐ No
Please indicate, in preference order, how you wish to be listed in the directory.	
Primary Specialty:	Secondary Specialty:

After-Hours Coverage	
Do you provide 24-hour coverage?	**Describe Coverage**
☐ Yes ☐ No ☐ NA	
Do you have an answering service/machine?	**Is your answering service/machine available at all times when you are not in the office?**
☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA
List below other after-hours arrangements or special instructions to patients for after-hours care needs:	

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Back-up Coverage

(Please list the name, specialty, and phone number of partner(s) or associate(s) or physician(s) covering your practice in your absence.)

Name	Specialty	Partner, Associate, Or Covering	Phone Number
			( ) -
			( ) -
			( ) -
			( ) -

Admitting Service

Do you admit patients to the hospital under your own service?	If no, to whom do you admit?
☐ Yes ☐ No ☐ NA	

Practitioner Extenders

Please check any of the following practitioner extender types and list individual names who you either employ or utilize for direct patient care.

☐ Physician's Assistant:	☐ Nurse Practitioner:
☐ Nurse Midwife:	☐ Other (specify):

Workers' Compensation Information

Do you accept Workers' Compensation Patients?	☐ Yes ☐ No
If yes, please provide the following information:	a. Are staff trained in identification and care of patients with work-related illness/injury and provide care/services with an active return to work philosophy? ☐ Yes ☐ No b. Modified or alternative duty is actively evaluated for each Workers' Compensation claimant. ☐ Yes ☐ No c. Office will accommodate urgent walk-ins (or non-urgent appointments within 48 hours) to treat injured or ill workers and facilitate their return to work, if possible. ☐ Yes ☐ No d. Staff are available and willing to provide compensation representatives information regarding a claimant's care. ☐ Yes ☐ No

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3. Medical/Professional Education:

(Attach copy of diploma. If international graduate, submit ECFMG Certificate.) If additional space is needed, please photocopy this page and attach. All time gaps greater than three (3) months must be accounted for in Section 11.

Name of School	Degree Received	Dates of Attendance (List Mo/Yr)	
		From:	To:
Street Address	**Phone # (if known)**	**Fax # (if known)**	**Graduation Date**
	( ) -	( ) -	
City	**State**	**Country**	**Zip Code**

Name of School	Degree Received	Dates of Attendance (List Mo/Yr)	
		From:	To:
Street Address	**Telephone # (if known)**	**Fax # (if known)**	**Graduation Date**
	( ) -	( ) -	
City	**State**	**Country**	**Zip Code**

4. Professional Training - Internship/Residency/Fellowship/Preceptorship/Other

List all, completed or not. (Attach copies of all program certificates.) **All time gaps greater than three (3) months must be accounted for in Section 11.**

Training Institution		Program	
		☐ Internship ☐ Fellowship ☐ Other: ☐ Residency ☐ Preceptorship	
Street Address		**City**	
State	**Country**		**Zip Code**
Telephone # (if known)		**Fax # (if known)**	
( ) -		( ) -	
Type of Training/Specialty	**Dates of Training (Mo/Yr)**		**Was program successfully completed?**
	From: To:		☐ Yes ☐ No If no, explain:
Your Program Director's Name		**Current Program Director's Name (if known)**	

Training Institution		Program	
		☐ Internship ☐ Fellowship ☐ Other: ☐ Residency ☐ Preceptorship	
Street Address		**City**	
State	**Country**		**Zip Code**
Telephone # (if known)		**Fax # (if known)**	
( ) -		( ) -	
Type of Training/Specialty	**Dates of Training (Mo/Yr)**		**Was program successfully completed?**
	From: To:		☐ Yes ☐ No If no, explain:
Your Program Director's Name		**Current Program Director's Name (if known)**	

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Training Institution		Program		
		☐ Internship ☐ Residency	☐ Fellowship ☐ Preceptorship	☐ Other:
Street Address		**City**		
State	**Country**		**Zip Code**	
Telephone # (if known)		**Fax # (if known)**		
( ) -		( ) -		
Type of Training/Specialty	**Dates of Training (Mo/Yr)**		**Was program successfully completed?**	
			☐ Yes ☐ No If no, explain:	
Your Program Director's Name		**Current Program Director's Name (if known)**		

Training Institution		Program		
		☐ Internship ☐ Residency	☐ Fellowship ☐ Preceptorship	☐ Other:
Street Address		**City**		
State	**Country**		**Zip Code**	
Telephone # (if known)		**Fax # (if known)**		
( ) -		( ) -		
Type of Training/Specialty	**Dates of Training (Mo/Yr)**		**Was program successfully completed?**	
			☐ Yes ☐ No If no, explain:	
Your Program Director's Name		**Current Program Director's Name (if known)**		

5. State License(s): List **all** **current** and **past** professional licenses (Submit copy of current licenses)

State	License #	Issue Date	Expiration Date	Status (Please check)	Is/was license restricted?	Reason License is/was Inactive or Restricted
				☐ Active ☐ Inactive	☐ Yes ☐ No	
				☐ Active ☐ Inactive	☐ Yes ☐ No	
				☐ Active ☐ Inactive	☐ Yes ☐ No	
				☐ Active ☐ Inactive	☐ Yes ☐ No	
				☐ Active ☐ Inactive	☐ Yes ☐ No	

Does the scope of your practice require the supervision of another practitioner?	☐ Yes ☐ No
If Yes, please list name of each supervising practitioner:	Practitioner Name:

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6. Certifications/Registrations

☐ **Check here if entire section is not applicable to applicant.**

Federal DEA Certificate
☐ **Not applicable**
(Submit copy of current DEA Certificate)

Certificate #	Expiration Date	Unlimited?
		☐ Yes ☐ No If no, explain:

State DEA or CDS Certificate(s)
☐ **Not applicable**
(Submit copy of current State Controlled Dangerous Substance Certificates, if applicable)

Certificate #	Expiration Date	Unlimited?
		☐ Yes ☐ No If no, explain:

Other Certificate(s)/Formal Training
(Please check below if currently certified. Submit copy(s))

- ☐ Basic Life Support (BLS)
- ☐ Advanced Cardiac Life Support (ACLS)
- ☐ Pediatric Advanced Life Support (PALS)
- ☐ Advanced Trauma Life Support (ATLS)
- ☐ Neonatal Advanced Life Support (NALS)
- ☐ Anesthesia Permit
- ☐ Health Care Practitioner (Core C)
- ☐ Neonatal Resuscitation Program (NRP)
- ☐ Therapeutics Classification Number (Optometrists only)
- ☐ Other (please list below or on a separate sheet and include descriptions):

7. Specialty Board Certification: Submit copies of board certifications and/or qualification confirmation letter.

☐ **Check here if entire section is not applicable to applicant.**

Are you board certified? ☐ **Yes** ☐ **No** **(If yes, list below)**

Certifying Board Name & Specialty	Initial Certification Date	Most Recent Recertification Date	Next Expiration Date

If not certified, are you qualified to sit for the examination?	☐ Yes ☐ No
If not certified, please indicate your status in the certifying process:	☐ Failed to pass specialty board examination • How many times have you taken the exam but failed to pass? _____ • Last date(s) exam was taken: _____ ☐ Date(s) board examination was taken/retaken and date board exam is scheduled, if applicable: • Date(s) taken/retaken: _____ • Date scheduled, if applicable: _____ ☐ Not eligible to take specialty boards ☐ Not planning to take specialty boards ☐ Admissible with exam pending

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8. Professional Peer References

Please list three (3) professional peer references who have personal knowledge of your current clinical abilities, ethical character, health status, and ability to work cooperatively with others, and who will provide specific written comments on these and other relevant matters upon request. References will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you. These individuals must have acquired the requisite knowledge through observation of your professional practice over a reasonable period of time. At least one reference must be from the same specialty area, not formerly, currently or about to become associated with you in practice. At least one must be from an individual who has had organizational responsibility in a medical setting (e.g., Department Chair, Medical Director). If your training was completed within the past three (3) years, you may list your Program Director(s) as a professional reference. If you have been out of training for more than three (3) years, it is important to name individuals who are more currently familiar with your professional practice. The individuals should not be related to you by family or financial association.

Reference Name 1	Title		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number (if known)**		
( ) -	( ) -		
Relationship: **(instructor, department chair, chief of staff, colleague, etc.)**			
Reference Name 2	Title		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number (if known)**		
( ) -	( ) -		
Relationship: **(instructor, department chair, chief of staff, colleague, etc.)**			
Reference Name 3	**Title**		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number (if known)**		
( ) -	( ) -		
Relationship: **(instructor, department chair, chief of staff, colleague, etc.)**			

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9. Hospital/Health Care Entity Affiliations (list current affiliation first)

☐ **Check here if entire section is not applicable to applicant.**

List **ALL** health care facilities at which you currently have, or have had, privileges. **Explain gaps greater than three (3) months in Section 11.**

Name of Current Primary Hospital Affiliation	**Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.)**		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number**		
( ) -	( ) -		
Department/Service	**Department Chair's Name**		
Staff Status	**# Admits/Month**	**Percent of time spent at facility**	
Restricted?	**Dates of Affiliation (Mo/Yr)**		
☐ Yes ☐ No If yes, explain:	From: To:		
Reason for leaving, if applicable			

Name of Affiliation/Hospital/Healthcare Entity	**Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.)**		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number**		
( ) -	( ) -		
Department/Service	**Department Chair's Name**		
Staff Status	**# Admits/Month**	**Percent of time spent at facility**	
Restricted?	**Dates of Affiliation (Mo/Yr)**		
☐ Yes ☐ No If yes, explain:	From: To:		
Reason for leaving, if applicable			

Name of Affiliation/Hospital/Healthcare Entity	**Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.)**		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number**		
( ) -	( ) -		
Department/Service	**Department Chair's Name**		

Staff Status	# Admits/Month	Percent of time spent at facility

Restricted?	Dates of Affiliation (Mo/Yr)
☐ Yes ☐ No If yes, explain:	From: To:

Reason for leaving, if applicable

9. Additional Affiliations:

(Photocopy this page for additional affiliations)

Name of Affiliation/Hospital/Healthcare Entity	Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.)

Street Address	City	State	Zip

Telephone Number	Fax Number
( ) -	( ) -

Department/Service	Department Chair's Name

Staff Status	# Admits/Month	Percent of time spent at facility

Restricted?	Dates of Affiliation (Mo/Yr)
☐ Yes ☐ No If yes, explain:	From: To:

Reason for leaving, if applicable

Name of Affiliation/Hospital/Healthcare Entity	Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.)

Street Address	City	State	Zip

Telephone Number	Fax Number
( ) -	( ) -

Department/Service	Department Chair's Name

Staff Status	# Admits/Month	Percent of time spent at facility

Restricted?	Dates of Affiliation (Mo/Yr)
☐ Yes ☐ No If yes, explain:	From: To:

Reason for leaving, if applicable

Name of Affiliation/Hospital/Healthcare Entity	Type of Hospital/Health Care Entity (e.g., Hospital, Nursing Home, etc.)

Street Address	City	State	Zip

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Telephone Number	**Fax Number**		
( ) -	( ) -		
Department/Service	**Department Chair's Name**		
Staff Status	**# Admits/Month**	**Percent of time spent at facility**	
Restricted?	**Dates of Affiliation (Mo/Yr)**		
☐ Yes ☐ No If yes, explain:	From: To:		
Reason for leaving, if applicable			

10. Work History/Experience:

List in chronological order (beginning with current) all current and previous professional work history including Military Service. You must explain gaps greater than three (3) months in Section 11. (If additional space is needed, please photocopy this page and attach.)

Practice/Employer	**Contact Name**		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number (if known)**		
( ) -	( ) -		
Dates of Employment (Month/Year)	**Job Title or Type of Work Performed**		
From: To:			
Reason for leaving, if applicable			

Practice/Employer	**Contact Name**		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number (if known)**		
( ) -	( ) -		
Dates of Employment (Month/Year)	**Job Title or Type of Work Performed**		
From: To:			
Reason for leaving, if applicable			

Practice/Employer	**Contact Name**		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number (if known)**		
( ) -	( ) -		
Dates of Employment (Month/Year)	**Job Title or Type of Work Performed**		

From: To:	
Reason for leaving, if applicable	

Practice/Employer	**Contact Name**		
Street Address	**City**	**State**	**Zip**
Telephone Number	**Fax Number (if known)**		
( ) -	( ) -		
Dates of Employment (Month/Year)	**Job Title or Type of Work Performed**		
From: To:			
Reason for leaving, if applicable			

11. Time Gaps

Provide information for all time frames of three (3) months or more that are not covered in Medical/Professional Education, Professional Training, Hospital/Health Care Entity Affiliations, or Work History/Experience sections (such as extended travel, maternity leave, relocation, etc.).

☐ **Check here if entire section is not applicable to applicant.**

Section	Dates	Explanation
Medical/Professional Education	From: To:	
	From: To:	
	From: To:	
Professional Training	From: To:	
	From: To:	
	From: To:	
Hospital/Health Care Entity Affiliations	From: To:	
	From: To:	
	From: To:	
Work History/Experience	From: To:	
	From: To:	
	From: To:	

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12. Continuing Education Requirements

☐ **Check here if entire section is not applicable to applicant.**

A. Have you completed the continuing education hours as required by your State Licensing Board during the past two (2) years OR the required CME/CEU hours (if applicable) from the State licensing board in which you are currently practicing?	☐ Yes	☐ No

B. Attach certificates as noted on Page 1 for the CME/CEU sessions you have completed in last two (2) years (if required by Credentialing Entity).

13. Professional Associations/Organizations

List the associations/organizations related to your profession in which you are a member. Please include dates of affiliations. Include faculty appointments.

☐ **Check here if not applicable**

Professional Association/Organization	Dates of Affiliation
	From: To:
Professional Association/Organization	**Dates of Affiliation**
	From: To:
Professional Association/Organization	**Dates of Affiliation**
	From: To:
Professional Association/Organization	**Dates of Affiliation**
	From: To:
Professional Association/Organization	**Dates of Affiliation**
	From: To:

14. Professional Liability Insurance Coverage:

Submit a copy of your current professional liability insurance coverage face sheet showing coverage in your practice specialty. Please list current and previous insurance carriers for the last ten (10) years in chronological order beginning with most current. (If additional space is needed, please photocopy this page and attach.)

Current Insurance Carrier		Telephone Number		
		( ) -		
Address		**City**	**State**	**Zip**
Coverage Effective Date	**Coverage Termination Date**	**Amount of Coverage**	**If Umbrella/Excess coverage, amount of coverage**	
		$ million/occurrence $ million/aggregate	$	
Policy Number	**Type of Coverage**		**Do you have prior acts coverage?**	
	☐ Claims Made ☐ Occurrence		☐ No ☐ Yes	

Second Current Insurance Carrier		Telephone Number		
		( ) -		
Address		**City**	**State**	**Zip**
Coverage Effective Date	**Coverage Termination Date**	**Amount of Coverage**	**If Umbrella/Excess coverage, amount of coverage**	
		$ million/occurrence $ million/aggregate	$	
Policy Number	**Type of Coverage**		**Do you have prior acts coverage?**	
	☐ Claims Made ☐ Occurrence		☐ No ☐ Yes	

Previous Insurance Carrier		Telephone Number		
		( ) -		
Address		**City**	**State**	**Zip**
Coverage Effective Date	**Coverage Termination Date**	**Amount of Coverage**	**If Umbrella/Excess coverage, amount of coverage**	
		$ million/occurrence $ million/aggregate	$	
Policy Number	**Type of Coverage**		**Do you have prior acts coverage?**	
	☐ Claims Made ☐ Occurrence		☐ No ☐ Yes	

Previous Insurance Carrier		Telephone Number		
		( ) -		
Address		**City**	**State**	**Zip**
Coverage Effective Date	**Coverage Termination Date**	**Amount of Coverage**	**If Umbrella/Excess coverage, amount of coverage**	
		$ million/occurrence $ million/aggregate	$	
Policy Number	**Type of Coverage**		**Do you have prior acts coverage?**	
	☐ Claims Made ☐ Occurrence		☐ No ☐ Yes	

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15. Professional Liability Insurance Coverage Disclosure:

If the answer to any of these questions is yes, please provide a full explanation of the details of each and every matter on the attached Professional Liability Information Addendum. The explanation must include the name of the court in which the suit was filed, the caption and docket number of the case, and the name and address of the attorney defending you, and all other relevant details. Include suits in which a judgment or settlement was made against a professional corporation of which you are/were a member, shareholder, or employee in any matter in which you were involved in the patient's care.

A. Has your professional liability insurance coverage ever been terminated by action of the insurance company?	☐ No	☐ Yes
B. Have you ever been denied professional liability insurance coverage?	☐ No	☐ Yes
C. Has any (current or previous) professional liability insurance carrier excluded any specific procedures or specific area of practice (e.g., obstetrics, surgery, etc.) from your coverage?	☐ No	☐ Yes
D. During the time of your professional practice, have you had any professional liability claims, suits, settlements, or judgments filed against you or are any currently pending?	☐ No	☐ Yes
E. Have any restrictions ever been placed on your professional liability insurance coverage?	☐ No	☐ Yes
F. Have you ever practiced without professional liability coverage?	☐ No	☐ Yes
G. Are there any incidents for which you have been contacted by an attorney regarding potential professional liability (e.g., settlement requests, writ of summons, etc.)?	☐ No	☐ Yes

State of West Virginia Credentialing Form: Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment. (If more space is needed, please supply the information on a separate sheet and attach.)

Professional Liability Information Addendum

(Photocopy this form for each case/action)

Please supply the following and sign and date this form:

- **Information for each professional liability action you have had taken against you, including those pending.**
- **Information for each settlement, or decision for the plaintiff that has ever occurred on your behalf.**
- **Practitioner Signature and Date**

All information is held in strict confidence and used for credentialing and recredentialing purposes only. Failure to supply sufficient details may prevent your application from being approved. In addition to completion of this form, practitioner may also submit any additional supporting documentation.

☐ **Check here if entire section is not applicable to applicant (and sign below even if no suits or settlements).**
☐ **Check here if no professional liability actions/claims filed (and sign below even if no suits or settlements).**

1. Case Number	**2. Carrier Name**
3. Name of Plaintiff	**4. Date of Incident**
5. Date Filed	**6. Date Closed**
7. What was/is your status in the case?	**8. What is the status of the case?**
☐ Primary Defendant ☐ Co-Defendant ☐ Other, please explain:	☐ Dropped ☐ Pending ☐ Settled Out of Court ☐ Found for Defendant ☐ Dismissed Without Payment ☐ Found for Plaintiff ☐ Under Appeal
9. Amount of Any Settlement or Award?	**10. Date of any Settlement or Award**

Please explain the following in detail. (If an item does not apply please check "N/A")

11. What was the alleged harm to the patient?		☐ N/A
12. What were you alleged to have done incorrectly or failed to do?		☐ N/A
13. Describe the patient's illness and related effects of the alleged harm.		☐ N/A
14. Describe any other details you believe are pertinent to the case.		☐ N/A
15. Identify any other parties named in the suit.		☐ N/A

Practitioner Signature (REQUIRED)	**Date (REQUIRED)**

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16. Practice Disclosure Information

If the answer to any question below is yes, please provide a full explanation of the details on a separate sheet and attach.

A. Have any investigations been initiated or are any pending against you by any state licensure board, registration board, or regulatory agency?	☐ No	☐ Yes	
B. Has your license to practice in any state ever been voluntarily or involuntarily relinquished, restricted, denied, reduced, limited, suspended, placed on probation, revoked, or subject to any disciplinary action including reprimand?	☐ No	☐ Yes	
C. Have you ever been suspended, sanctioned, or otherwise restricted from participating or been the subject of an investigation in any private, federal, or state health insurance program (e.g., Medicare, Medicaid)?	☐ No	☐ Yes	
D. Has your narcotics (DEA) registration certificate (federal or state) ever been voluntarily or involuntarily relinquished, limited, suspended, not renewed, placed on probation, revoked, or challenged?	☐ No	☐ Yes	☐ NA
E. Have you ever been convicted of or plead no contest to any criminal (felony or misdemeanor) charges including a drug or alcohol-related offense or motor vehicle offenses, but not including minor traffic or parking violations? Are any such proceedings currently pending?	☐ No	☐ Yes	
F. Have you ever had an academic appointment denied, limited, revoked, suspended, reduced, placed on probation, not renewed, or other adverse action taken?	☐ No	☐ Yes	☐ NA
G. Have you ever been refused membership on the medical or allied health staff of any hospital or institution or been denied advancement in staff status?	☐ No	☐ Yes	☐ NA
H. Has your employment, medical staff status, appointment, reappointment, or clinical privileges, or scope of practice ever been voluntarily or involuntarily suspended, restricted, reduced, revoked, denied, relinquished, not been renewed or subjected to probationary conditions or limited at any hospital, managed care organization or other health care entity?	☐ No	☐ Yes	
I. Have you ever been denied membership or renewal, or been reprimanded, censured, suspended, revoked, placed on probation, or otherwise sanctioned by any health care organization, including but not limited to, hospitals, HMOs, PPOs, IPAs, PHOs, professional associations or societies, professional standards review organization or peer review organizations, or any other health care facilities, based on professional competence?	☐ No	☐ Yes	
J. Have your ever withdrawn your application for appointment, reappointment or request for clinical privileges or resigned from the medical or allied health staff of a hospital, managed care organization, or other health care entity while under investigation or before a decision about your appointment or reappointment or clinical privileges was rendered by the governing board of any hospital, managed care organization or any other health care entity?	☐ No	☐ Yes	
K. Have you ever been allowed to resign your position or voluntarily relinquish specific clinical privileges rather than face any charge or investigation on the part of the medical staff of a hospital, managed care organization, or other health care entity?	☐ No	☐ Yes	
L. Are there currently pending adverse actions on your employment, medical staff appointment, reappointment, clinical privileges or scope of practice at any hospital, managed care organization, or other health care entity?	☐ No	☐ Yes	
M. Has any investigation (other than normal performance improvement reviews) involving your clinical practice, competence or professional conduct ever been initiated by any hospital, managed care organization, governmental agency, other health care entity, or branch of the armed forces?	☐ No	☐ Yes	
N. Has your request for any specific clinical privileges or scope of practice ever been denied (as a result of disciplinary action) or granted with stated limitations or conditions (aside from ordinary initial probationary requirements of proctorship)? Are such proceedings currently pending?	☐ No	☐ Yes	

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O. Do you have any knowledge of any civil actions pending against you by any hospital, law enforcement agency, professional group or society?	☐ No	☐ Yes	
P. Have you had any charges of unprofessional conduct brought against you?	☐ No	☐ Yes	
Q. Have you had any charges of fraud brought against you?	☐ No	☐ Yes	
R. Have you received any confirmed Quality Citations from a Peer Review Organization (PRO) in the last two (2) years? If you answered yes, on a separate sheet, indicate the address of the PRO that cited you, the circumstances of the citation and the number of points you were fined.	☐ No	☐ Yes	

Health Status

Note: Your application will be processed in the usual manner regardless of how you answer questions A and B. If you have answered "No" to question A or B, please explain completely on a separate sheet. If you are found to be qualified, a representative will contact you to determine what accommodations are necessary and feasible to allow you to practice safely.

A. Are you physically and mentally able to perform all the essential functions or services necessary to exercise the privileges or services applied for with or without a reasonable accommodation?	☐ Yes	☐ No
B. Are you able to perform these functions without significant risk of injury to yourself or others?	☐ Yes	☐ No
C. Do you illegally use drugs?	☐ Yes	☐ No
Have you used illegal drugs within the last two years?	☐ Yes	☐ No
D. Do you currently take any medications that may affect your ability to perform the clinical privileges or scope of practice requested competently and safely?	☐ Yes	☐ No

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Health Care Entity:	

WEST VIRGINIA PRACTITIONER
ATTESTATION/AUTHORIZATION AND RELEASE OF INFORMATION

By submitting this attestation/authorization and release of information form in conjunction with the West Virginia Credentialing Form (WVCF) and/or the West Virginia Practitioner Attestation/Authorization, I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership and/or participating status with the Health Care Entity indicated on the WVCF for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and/or other qualifications.

2. I further understand and acknowledge that the Health Care Entity or designated Agent will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Health Care Entity as part of the verification and credentialing process.

3. I authorize all individuals, institutions, and entities or organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated Health Care Entity(ies), their staffs and agents.

4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the requested clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.

5. I attest to the accuracy and completeness of the information provided. I understand and agree that any misstatements in or omissions from the WVCF Attestation/Authorization and attachments hereto may constitute cause for denial of the application or summary dismissal or termination of membership/clinical privileges/participation agreement.

6. I agree to exhaust all available procedures and remedies as outlined by in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Health Care Entity(ies) where I have membership and/or clinical privileges/participation.

7. I understand that completion and submission of the WVCF Attestation/Authorization and Release of Information does not automatically grant me membership or clinical privileges/participating status with the Health Care Entity(ies) indicated on the WVCF or Attestation/Authorization.

8. I further acknowledge that I have read and understand the foregoing Attestation/Authorization and Release of Information. A photocopy of this Attestation/Authorization and Release of Information shall be as effective as the original, and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation/authorization.

9. I release from liability any and all individuals and organizations who provide information to the credentialing entity in good faith and without malice concerning my professional qualifications and competence, and the credentialing entity, from liability for their acts performed and statements made relating but not limited to verifying, evaluating and acting upon my credentials and qualifications.

Print Name Here: _____

Signature: _____ Date: _____

NOTE: Through above signature, I hereby affirm that contents are current, accurate, and complete as of the signature date.

Modification to the wording or format of the WVCF/Attestation/Authorization and Release of Information may invalidate an application.

Credentialing Entity may supplement additional Attestation/Authorization/Release of Information through an additional release document as required by the entity.

The Entities will treat this application and any information secured in connection therewith in strict confidence in accordance with the Entities' policies and/or Medical Staff Bylaws and preserve with all reasonable safeguards the privacy of the Applicant.

ADDENDUM

VERIFICATION OF PROFESSIONAL LIABILITY

I, the undersigned, authorize my CURRENT professional liability insurance carrier,

_____

(Enter Current Professional Liability Insurance Carrier Name)

_____

(Enter Street Address) (City) (State & Zip)

to send verification of my professional liability coverage, to include dates of coverage, amounts of coverage, and any limitations in coverage, to _____ .

(Entity Specific)

_____ is to hereinafter be

(Entity Specific)

a Certificate Holder and is to be notified of the amount of my coverage and any future changes in my insurance status, to include all information regarding claims history (but not necessarily limited to judgments entered, claims settled, cases and lawsuits pending), and any restriction regarding specific privileges which may be excluded from coverage.

I will notify _____ of any

(Entity Specific)

changes in Professional Liability carriers so that another Verification of Professional Liability form can be completed.

_____ _____

Practitioner's Signature Date

_____

Printed Name

_____

Policy Number

(Instructions: Please complete, sign, date and return to entity named above with your initial application.)