

State of West Virginia Recredentialing Form

Please complete each section thoroughly. Information submitted on the application should be representative of activity/information that occurred or changed on or after the Date of Last Credentialing listed below.

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.

Date of Last Credentialing (may be obtained from Entity if not provided)	
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 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 **(if changed since date of last credentialing)**
- 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

Recredentialing 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 (Entire section must be completed)				
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)				
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:		
Current Home Address		City	State	Zip Code
Home Telephone		Is this # unlisted?	Home Fax	
() -		<input type="checkbox"/> Yes <input type="checkbox"/> No	() -	
If citizenship status or VISA status has changed, please indicate below and attach an explanation as well as pertinent documentation.				
<input type="checkbox"/> Citizenship/VISA status has changed.				
Language(s) Spoken (other than English)				

2. Office Practice Information: (Complete only for information changed since last date of credentialing)

Check if entire section unchanged since last date of credentialing

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	<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Group <input type="checkbox"/> Corporation	<input type="checkbox"/> Hospital Based <input type="checkbox"/> Teaching or Research <input type="checkbox"/> 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?				
<input type="checkbox"/> Yes <input type="checkbox"/> By referral only <input type="checkbox"/> No <input type="checkbox"/> NA		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA If Yes, please list:				
Handicap Accessible?		Public Transit Available?				
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA				
Does the office have other services available for disabled? (TTY, ASI, Mental/physical impairments, etc.)		If yes, list below what services are available				
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA						
Office Manager's Name		Nurse Manager's Name				
<input type="checkbox"/> N/A		<input type="checkbox"/> N/A	Name _____ Phone # _____ <input type="checkbox"/> N/A			
Office Hours _____						
<input type="checkbox"/> Check if not applicable <input type="checkbox"/> 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)						
<input type="checkbox"/> Lab Services		<input type="checkbox"/> On-Site		Reference Lab Name:	CLIA Number and Type of Certification:	
<input type="checkbox"/> Radiology Services		<input type="checkbox"/> EKG		<input type="checkbox"/> Sigmoidoscopy	<input type="checkbox"/> Audiology Services	<input type="checkbox"/> Treadmill
<input type="checkbox"/> Other (Please list):						
<input type="checkbox"/> List any special diagnostic or treatment procedures performed in your office:						

Patient Population			
Do you limit the age of patients you treat?		If yes, what ages do you treat?	
<input type="checkbox"/> Yes	<input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Group/Practice Name (Check Payable To):			
Address (Building, Street, Suite #)		City	State
			Zip Code
Billing Office Telephone 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?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details on separate sheet.	
Practice Classification			
<input type="checkbox"/> Primary Care Physician (Family Practitioners, Internists, or Pediatricians who deliver primary health care services) <input type="checkbox"/> Specialist Physician (Physicians other than primary care physicians in their designated clinical practice) <input type="checkbox"/> Allied Health Professional (Licensed, certified, or registered non-physician practitioners of direct patient care services) <input type="checkbox"/> 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?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> 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	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA			
Do you have an answering service/machine?		Is your answering service/machine available at all times when you are not in the office?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
List below other after-hours arrangements or special instructions to patients for after-hours care needs:			

Back-up Coverage (Please list the name, specialty, and telephone number of partner(s) or associate(s) or physician(s) covering your practice in your absence.)			
Name	Specialty	Partner, Associate, Or Covering	Telephone Number
			() -
			() -
			() -
			() -
Admitting Service			
Do you admit patients to the hospital under your own service?		If no, to whom do you admit?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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.			
<input type="checkbox"/> Physician's Assistant:		<input type="checkbox"/> Nurse Practitioner:	
<input type="checkbox"/> Nurse Midwife:		<input type="checkbox"/> Other (specify):	
Workers' Compensation Information			
Do you accept Workers' Compensation Patients?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please provide the following information:		<p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Modified or alternative duty is actively evaluated for each Workers' Compensation claimant. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Staff are available and willing to provide compensation representatives information regarding a claimant's care. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

Note: Section 3 (Medical/Professional Education) and Section 4 (Professional Training) have been intentionally omitted. If additional formal education/training has been obtained since the date of last credentialing, please complete Sections 3 and 4 from the Credentialing application as appropriate and attach.

3. Medical/Professional Education:

Please provide the following information for your medical school of graduation.

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

NOTE: The remainder of Section 3 (Medical/Professional Education) and Section 4 (Professional Training) have been intentionally omitted. If additional formal education/training has been obtained since the date of last credentialing, please complete Sections 3 and 4 from the Credentialing application as appropriate and attach.

5. State License(s): List all current 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
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the scope of your practice require the supervision of another practitioner?				<input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please list name of each supervising practitioner:				Practitioner Name:		
6. Certifications/Registrations						
<input type="checkbox"/> Check here if entire section is not applicable to applicant or if no changes since last credentialing date.						
Federal DEA Certificate <input type="checkbox"/> Not applicable (Submit copy of current DEA Certificate)						
Certificate #		Expiration Date	Unlimited?			
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	If no, explain:	
State DEA or CDS Certificate(s) <input type="checkbox"/> Not applicable (Submit copy of current State Controlled Dangerous Substance Certificates, if applicable)						
Certificate #		Expiration Date	Unlimited?			
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	If no, explain:	
Other Certificate(s)/Formal Training (Please check below if currently certified. Submit copy(s))						
<input type="checkbox"/> Basic Life Support (BLS) <input type="checkbox"/> Advanced Cardiac Life Support (ACLS) <input type="checkbox"/> Pediatric Advanced Life Support (PALS) <input type="checkbox"/> Advanced Trauma Life Support (ATLS) <input type="checkbox"/> Neonatal Advanced Life Support (NALS) <input type="checkbox"/> Anesthesia Permit <input type="checkbox"/> Health Care Practitioner (Core C) <input type="checkbox"/> Neonatal Resuscitation Program (NRP) <input type="checkbox"/> Therapeutics Classification Number (Optometrists only) <input type="checkbox"/> Other (please list below or on a separate sheet and include descriptions):						

7. Specialty Board Certification: Complete for information changed SINCE DATE OF LAST CREDENTIALING. Submit copies of board certifications and/or qualification confirmation letter.				
<input type="checkbox"/> Check here if entire section is not applicable to applicant or if no changes since last credentialing date.				
Are you board certified? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
If not certified, please indicate your status in the certifying process:	<ul style="list-style-type: none"><input type="checkbox"/> Failed to pass specialty board examination<ul style="list-style-type: none">• How many times have you taken the exam but failed to pass? _____• Last date(s) exam was taken: _____<input type="checkbox"/> Date(s) board examination was taken/retaken and date board exam is scheduled, if applicable:<ul style="list-style-type: none">• Date(s) taken/retaken: _____• Date scheduled, if applicable: _____<input type="checkbox"/> Not eligible to take specialty boards<input type="checkbox"/> Not planning to take specialty boards<input type="checkbox"/> Admissible with exam pending			

NOTE: Section 8 (Professional Peer References) has been intentionally omitted; however, may be required by specific entity in which case Section 8 from Credentialing application may be required as indicated on Page 1.

9. Hospital/Health Care Entity Affiliations:			
<input type="checkbox"/> Check here if entire section is not applicable to applicant.			
List ALL health care facilities at which you currently have privileges or have had privileges SINCE DATE OF LAST CREDENTIALING. Explain gaps greater than three (3) months during the period in Section 11.			
Name of Current Primary Hospital Affiliation		Type of Affiliation (e.g., Hospital, Nursing Home, etc.)	
Street Address		City	State
Telephone Number () -		Fax Number () -	
Department/Service		Department Chair's Name	
Staff Status		# Admits/Month	Percent of time spent at facility
Restricted? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:		Dates of Affiliation (Mo/Yr) From: _____ To: _____	
Reason for leaving, if applicable _____			
Name of Affiliation/Hospital/Healthcare Entity		Type of Affiliation (e.g., Hospital, Nursing Home, etc.)	
Street Address		City	State
Telephone Number () -		Fax Number () -	
Department/Service		Department Chair's Name	
Staff Status		# Admits/Month	Percent of time spent at facility
Restricted? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:		Dates of Affiliation (Mo/Yr) From: _____ To: _____	
Reason for leaving, if applicable _____			
Name of Affiliation/Hospital/Healthcare Entity		Type of Affiliation (e.g., Hospital, Nursing Home, etc.)	
Street Address		City	State
Telephone Number () -		Fax Number () -	
Department/Service		Department Chair's Name	

State of West Virginia Recredentialing 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.)

Staff Status	# Admits/Month	Percent of time spent at facility	
Restricted?		Dates of Affiliation (Mo/Yr)	
<input type="checkbox"/> Yes <input type="checkbox"/> 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 Affiliation (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)		
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:		From:	To:

Reason for leaving, if applicable

Name of Affiliation/Hospital/Healthcare Entity	Type of Affiliation (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)		
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:		From:	To:

Reason for leaving, if applicable

Name of Affiliation/Hospital/Healthcare Entity	Type of Affiliation (e.g., Hospital, Nursing Home, etc.)		
Street Address	City	State	Zip

State of West Virginia Recredentialing 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.)

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)		
<input type="checkbox"/> Yes <input type="checkbox"/> 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 SINCE THE LAST CREDENTIALING DATE, 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			

State of West Virginia Recredentialing 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.)

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 SINCE LAST CREDENTIALING DATE that are not covered in Hospital/Facility Affiliations and/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
Hospital/Health Care Entity Affiliations	From:	
	To:	
	From:	
Work History/Experience	To:	
	From:	
	To:	
From:		
	To:	
	From:	
To:		
	From:	
	To:	

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 completed in last two (2) years (if required by Credentialing Entity).

13. Professional Associations/Organizations (optional for recredentialing)

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:
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 SINCE THE LAST CREDENTIALING DATE 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?
		<input type="checkbox"/> Claims Made	<input type="checkbox"/> Occurrence	<input type="checkbox"/> No <input type="checkbox"/> 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?
		<input type="checkbox"/> Claims Made	<input type="checkbox"/> Occurrence	<input type="checkbox"/> No <input type="checkbox"/> 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?
		<input type="checkbox"/> Claims Made	<input type="checkbox"/> Occurrence	<input type="checkbox"/> No <input type="checkbox"/> 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?
		<input type="checkbox"/> Claims Made	<input type="checkbox"/> Occurrence	<input type="checkbox"/> No <input type="checkbox"/> Yes

15. Professional Liability Insurance Coverage Disclosure: (Respond only for actions since date of last credentialing.)

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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
B. Have you ever been denied professional liability insurance coverage?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
E. Have any restrictions ever been placed on your professional liability insurance coverage?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
F. Have you ever practiced without professional liability coverage?	<input type="checkbox"/> No	<input type="checkbox"/> 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.)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

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, with any actions or change of status SINCE LAST DATE OF CREDENTIALING, including those pending.
- Information for each settlement, or decision for the plaintiff that has occurred on your behalf SINCE LAST DATE OF CREDENTIALING.
- 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?		
<input type="checkbox"/> Primary Defendant <input type="checkbox"/> Co-Defendant <input type="checkbox"/> Other, please explain:	<input type="checkbox"/> Dropped <input type="checkbox"/> Pending <input type="checkbox"/> Settled Out of Court	<input type="checkbox"/> Found for Defendant <input type="checkbox"/> Dismissed Without Payment <input type="checkbox"/> Found for Plaintiff <input type="checkbox"/> 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?		<input type="checkbox"/> N/A
12. What were you alleged to have done incorrectly or failed to do?		<input type="checkbox"/> N/A
13. Describe the patient's illness and related effects of the alleged harm.		<input type="checkbox"/> N/A
14. Describe any other details you believe are pertinent to the case.		<input type="checkbox"/> N/A
15. Identify any other parties named in the suit.		<input type="checkbox"/> N/A
Practitioner Signature (REQUIRED)	Date (REQUIRED)	

16. Practice Disclosure Information: (Complete based upon activity SINCE LAST DATE OF CREDENTIALING)			
<p>If the answer to any question below is yes since your last recredentialing date, please provide a full explanation of the details on a separate sheet and attach.</p>			
A. Have any investigations been initiated or are any pending against you by any state licensure board, registration board, or regulatory agency?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> 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)?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
F. Have you ever had an academic appointment denied, limited, revoked, suspended, reduced, placed on probation, not renewed, or other adverse action taken?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
J. Have you 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?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
O. Do you have any knowledge of any civil actions pending against you by any hospital, law enforcement agency, professional group or society?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
P. Have you had any charges of unprofessional conduct brought against you?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Q. Have you had any charges of fraud brought against you?	<input type="checkbox"/> No	<input type="checkbox"/> 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.	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Health Status			
<p>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.</p>			
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
B. Are you able to perform these functions without significant risk of injury to yourself or others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
C. Do you illegally use drugs? Have you used illegal drugs within the last two years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Health Care Entity:	
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**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 Recredentialing Form (WVRF) 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 WVRF 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 WVRF 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 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 WVRF 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 WVRF 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 WVRF/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.)

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: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ►					
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.

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.

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, or
2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
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.

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 social security card. 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 social security card 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

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

²However, 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/online/ss-5.pdf. 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) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee ¹ 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.)

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, and the District of Columbia 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.