Washington Practitioner Application

To use the Washington Practitioner Application (WPA), follow these instructions:

- **Keep an <u>unsigned</u> and <u>undated</u> copy of the application on file for future requests.** When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate.
- Please sign and date pages 11 and 13.
- Please document any YES responses on the Attestation Question page.
- Identify the health care related organization(s) to which this application is being submitted in the space provided below.
- Attach copies of requested documents each time the application is submitted.
- If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- If a section does not apply to you, please check the provided box at the top of the section.
- Expect addendums from the requesting organizations for information not included on the WPA.

This application is submitted to:

1. INSTRUCTIONS

This form should be **typed or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered. *<u>Please do not use abbreviations</u>*. **Current copies of the following documents must be submitted with this application:** (all are required for MDs, DOs; as applicable for other health practitioners).

- DEA Certificate
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application. Dates need to be listed in mm/yyyy Format)

**** All sections must be completed in their entirety. ****

2. PRACTITIONER INFORMATION – Legal Name Required

Last Name: (include suffix; Jr., Sr., III)	First:	Middle:	Degree(s):

List any other name(s) under which you have been known by reference, licensing and or educational institutions, including the date of name change(s) if known (mm/dd/yyyy):

Home Mailing Address:	City:	
	State:	Zip Code:

Home Telephone Number: ( )	Pager Number: ( )	Cell Phone Number: ( )	E-Mail Address:

Birth Date: (mm/dd/yyyy)	Birth Place (city, state, country):	Citizenship:	Race/Ethnicity (Optional):

Social Security Number:	☐ "Male" ☐ "Female" ☐ "X"	Languages Spoken Fluently by Practitioner:

Have you ever voluntarily opted-out of Medicare? Yes☐ No ☐

NPI:	Medicare Number: (WA)	Medicaid (DSHS) Number(s):	L & I Number(s):

Specialty primarily practicing:	Sub specialties primarily practicing:

Other Professional Interests in Practice, Research, etc.:

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3. PRIMARY PRACTICE INFORMATION Practitioner Start Date (MM/YYYY): **CHECK ALL THAT APPLY**

Practice Setting
☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐ Primary Care Site ☐ Urgent Care ☐Other

Practitioner Profile
☐ PCP ☐ Specialist ☐ Both PCP & OB OB in your practice ☐ Yes ☐ No Deliveries ☐ Yes ☐ No

Do you offer Telehealth? ☐ Yes ☐ No Are you exclusively Telehealth? ☐ Yes ☐ No	If Telehealth: ☐ Audio ☐ Visual ☐ Both
Name of Practice / Affiliation or Clinic Name:	Department Name (if hospital based):
Primary Office Street Address:	City / State: / Zip Code: / Org. NPI#:
Patient Appointment Telephone Number: ( )	Fax Number: ( )
Mailing Address: (if different from above)	
Billing Address: (if different from above)	
Office Manager / Administrator Name: / Administration Telephone Number: ( ) / Practice Website:	
E-mail Address:	Fax Number: ( )
Credentialing Contact (if different from above):	Telephone Number: ( )
Credentialing Address: (if different from above)	
E-mail Address:	Fax Number: ( )
Name Affiliated with Tax ID Number:	Federal Tax ID Number:
Is the office wheelchair accessible? ☐Yes ☐No Are Gender Affirming treatment services offered? ☐Yes ☐No or ☐ Unknown	Office Hours
Are you accepting new patients? ☐Yes ☐No Have you limited your practice in any way (e.g. 18 years or older?) ☐Yes ☐No If yes, please explain: Do you currently supervise ARNP's or PA's? ☐Yes ☐No If yes, please provide the name and specialty below: Please list languages fluently spoken by office staff:	Monday: _____ Tuesday: _____ Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____ Sunday:_____ Do you provide 24 hour coverage? ☐Yes ☐No If no, please explain how your patients obtain advice and care after hours:

A. Hospital Inpatient Coverage Plan (for those without admitting privileges) **Does Not Apply** ☐

Name of Admitting Physician/Practice/Clinic/Group:	Hospital Where privileged:

B. Office Covering Practitioners/Call Group **Does Not Apply** ☐

Provider Name, Degree	Specialty	Address	Phone Number

Attach a list of additional admitting physician/practice/clinic/group or covering practitioners if needed

Practitioner Start Date at SECONDARY Practice location (MM/YYYY)			**CHECK ALL THAT APPLY**
Practice Setting ☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐ Primary Care Site ☐ Urgent Care ☐Other			
Practitioner Profile ☐ PCP ☐ Specialist ☐ Both PCP & OB OB in your practice ☐ Yes ☐ No Deliveries ☐ Yes ☐ No			
Do you offer Telehealth? ☐ Yes ☐ No Are you exclusively Telehealth? ☐ Yes ☐ No		If Telehealth: ☐ Audio ☐ Visual ☐ Both	
Name of Secondary Practice / Affiliation or Clinic Name:		Department Name (if hospital based):	
Primary Office Street Address:		City:	
		State: OR	Zip Code:	Org. NPI#
Patient Appointment Telephone Number: ( )		Fax Number: ( )	
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Office Manager / Administrator Name:	Administration Telephone Number: ( )	Practice Website:	
E-mail Address:		Fax Number: ( )	
Credentialing Contact (if different from above):		Telephone Number: ( )	
Credentialing Address: (if different from above)			
E-mail Address:		Fax Number: ( )	
Name Affiliated with Tax ID Number:		Federal Tax ID Number:	
Is the office wheelchair accessible? ☐Yes ☐No Are Gender Affirming treatment services offered? ☐Yes ☐No or ☐ Unknown		Office Hours	
Are you accepting new patients? ☐Yes ☐No Have you limited your practice in any way (e.g. 18 years or older?) ☐Yes ☐No If yes, please explain: Do you currently supervise ARNP's or PA's? ☐Yes ☐No If yes, please provide the name and specialty below: Please list languages fluently spoken by office staff:		Monday: _____ Tuesday: _____ Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____ Sunday:_____ Do you provide 24 hour coverage? ☐Yes ☐No If no, please explain how your patients obtain advice and care after hours:	

A. Hospital Inpatient Coverage Plan (for those without admitting privileges)	**Does Not Apply** ☐
Name of Admitting Physician/Practice/Clinic/Group:	Hospital Where privileged:

B. Office Covering Practitioners/Call Group			**Does Not Apply** ☐
Provider Name, Degree	Specialty	Address	Phone Number

Attach a list of additional admitting physician/practice/clinic/group or covering practitioners if needed

LIST OTHER OFFICE LOCATIONS WITH THE ABOVE INFORMATION ON A SEPARATE SHEET

4. PROFESSIONAL LICENSURE, REGISTRATIONS AND CERTIFICATIONS
(Attach Additional Sheet if Necessary)

Washington State Professional License/Registration/Cert Number:	Issue Date:	Expiration Date:
Name of Sponsor if required by licensure, (e.g. Physician's Assistant).		
Pharmacists Collaborative Drug Therapy Agreement (CDTA) Number(s):		
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Date Issued:

5. ALL OTHER PROFESSIONAL LICENSES, REGISTRATIONS AND CERTIFICATIONS

State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:

6. UNDERGRADUATE EDUCATION (*Do not abbreviate*) **Does Not Apply** ☐

School/College/University/Vocational Education:	Degree Received (be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)
Mailing Address:	City:	State:	Zip Code:
College or University Name:	Degree Received (be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)
Mailing Address:	City:	State:	Zip Code:

7. MASTER DEGREE PROGRAM OR POST GRADUATE EDUCATION **Does Not Apply** ☐

Institution:	Address	City	State	Zip Code:
Dates Attended (mm/yyyy - mm/yyyy): ( ) - ( )	Program or Course of Study:			
Faculty Director:	Degree:			

8. MEDICAL/PROFESSIONAL EDUCATION (*Do not abbreviate*)

Medical/Professional School:	Start Date: (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:
Medical/Professional School:	Start Date (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:

9. INTERNSHIP/PGYI (Attach Additional Sheet if Necessary) **Does Not Apply** ☐

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Internship:	Specialty:	From (mm/yyyy):	To (mm/yyyy):

10. RESIDENCIES (Attach Additional Sheet if Necessary) **Does Not Apply** ☐

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

11. FELLOWSHIPS (Attach Additional Sheet if Necessary) **Does Not Apply** ☐

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

12. PRECEPTORSHIP (Attach Additional Sheet if Necessary) **Does Not Apply** ☐

Institution:	Address:	City:	State:	Zip Code:
Telephone Number	Fax Number		Email Address	
Dates Attended (mm/yyyy - mm/yyyy): ( ) - ( )	Training:		Department Chairman:	

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13. FACULTY/TEACHING APPOINTMENTS (Attach Additional Sheet if Necessary) **Does Not Apply** ☐

Institution:	Address:	City:	State:	Zip Code:
Telephone Number	Fax Number	Email Address		
Dates Attended (mm/yyyy - mm/yyyy): ( ) - ( )	Position:	Faculty Director:		

14. BOARD CERTIFICATION **Does Not Apply** ☐

Are you board or otherwise professionally certified?

☐ **Yes** If "Yes", please complete below: ☐ **No** If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.

Issuing Board/Entity and State Issued	Specialty	Date Certified	Date Recertified	Expiration Date (if any)

Have you applied for certification other than those indicated above? ☐ Yes ☐ No

If so, list certification and date:

Certification number if applicable:

If you participate in a specialty which does not have board certification, please indicate specialty:

15. OTHER CERTIFICATIONS ACLS, BLS, ATLS, PALS, NALS (e.g., Fluoroscopy, Radiography, etc.)
(Attach Certificate if Applicable)

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

16. HOSPITAL, MILITARY, & OTHER INSTITUTIONAL AFFILIATIONS **Does Not Apply** ☐

Please list in **reverse chronological order (with the current affiliation(s) first)** all institutions where you (A) Current Hospital affiliation, (B) Previous Hospital Affiliations, (C) Current Military Affiliation, (D) Previous Military Affiliations (E) Applications in process This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.

A. CURRENT HOSPITAL AFFILIATIONS (*Do not abbreviate*)

Name of Primary Admitting Hospital:		Department:
Mailing Address		City, State , Zip
Phone number:		Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date (mm/yyyy):	Medical Staff/Credentialing E-mail Address:

Can you admit / follow clients of your primary, secondary, other practice locations? **Does Not Apply** ☐
☐ **Primary practice admits only** ☐ **Secondary Practice admits only** ☐ **can admit to for all locations**

Name of Secondary Admitting Hospital:		Department:
Mailing Address		City, State, Zip
Phone number:		Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date (mm/yyyy):	Medical Staff/Credentialing E-mail Address:

Can you admit / follow clients of your primary, secondary, other practice locations? **Does Not Apply** ☐
☐ Primary practice admits only ☐ Secondary Practice admits only ☐ Can admit to for all location**s**

Name of Other Institutions:		Department:	
Mailing Address		City, State, Zip	
Phone number:		Fax Number:	
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date (mm/yyyy):	Medical Staff/Credentialing E-mail Address:	
Can you admit / follow clients of your primary, secondary, other practice locations? **Does Not Apply** ☐ ☐ Primary practice admits only ☐ Secondary Practice admits only ☐ Can admit to for all locations			

B. PREVIOUS HOSPITAL AFFILIATIONS (Do not abbreviate)

Name of Admitting Hospital:		Department:	
Mailing Address		City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):		From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:	Medical Staff E-mail Address:		

Name of Admitting Hospital:		Department:	
Mailing Address		City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):		From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:	Medical Staff E-mail Address:		

Name of Admitting Hospital:		Department:	
Mailing Address		City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):		From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:	Medical Staff E-mail Address:		

C. CURRENT MILITARY AFFILIATIONS (Do not abbreviate) Please include Military Reserves

Name of Primary Base:	Division
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date (mm/yyyy):

D. PREVIOUS MILITARY AFFILIATIONS (Do not abbreviate)

Name of Primary Base:	Division
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date (mm/yyyy):

E. APPLICATIONS IN PROCESS (*Do not abbreviate*)			
Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:
Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted(mm/yyyy)	
Mailing Address:	City:	State:	Zip Code:

17. WORK HISTORY (*Do not abbreviate)*

Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. Curriculum vitae is not sufficient.

Name of Practice / Employer:	Contact Name:			Telephone Number:	
Reason for Leaving:	Email Address			Fax Number:	
Mailing Address	City:	State:	Zip:	From (mm/yyyy)	To (mm/yyyy)
Name of Malpractice Carrier During Employment:					
Name of Practice / Employer:	Contact Name:			Telephone Number:	
Reason for Leaving:	Email Address			Fax Number:	
Mailing Address:	City:	State: OR	Zip Code:	From (mm/yyyy):	To (mm/yyyy):
Name of Malpractice Carrier During Employment:					
Name of Practice / Employer:	Contact Name:			Telephone Number:	
Reason for Leaving:	Email Address			Fax Number:	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):
Name of Malpractice Carrier During Employment:					

18. GAPS IN HISTORY. Please account for all gaps between dates of medical/professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable:

	From (mm/yyyy):	To (mm/yyyy):

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19. PEER REFERENCES

List at least **three** professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who, through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. **Please provide approximate From and To dates you have known the identified peer reference.** If you have been out of residency or fellowship for a period of less than three years, one reference must be from the Program Director. Allied Health Providers must provide at least one reference from their same discipline.

Name of Reference:		Title and Specialty:	E-mail Address:	
Mailing Address:		City:	State:	Zip Code:
Telephone Number:	Fax Number:	Cell Phone Number: (Optional)	From (MM/YY)	To (MM/YY):
Name of Reference:		Title and Specialty:	E-mail Address:	
Mailing Address:		City:	State:	Zip Code:
Telephone Number:	Fax Number:	Cell Phone Number: (Optional)	From (MM/YY)	To (MM/YY):
Name of Reference:		Title and Specialty:	E-mail Address:	
Mailing Address:		City:	State:	Zip Code:
Telephone Number:	Fax Number:	Cell Phone Number: (Optional)	From (MM/YY)	To (MM/YY):

20. PROFESSIONAL AFFILIATIONS (*Do not abbreviate*)

Please List Membership In All Professional Societies Complete Name of Society:	Date Joined	Current Member
		☐ YES ☐ NO
		☐ YES ☐ NO

21. PROFESSIONAL LIABILITY (*Do not abbreviate*)

A. Current Insurance Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: $	Aggregate amount: $	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):

B. PREVIOUS PROFESSIONAL LIABILITY CARRIERS WITHIN THE LAST TEN YEARS (Do not abbreviate) (Attach Additional Sheet if Necessary)

Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: $	Aggregate amount: $	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):

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Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: $	Aggregate amount: $	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: $	Aggregate amount: $	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: $	Aggregate amount: $	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: $	Aggregate amount: $	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: $	Aggregate amount: $	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:	Claims History/Verification E-mail Address:	
Per claim amount: $	Aggregate amount: $	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):

WASHINGTON PRACTITIONER ATTESTATION QUESTIONS - *To be completed by the practitioner*

Please answer all of the following questions. If your answer to any of the following questions is 'Yes", provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

A.	**PROFESSIONAL SANCTIONS**			
1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?			
	a.	License to practice any profession in any jurisdiction	YES ☐	NO☐
	b.	Other professional registration or certification in any jurisdiction	YES ☐	NO☐
	c.	Specialty or subspecialty board certification	YES ☐	NO☐
	d.	Membership on any hospital medical staff	YES ☐	NO☐
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	YES ☐	NO☐
	f.	Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program	YES ☐	NO☐
	g.	Professional society membership or fellowship	YES ☐	NO☐
	h.	Participation/membership in an HMO, PPO, IPA, PHO, Health Plan or other entity	YES ☐	NO☐
	i.	Academic Appointment	YES ☐	NO☐
	j.	Authority to prescribe controlled substances (DEA or other authority)	YES ☐	NO☐
2.	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		YES ☐	NO☐
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		YES ☐	NO☐
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		YES ☐	NO☐
B.	**CRIMINAL HISTORY**			
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		YES ☐	NO☐
	a.	Do you have notice of any such anticipated charges?	YES ☐	NO☐
	b.	Are you currently under governmental investigation?	YES ☐	NO☐
C.	**AFFIRMATION OF ABILITIES**			
1.	Do you presently use any drugs illegally?		YES ☐	NO☐
2.	Do you have any physical, mental health, or substance use condition that currently impairs, or could impair, your ability to practice your profession in a competent, ethical, and professional manner? **If the answer to this question is yes, please complete Section 23 below**.		YES ☐	NO☐
3.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		YES ☐	NO☐
D.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section,** please document in Section 22. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)			
1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?		YES ☐	NO☐
2.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgement (court-ordered damage award) in a professional lawsuit?		YES ☐	NO☐
3.	Are there any such claims being asserted against you now?		YES ☐	NO☐
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g., reduced limits, restricted coverage, surcharged)?		YES ☐	NO☐
5.	Are any of the privileges that you are requesting not covered by your current malpractice coverage?		YES ☐	NO☐

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Applicant's Signature:_____ Date_____

Type or Print name here_____

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22. PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL **Does Not Apply** ☐

Practitioner Name:(print or type)

Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected PHI. Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.

Date and clinical details of the incident, with preceding events:
Date: Details:

Your role and specific responsibility in the incident:

Subsequent events, including patient's clinical outcome:

Date suit or claim was filed:

Name and Address of Insurance Carrier that handled the claim:

Your status in the legal action (primary defendant, co-defendant, other):

Current status of suit or other action:

Date of settlement, judgment, or dismissal:

If case was settled out-of-court, or with a judgment, settlement amount attributed to you? **$**

23. Physician/Practitioner Health Program Disclosure Please complete below details if you answered yes to Question C.2 above		**Does Not Apply** ☐
Name of Monitoring Program		
Address of Monitoring Program		
Point of Contact Name:	Phone Number	Verification E-mail Address:

24. ATTESTATION

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A copy, or electronic PDF with signature authentication, of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name Here: _____

Signature: _____

(Stamped signature is not acceptable)

Date: _____

Review dates and initials:

_____

_____

_____

_____

_____

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