Idaho Practitioner Credentials Verification Application

To use the Idaho Practitioner Application (IPA), follow these instructions

- Complete the application in its entirety using black or blue ink. **Keep an unsigned and undated 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 8 and 10. Please document any YES responses on the Attestation Question page.
- Prior to submitting this application to any health care related organization, inquire with the organization, as you may need authorization (through a pre-application process) before the application is accepted. 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 IPA.

This application is submitted to

I. Instructions

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

- State Professional License(s)
- DEA Certificate w/ Idaho address
- ECFMG (if applicable)
- ISBP Certificate
- Passport photo (for hospitals only)
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application.)

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

II. Practitioner Information

Last name (include suffix; Jr., Sr., III)	First (do not abbreviate)	Middle (do not abbreviate)

Other name(s) under which you have been known by reference, licensing and or educational institutions?	Degree(s)

Home telephone number	Pager number	Cell number	E-mail address

Home mailing address	City	State	Zip code

Birth date	Birth place (city, state, country)	Social security number	Citizenship

Languages spoken by practitioner	Type of Provider ☐ PCP ☐ Urgent Care ☐ Specialist	Gender ☐ Male ☐ Female

NPI	Medicare UPIN	Medicare number (ID)	Medicaid number(s)

Other professional interests in practice, research, etc.	Taxonomy (10-digit code identifying specialty or subspecialty)	Subspecialties

III. Practice Information

Effective Date at Primary Practice location _____

Name of practice, affiliation or clinic name	Department name (if hospital based)

Primary office street address	City	State	Zip code

Patient appointment telephone number	Fax number	Name affiliated with tax ID number	Federal tax ID number

Mailing address (if different from above)	City	State	Zip code

Modification to the wording or format of the Idaho Practitioner Application may invalidate the application.

III. Practice Information (Continued)

Billing address (if different from above)	City	State	Zip code
Office manager / Administrator name	Administration telephone number	Fax number	E-mail address
Credentialing contact (if different from above)	Credentialing telephone number	Fax number	E-mail address

Effective Date at Secondary Practice location _____

Name of secondary practice, affiliation or clinic name		Department name (if hospital based)	
Secondary office street address	City	State	Zip code
Patient appointment telephone number	Fax number	Name affiliated with tax ID number	Federal tax ID number
Mailing address (if different from above)	City	State	Zip code
Billing address (if different from above)	City	State	Zip code
Office manager / Administrator name	Administration telephone number	Fax number	E-mail address
Credentialing contact (if different from above)	Credentialing telephone number	Fax number	E-mail address

List other office locations with above information on a separate sheet.

IV. Professional Licensure

Idaho State professional license/registration/certificate number		Status ☐ Active ☐ Inactive ☐ Temporary	
Issue date	Expiration date	**Name of sponsor if required by licensure, (i.e. Physician's Assistant).**	
Drug Enforcement Administration (DEA) registration number		Issue date	Expiration date
State controlled substance certificate number		Issue date	Expiration date
ECFMG number (applicable to foreign medical graduates)		Date issued	

V. All Other Professional Licenses

State	License/registration/certificate number		Date issued
Expiration date	Year relinquished	Reason	
State	License/registration/certificate number		Date issued
Expiration date	Year relinquished	Reason	
State	License/registration/certificate number		Date issued
Expiration date	Year relinquished	Reason	

VI. Under-graduate Education

Name of college or university			**Does Not Apply** ☐
Degree received		Graduation date	
Mailing address	City	State	Zip code
Name of college or university			
Degree received		Graduation date	
Mailing address	City	State	Zip code

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(*Do not abbreviate*) (Attach additional sheet if necessary)

VII. Medical/Professional Education

Medical/Professional school

Start date	Graduation date	Degree received

Mailing address	City	State	Zip code
	Phone	Fax	

Medical/Professional School

Start date	Graduation date	Degree received

Mailing address	City	State	Zip code
	Phone	Fax	

(*Do not abbreviate*) (Attach additional sheet if necessary)

VIII. Graduate Education

Institution **Does Not Apply** ☐

Program or course of study	Faculty director

Mailing address	City	State	Zip code
Dates attended (/) - (/)	Phone	Fax	

(*Do not abbreviate*) (Attach additional sheet if necessary)

IX. Internship/PGYI

Institution **Does Not Apply** ☐

Program director

Mailing address	City	State	Zip code
Start date / Completion date	Phone	Fax	
Type of internship	Specialty		

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

(*Do not abbreviate*) (Attach additional sheet if necessary)

X. Residencies

Institution **Does Not Apply** ☐

Program director

Mailing address	City	State	Zip code
Start date / Completion date	Phone	Fax	
Type of residency	Specialty		

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

Institution **Does Not Apply** ☐

Program director

Mailing address	City	State	Zip code
Start date / Completion date	Phone	Fax	
Type of residency	Specialty		

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

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(*Do not abbreviate*) (Attach additional sheet if necessary)

XI. FELLOWSHIPS

Institution — Does Not Apply ☐

Program director

Mailing address	City	State	Zip code

Start date	Completion date	Phone	Fax

Course of study

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

Institution — Does Not Apply ☐

Program director

Mailing address	City	State	Zip code

Start date	Completion date	Phone	Fax

Course of study

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

(*Do not abbreviate*) (Attach additional sheet if necessary)

XII. PRECEPTORSHIP

Institution — Does Not Apply ☐

Department chairman

Mailing address	City	State	Zip code

Start date	Completion date	Phone	Fax

Training

(*Do not abbreviate*) (Attach additional sheet if necessary)

XIII. FACULTY APPOINTMENT

Institution — Does Not Apply ☐

Faculty director

Mailing address	City	State	Zip code

Start date	Completion date	Phone	Fax

Position

(*Do not abbreviate*) (Attach additional sheet if necessary)

XIV. BOARD CERTIFICATION

Are you board or otherwise professionally certified? — Does Not Apply ☐

☐ **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	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

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

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(*Do not abbreviate*) (Attach additional sheet if necessary)

XV. Other Certifications

ACLS, BLS, ATLS, PALS, NRP, NALS (i.e., Fluoroscopy, Radiography, etc. – Attach certificate if applicable)		Does Not Apply ☐
Type	Number	Expiration date
Type	Number	Expiration date
Type	Number	Expiration date
Type	Number	Expiration date

XVI. Hospital and Other Institutional Affiliations

Does Not Apply ☐

Please list in **reverse chronological order (with the current affiliation(s) first)** all institutions where you (A) have current affiliations, (B) applications in process, (C) have had previous affiliations or, if no current affiliation, (D) have a current coverage plan. 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.

(*Do not abbreviate*) (Attach additional sheet if necessary)

A. Current Affiliations

Name of primary facility (Do you have admitting privileges? ☐ **Yes** ☐ **No**)			
Department	Department / Clinical Chair	Status (active, provisional, courtesy, temporary, etc.)	
Mailing address	City	State	Zip code
Phone number	Fax number	Appointment date	
Name of secondary facility (Do you have admitting privileges? ☐ **Yes** ☐ **No**)			
Department	Department / Clinical Chair	Status (active, provisional, courtesy, temporary, etc.)	
Mailing address	City	State	Zip code
Phone number	Fax number	Appointment date	
Name of other facility (Do you have admitting privileges? ☐ **Yes** ☐ **No**)			
Department	Department / Clinical Chair	Status (active, provisional, courtesy, temporary, etc.)	
Mailing address	City	State	Zip code
Phone number	Fax number	Appointment date	

(*Do not abbreviate*) (Attach additional sheet if necessary)

B. Applications In Process

Hospital/Institution			
Mailing address	City	State	Zip code
Phone number	Fax number	Date application submitted	
Hospital/Institution			
Mailing address	City	State	Zip code
Phone number	Fax number	Date application submitted	

(*Do not abbreviate*) (Attach additional sheet if necessary)

C. Previous Affiliations

Name of facility			**Does Not Apply** ☐
Department		Department / Clinical Chair	
Mailing address	City	State	Zip code
Phone number	Fax number	Previous status (active, provisional, courtesy, temporary, etc.)	
Reason for leaving		Appointment date (from– to)	
Name of facility			
Department		Department / Clinical Chair	
Mailing address	City	State	Zip code
Phone number	Fax number	Previous status (active, provisional, courtesy, temporary, etc.)	
Reason for leaving		Appointment date (from– to)	
Name of other facility			
Department		Department / Clinical Chair	
Mailing address	City	State	Zip code
Phone number	Fax number	Previous status (active, provisional, courtesy, temporary, etc.)	
Reason for leaving		Appointment date (from– to)	

(for those without admitting privileges)

D. Inpatient Coverage Plan

Please attach signed letter of agreement from the physician or group representative that admits and manages the inpatient care for your patients. **Does Not Apply** ☐

Name of admitting physician/practice/clinic/group	Hospital where privileged

(*Do not abbreviate*) (Attach additional sheet if necessary)

XVII. Work History

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

Name of current practice/employer				
Contact name	Telephone number	Fax number	From	To
Mailing address	City	State	Zip code	
Name of practice/employer				
Contact name	Telephone number	Fax number	From	To
Mailing address	City	State	Zip code	
Reason for leaving				

XVII. Work History (Continued)

Name of practice/employer				
Contact name	Telephone number	Fax number	From	To
Mailing address	City	State	Zip code	
Reason for leaving				

Please account for all gaps in time between date of medical / professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable.

Activity / Name	From	To

(*Do not abbreviate*)

XVIII. Professional Affiliations

Please list membership in all professional societies. Complete Name of Society	Date Joined	Current Member	
		Yes	No

XIX. Peer References

List **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. One reference must be from same discipline.

Name of reference		Title and specialty	
Mailing address	City	State	Zip code
E-mail address	Telephone number	Fax number	Cell phone number (optional)

Name of reference		Title and specialty	
Mailing address	City	State	Zip code
E-mail address	Telephone number	Fax number	Cell phone number (optional)

Name of reference		Title and specialty	
Mailing address	City	State	Zip code
E-mail address	Telephone number	Fax number	Cell phone number (optional)

(*Do not abbreviate*)

XX. Professional Liability

Current insurance carrier			Policy number
Mailing address	City	State	Zip code
Phone number	Fax number	Origination (retroactive) date	
Per claim amount	Aggregate amount	Effective date	Expiration date

Please list **ALL** professional liability carriers within the past ten years

Name of carrier			Policy number
Mailing address	City	State	Zip code
Phone number	Fax number	From	To
Name of carrier			Policy number
Mailing address	City	State	Zip code
Phone number	Fax number	From	To
Name of carrier			Policy number
Mailing Address	City	State	Zip code
Phone number	Fax number	From	To

XXI. Professional Liability Action Detail – Confidential

Practitioner name(print or type) **Does Not Apply** ☐

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 health information (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? **$**

IDAHO 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.*

			Yes	No
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		
	b.	Other professional registration or certification in any jurisdiction		
	c.	Specialty or subspecialty board certification		
	d.	Membership on any hospital medical staff		
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.		
	f.	Medicare, Medicaid, FDA, governmental, national or international regulatory agency or any public program		
	g.	Professional society membership or fellowship		
	h.	Participation/membership in an HMO, PPO, IPA, PHO or other entity		
	i.	Academic Appointment		
	j.	Authority to prescribe controlled substances (DEA or other authority)		
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?			
③	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?			
④	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?			
B.	**CRIMINAL HISTORY**		**Yes**	**No**
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?			
	a.	Do you have notice of any such anticipated charges?		
	b.	Are you currently under governmental investigation?		
C.	**AFFIRMATION OF ABILITIES**		**Yes**	**No**
①	Do you presently use any drugs illegally?			
②	Do you have, or have you ever had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or could affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.			
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?			
D.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section,** please document in Section XXI. 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?			
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?			
③	Are there any such claims being asserted against you now?			
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)?			
⑤	Are any of the privileges that you are requesting not covered by your current malpractice coverage?			
E.	**ATTESTATION**			

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.

Typed or printed name	Signature	Date

Modification to the wording or format of the Idaho Practitioner Application may invalidate the application.

XXII. 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 photocopy 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

XX. ATTESTATION QUESTIONS – This section to be completed by the Practitioner.

Modification to the wording or format of these Attestation Questions will invalidate the application.

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on a separate sheet**. Please sign and date each additional sheet.**

A.	Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction **ever been** denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, or have you **ever been** fined or received a letter of reprimand or is any such action pending or under review?	YES ☐ NO ☐
B.	Have you **ever been** suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	YES ☐ NO ☐
C.	Have you **ever been** denied clinical privileges, membership, contractual participation or employment by any health care related organization*****, or have clinical privileges, membership, participation or employment at any such organization **ever been** placed on probation, suspended, restricted, revoked, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES ☐ NO ☐
D.	Have you **ever** surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization***** while under investigation or potential review?	YES ☐ NO ☐
E.	Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization*** ever been** withdrawn on your request prior to the organization's final action?	YES ☐ NO ☐
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization **ever been** revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES ☐ NO ☐
G	Have you **ever** had board certification revoked?	YES ☐ NO ☐
H	Have you **ever been** the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES ☐ NO ☐
I.	Have you ever been charged with a criminal violation (felony or misdemeanor)?	YES ☐ NO ☐
J.	Do you presently use any illegal drugs?	YES ☐ NO ☐
K	Do you now have, or have you had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation, the privileges requested? If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.	YES ☐ NO ☐
L.	Are you **unable** to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	YES ☐ NO ☐
M.	Have any professional liability claims or lawsuits **ever been** closed and/or filed against you? If yes, please complete **Attachment A, Professional Liability Action Detail,** for **each** past or current claim and/or lawsuit.	YES ☐ NO ☐
N.	Has your professional liability insurance **ever been** terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you **ever been** denied professional liability insurance?	YES ☐ NO ☐

e.g.** ***hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature:	**Date:**

OREGON PRACTITIONER CREDENTIALING APPLICATION

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this application, I understand and agree to the following:

1. I understand and acknowledge that, as an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [*e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, medical school faculty position or other health delivery entity or system*] indicated on this application , I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have provided peer references familiar with my professional competence and ethical character, if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.

2. I further understand and acknowledge that the health care related organization(s) or designated agent would 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 related organization(s) as a part of the verification and Credentialing process.

3. I authorize all individuals, institutions, entities of other hospitals 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 may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated health care related organization(s), 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 clinical privileges/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 release from any liability, to the fullest Extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the health care related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the health care related organization(s) designated herein, unless revoked by me in writing.

7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies.

8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the health care related organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.

9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release 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.

Printed Name:	
Signature:	**Date:**

I grant permission for the release of the credentials information contained in this practitioner application to the following health care related organization(s):

Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.

Form **W-9**
(Rev. November 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ---------- ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
| | | | - | | - | | | | |

or

Employer identification number
| | | - | | | | | | | |

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here **Signature of U.S. person** ► **Date** ►

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules regarding partnerships* on page 1.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.socialsecurity.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules regarding partnerships* on page 1.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.