

# NECESSARY ATTACHMENTS TO PROVIDER APPLICATION CHECKLIST SHEET

- ❑ **TEXAS STANDARDIZED CREDENTIALING APPLICATION** - Attachment must be signed by the provider applying
- ❑ **MALPRACTICE NARRATIVE ADDENDUM** - Malpractice Claims History must be completed, in detail, any claims/suits filed, dropped or pending.
- ❑ **CONTRACT PAGE & FEE SCHEDULE SHEET** - Attachment must be signed by the provider applying
- ❑ **ACKNOWLEDGE, CONSENT AND RELEASE FORM** - Attachment must be signed by the provider applying
- ❑ **CREDENTIALIAED SPECIALTIES SHEET** - choose attached applicable form
- ❑ **CURRENT W-9**
- ❑ **UPIN** - Universal Personal Identification Number -MD/DO ONLY
- ❑ **PROFESSIONAL MALPRACTICE LIABILITY** – All providers
- ❑ **STATE LICENSE** - Current copy
- ❑ **DEA** - Current copy of Federal Certificate, MD/DO
- ❑ **DPS** - Current copy of State Certificate, MD/DO
- ❑ **CURRICULUM VITAE or RESUME** – All providers
- ❑ **BOARD CERTIFICATION OR BOARD ELIGIBILITY** - MD/DO, if applicable
- ❑ **RESIDENCY, FELLOWSHIP AND OTHER ADVANCED TRAINING** - MD/DO only
- ❑ **DIPLOMA/CERTIFICATES** - school/university/program where training/education was received, all providers
- ❑ **PLEASE RETURN APPLICATION TO:**

**TML IEBP  
ATTN: MELISSA PONCE  
1821 RUTHERFORD LANE #300  
AUSTIN TX 78754**

**PLEASE CHECK TO INSURE ALL REQUIRED/APPLICABLE DOCUMENTS ARE ENCLOSED PRIOR TO RETURNING YOUR APPLICATION. FAILURE TO DO SO WILL DELAY THE PROCESS OF APPROVING YOUR APPLICATION.**



**PROVIDER AGREEMENT**  
**By and Between**  
**TML Intergovernmental Employee Benefits Pool**  
**And**

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THIS **PROVIDER** AGREEMENT, "Agreement" made and entered into on the \_\_\_\_\_ day of \_\_\_\_\_, 2005, is by and between TML INTERGOVERNMENTAL EMPLOYEE BENEFITS POOL, hereinafter referred to as the "**Pool**"; and \_\_\_\_\_ hereafter referred to as the "**Provider**."

**I. RECITALS**

**WHEREAS**, the **Pool**, an Intergovernmental Risk Pool, operating pursuant to Chapter 172 of the Texas Local Government Code, desires to make appropriate Healthcare Service available at a reasonable cost to the eligible plan participants, who are covered by the healthcare benefit plans that have been established by the employer members of the **Pool**; and

**WHEREAS**, **Provider** is a hospital, physician, and/or other healthcare providing entity organized specifically to facilitate the provision of healthcare services to individuals; and

**WHEREAS**, the **Pool** desires to contract with the **Provider** to arrange for the provision of Healthcare Services to Covered Individuals pursuant to the terms and conditions of this Agreement; and

**NOW, THEREFORE**, and in consideration of the premises and the mutual covenants herein contained, the receipt and adequacy of which are acknowledged by the parties, the parties agree as follows:

**II. DEFINITIONS**

For the purposes of this Agreement, certain terms are defined as follows:

- 2.1 Ancillary Providers:** Means durable medical equipment suppliers, home health agencies, infusion therapists, physical therapists, occupational therapists, outpatient surgery centers, ambulatory surgical centers, allied health professionals, chiropractic practitioners and laboratories.
- 2.2 Clean Claim:** The "Clean Claim" means a claim for services rendered to a Covered Individual, which is accurate, complete and includes all supporting documents. A "Clean Claim" does not include a claim where coordination of benefits is actively pursued medical claims review is necessary, subrogation is pursued, where work related, or where pre-existing conditions may exist. . A Clean Claim does not include a claim where supporting documents are required. Outpatient claims in excess of seven thousand five hundred dollars (\$7,500) and inpatient claims in excess of ten thousand dollars (\$10,000) will require itemized bills.

- 2.3 Covered Individuals Benefit Percentage:** A specific amount that is the Covered Individual's responsibility to pay to the **Provider** up to The Plan's out-of-pocket maximum.
- 2.4 Co-Payment:** A specific amount that is the Covered Individual's responsibility to pay to the **Provider** at the time of service. Co-Payments are usually connected with specific benefits and may be used instead of The Plan deductible and Covered Individual Benefit Percentage.
- 2.5 Coordination of Benefits (COB):** Means a process by which two (2) or more health benefit plans, providing the same Covered Individual the same or similar health benefits, share the aggregate benefits on the actual billed charges the individual receives for an illness or injury. One plan will be determined primary and the other secondary.
- 2.6 Covered Individual:** Means any individual who is eligible to receive Covered Services under the Plan.
- 2.7 Covered Services:** Means medically necessary services or supplies specified in the Covered Individual's Plan for which benefits will be paid when provided by a **Provider** acting within the scope of his/her license pursuant to this agreement.
- 2.8 Deductible:** The amount of eligible expenses which must be paid by a Covered Individual before benefits become payable by The Plan.
- 2.9 Emergency or Emergency Service:** Means an acute injury or the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the Covered Individual's life in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.
- 2.10 Explanation of Benefits (EOB):** Means the information provided by The Plan regarding payment or non-payment of medical treatment or services.
- 2.11 Fee Schedule:** Means the schedule, attached hereto as Attachment A and incorporated herein by reference, which specifies the maximum amount payable to the **Provider** for providing Covered Services to Covered Individuals.
- 2.12 Healthcare Facility:** Means all licensed facilities that have contracted with the **Pool** to render Covered Services to Covered Individuals.
- 2.13 Healthcare Service:** Means those services the **Provider** is licensed to provide and which he/she customarily provides to individuals; or those inpatient and outpatient services that a Healthcare Facility is licensed, equipped and staffed to provide, and which it customarily provides to individuals.
- 2.14 Hospital:** Means all licensed hospital facilities that have contracted with the **Pool** to render Covered Services to Covered Individuals.
- 2.15 Identification System:** The term "Identification System" means the method used to assure that **Providers** may identify Covered Individuals and may obtain eligibility verification and authorization, if applicable.

- 2.16 Integration of Benefits:** A process by which two (2) or more health benefit plans providing the same individual the same or similar health benefits limit the aggregate benefits the individual receives for an illness or injury to the amount payable by The Plan.
- 2.17 Medically Necessary Treatment:** Means medical or surgical services which a Covered Individual requires for the identification or treatment of illness, injury, disease or impairment, or skilled care which is consistent with the Covered Individual's diagnosis or symptoms which is appropriate with regards to standards of good medical practice.
- 2.18 Network Providers:** Means, collectively, the Ancillary Providers, Hospitals, Healthcare Facilities and Physicians, as defined in this Agreement.
- 2.19 Physician:** Means an individual licensed to practice medicine in the State of Texas who has contracted with the **Pool** to provide Covered Services to Covered Individuals.
- 2.20 The Plan:** Means a plan or plans of medical, hospital, dental or vision benefits adopted by a political entity which is a member of the **Pool**, the benefit plan booklet or any other legally enforceable instrument under which a Covered Individual may be entitled to Covered Services and which is in force with respect to such individual. The Plan(s) is attached as Attachment B and is incorporated by reference.
- 2.21 Pool:** The term "**Pool**" means the TML Intergovernmental Employee Benefits Pool, the entity responsible for the administration or payment of claims under The Plan.
- 2.22 Provider Agreement:** Means an Agreement between the **Provider** and the **Pool**.
- 2.23 Skilled Care:** Means the recognition and utilization of professional methods and procedures in the assessment, observation, or treatment of an illness or injury; and must be performed by or under the supervision of **Provider**.
- 2.24 Utilization Management:** A program which may include, without limitation, evaluation of the necessity, appropriateness, and efficiency of the use of Healthcare Services, procedures, and facilities on a prospective, concurrent, or retrospective basis.

### **III. INTERGOVERNMENTAL EMPLOYEE BENEFITS POOL RESPONSIBILITIES:**

- 3.1** The **Pool** shall define and determine all eligibility requirements for Covered Individuals. **Pool** shall establish procedures to verify the eligibility of Covered Individuals seeking services from **Provider**, including ID cards and an 800 number. The eligibility procedures shall be set out or referenced in The Plan.
- 3.2** The **Pool** agrees to establish, at its expense, an Identification System for the purpose of verifying the eligibility of Covered Individuals seeking services from **Provider**.
- 3.3** The contents, description, and nature of the benefits provided by The Plan(s), and dissemination to **Provider** and to Covered Individuals of all such information, whether or not required by law, shall be the sole responsibility of the **Pool** and shall be in accordance with federal, state, and local law.

- 3.4 The **Pool** shall maintain comprehensive general liability and other insurance as shall be necessary to insure the **Pool** and its agents, servants and employees, acting within the scope of their duties, against any claim or claims for damages arising directly or indirectly in connection with the performance or non-performance of any service provided under this Agreement by the **Pool**, its agents, servants, or employees.

#### IV. PROVIDER RESPONSIBILITIES

- 4.1 **Provider** shall provide medically necessary Healthcare Services to Covered Individuals in a manner similar to and within the same time availability in which **Provider** provides such services to any other individuals, and will not differentiate or discriminate against Covered Individuals as a result of this Agreement.
- 4.2 **Provider** shall provide Healthcare Services to Covered Individuals in the most cost-effective manner.
- 4.3 **Provider** shall provide Healthcare Services in a manner which assures availability, adequacy and continuity of care to Covered Individuals.
- 4.4. **Provider** shall maintain currently and for the duration of this Agreement, professional liability insurance coverage in such amount at least equal to or greater than one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) in the aggregate. For dependent/independent providers, amounts at least equal to or greater than two hundred thousand dollars (\$200,000) per occurrence and six hundred thousand dollars (\$600,000) in the aggregate. Evidence of such coverage shall be provided to the **Pool** upon request. The **Provider** shall agree to give the **Pool** not less than thirty days prior written notice of any cancellation, non-renewal, or material alterations of such coverage.
- 4.5 **Provider** shall prepare and maintain all appropriate medical, financial, administrative and other records which involve transactions relating to Covered Individuals receiving Healthcare Services. **Provider** agrees to maintain records on Covered Individuals in accordance with prudent record-keeping procedures and as required by any applicable federal, state, or local laws, rules or regulations.
- 4.6 **Provider** agrees to allow the **Pool** or its designee upon reasonable notice during normal business hours to have, without charge, access to and the right to examine, audit, excerpt, copy and transcribe any books, documents, papers, and records within its possession, which involve transactions relating to this Agreement. The **Provider** agrees to provide the **Pool** or its designee with appropriate working space. Upon request, photocopies of such records shall be provided to the **Pool** or its designee at \$.10/copy, not to exceed \$20.00/record. This provision shall survive the termination of this Agreement.
- 4.7 **Provider** shall comply, with the requirements of all laws and regulations applicable to the **Pool's** business, and shall maintain in effect all licenses, permits and all governmental and board authorizations and approvals as necessary for **Provider's** business operations and for the provision of Healthcare Services.

- 4.8** **Provider** shall immediately send written notice to the **Pool** of any legal, governmental, or other action taken against **Provider**, which could materially impair the ability of **Provider** to carry out the duties and obligations of this Agreement, including, but not limited to, actions related to 1) any revocation, suspensions, or limitation in staff privileges; 2) any disciplinary action taken by a hospital; and 3) suspension from participation in the Medicare or Medicaid program as a result of alleged fraud or abuse.
- 4.9** **Provider** affirms that the application, which is hereby incorporated by reference, contains true and correct information and **Provider** acknowledges that the **Pool** is relying on such information.
- 4.10** **Provider** shall cooperate fully with the **Pool** and provide such information as may be necessary to assist the **Pool** in the provider review and re-appointment process. The **Provider** will produce information regarding professional review, qualifications, and malpractice history from any source as long as this Agreement remains in effect.
- 4.11** The **Provider** shall share Covered Individual's medical records and forward medical records and clinical information in a timely manner to other healthcare providers treating a Covered Individual so long as the Covered Individual executes an appropriate release or where an exception to confidentiality requirements exists.
- 4.12** **Provider** shall permit the **Pool** or its designee to confer directly with **Provider** regarding Healthcare Services provided to Covered Individuals.
- 4.13** **Provider** warrants that it is licensed by its licensing agency to provide Healthcare Services in the State of Texas.
- 4.14** **Provider** shall make his/her best efforts to inform the Covered Individual that lesser benefits may be available under The Plan in the event a Network Provider refers or admits the Covered Individual to a healthcare provider other than a Network Provider.
- 4.15** **Provider** shall make his/her best effort to refer and admit Covered Individuals to other Network Providers except when 1) an emergency exists and the Network Provider is not available; 2) the Healthcare Service is not geographically available in a timely fashion; or 3) the Covered Individual refuses to accept the recommendation of a Network **Provider** and the **Provider** documents that the Covered Individual elected to receive the Healthcare Service from a non-network provider.
- 4.16** **Provider** shall comply and assist with implementing the **Pool's** Utilization Management plan or program as long as the Utilization Management plan or program complies with or does not conflict with the requirements of any government or regulatory compliance board.
- 4.17** **Provider** acknowledges that the **Pool** does not warrant or guarantee that **Provider** will be utilized by any particular number of Covered Individuals
- 4.18** **Provider** acknowledges that the **Pool** may remove **Provider** from participation under this Agreement at any time with or without cause by giving a thirty (30) day written notice to the **Provider**.

- 4.19** **Provider** agrees to assist the **Pool** in contacting the appropriate individuals for services not performed by **Provider**, i.e., emergency room, laboratory, anesthesiologist, etc.
- 4.20** **Provider** agrees to deliver Healthcare Services in the most cost efficient setting. A Healthcare Service will not be considered Medically Necessary if the Covered Individual's symptoms or conditions indicate that it would be safe to provide the service or supplies in a less comprehensive setting. The fact that any particular **Provider** may prescribe, order, recommend, or approve a service, supply or level of care does not, of itself, make such treatment Medically Necessary.

## V. REIMBURSEMENT AND BILLING

- 5.1** The **Provider** shall submit electronic claims direct or through a mutually agreed upon vendor for payment within ninety (90) days after providing Covered Services to Covered Individuals. All claims from **Provider** will be considered final unless adjustments are requested in writing with sixty (60) days after receipt of payment. **Provider** agrees that failure to submit claims within such time period will result in the disallowance of the claims for the purpose of payment, unless such failure is agreed upon by the **Pool** and **Provider** to be unavoidable.
- 5.2** The **Pool** shall make payment or arrange for payment within thirty (30) days of receipt of the **Provider's** paper Clean Claim and twenty-one (21) days of receipt of the **Provider's** electronic Clean Claim for Covered Services provided to Covered Individuals.
- 5.3** The **Provider** shall provide to the **Pool** all information necessary for the **Pool** to determine the liability including accurate and complete claims for Covered Services utilizing HCFA 1500, UB92, UB82 and coding schemes that are acceptable to the **Pool**.
- 5.4** The **Provider** shall agree to accept the amount specified on the fee schedule as payment in full for Covered Services provided to Covered Individuals. The fee schedule is effective regardless if TML Intergovernmental Employee Benefits Pool is the primary, secondary or tertiary payor. The fee schedule paid will be the lessor of billed charges or the amount specified on the fee schedule. The fee schedule will apply for work and non-work related incidents. **Provider** shall implement an assignment of benefits procedure for claims payment to be made directly to **Provider**. **Provider** may only collect co-payment at the time of service.
- 5.5** The **Provider** will be solely responsible for collection of any deductibles, coinsurance, co-payments, and charges for non-medically necessary services that are the Covered Individual's responsibility, provided that the total collected may not exceed the amount specified on the fee schedule. The collection effort for the Co-payment should be at the time of service. Deductibles, Covered Individual Benefit Percentage or charges for non-Medically Necessary services should be collected after the **Provider** is in receipt of payment and the EOB (Explanation of Benefits) from the **Pool**. **Provider** agrees not to balance bill the patient for any amounts other than the Deductible, Co-payments and/or Covered Individuals Benefit Percentage.

- 5.6 The **Provider** shall not seek payment from the Covered Individual for Healthcare Services that are not medically necessary except when a Covered Individual requests the **Provider** to provide Healthcare Services that are not medically necessary and agrees to reimburse the **Provider** for those provided Healthcare Services. The fee schedule will apply to non-medically necessary services. The fee schedule paid will be the lesser of billed charges, the amount specified on the fee schedule, or Reasonable & Customary. Provider's billed charges shall be subject to Reasonable & Customary when reimbursed at a percentage off of billed charges.
- 5.7 The **Provider** agrees to refund to the **Pool** all duplicate or erroneous claim payments regardless of the cause. After thirty (30) days notice of over payment by the **Pool**, **Provider** agrees the **Pool** has the right to offset unpaid refunds against future payments.

## VI. PARTICIPATING PROVIDER NETWORK DIRECTORY

- 6.1 For the term of this Agreement, **Provider** authorizes and requires the **Pool** to identify and publish name, address, phone number and available services in the **Pool** informational materials. For the term of this Agreement, the **Pool** authorizes the **Provider** to make public reference to his/her participatory status. In all other respects, each party reserves the right to control the use of its name and all symbols, trademarks, or service marks presently existing or later established.

## VII. INDEMNIFICATION

- 7.1 Each party will be responsible for its own acts or omissions that result in injury or damage to individuals or property that arise as a consequence of the party's performance of this Agreement whether or not as a result of negligence. This provision shall survive the termination of this Agreement.

## VIII. CONFIDENTIALITY

- 8.1 **Provider** and **Pool** understand and agree that all information and records related to Covered Individuals are privileged and confidential. To the extent provided by law, the parties agree to keep confidential and not disclose patient identifiable information to any third party without the prior written consent of the Covered Individual, except that information required for Utilization Management, quality assurance and claims adjudication will be released to the **Pool** and/or its designee. Provider shall conform to all confidentiality and/or privacy requirements of state and federal law.
- 8.2 All information and materials provided by the **Pool** to **Provider** will remain proprietary to the **Pool** including but not limited to contracts, reimbursement rates and methodology, and any operations manuals. This statement shall survive the termination of this Agreement.

## IX. TERM AND TERMINATION OF AGREEMENT

- 9.1 Term:** This Agreement shall remain in full force and effect until \_\_\_\_\_.
- 9.2 Automatic Renewal:** At the end of the initial term, this Agreement shall automatically renew for one year period(s) thereafter unless terminated as provided for in this Agreement.
- 9.3 Annual Fee Schedule Review:** Following the initial term of this Agreement the fee schedule shall be subject to review each year. Either party may propose modification of the fee schedule by April 1 with the modifications to be effective on the following October 1. Agreement must be reached by July 15. In the event the parties do not agree to modification of the fee schedule, this Agreement shall continue in effect until either party terminates this Agreement in accordance with the provisions of this Agreement.
- 9.4 Optional Termination:** In the event either party shall, with or without cause, at any time give to the other party advance written notice, this Agreement shall terminate on the future date specified in such notice. Such notice must be received thirty (30) days in advance of specified date.
- 9.5 Termination for Specific Breach:** This Agreement may be terminated by either party for the failure, by omission in any substantial manner, of the other party to keep, observe or perform any covenant, term or provision of this Agreement to be kept, observed or performed by either party and such default shall have continued for a period of thirty days after receipt of written notice thereof from the non-defaulting party to the defaulting party.
- 9.6 Legislative or Administrative Changes:** In the event that there is a change in the federal or state statutes or regulations or in the application thereof, any of which materially affects the reimbursement which the **Provider** may receive for its services furnished to Covered Individuals, either party with notice may propose a new basis for compensation for the **Provider** services furnished pursuant to this Agreement. If such notice of new basis is given and if the parties are unable to agree upon a new basis for compensation within sixty days thereafter, either party may terminate this Agreement by thirty days notice to the other on any future date specified in such notice.
- 9.7 Effect of Termination:** Upon termination of this Agreement, neither party shall have any further obligation unless noted hereunder, except that termination of this Agreement shall not affect the rights and obligations of the parties hereto 1) arising out of transactions occurring prior to termination, including without limitation (a) **Pool's** obligation pursuant to this Agreement to render, payment to the **Provider** for its services, and (b) **Provider's** obligation for continuity of care through patient discharge including medically appropriate transfer of care or other medically appropriate transition of care with adherence to contracted fee schedule; and 2) obligations, promises and covenants expressly made to extend beyond the term of this Agreement, including without limitation confidentiality of information, indemnities, and releases.

## X. GENERAL PROVISIONS

- 10.1 Amendment:** The **Pool** retains the right to amend this Agreement by providing notice to the **Provider** at least ninety (90) days in advance of the effective date of the amendment. The **Provider** has the right to terminate this Agreement by providing written notice at least thirty (30) days prior to the effective date of the amendment. Failure of the **Provider** to provide such notice to the **Pool** will constitute acceptance of the amendment by the **Provider**.
- 10.2 Assignment:** This Agreement shall be binding upon and inure to the benefit of the respective legal successors and assignees of the parties. However, neither this Agreement, or any rights or obligations hereunder may be assigned, delegated, or transferred in whole or in part without the prior written consent of the other party. Notwithstanding any requirement to the contrary, this contract may be assigned, without consent, to the TML Intergovernmental Employee Benefits Pool.
- 10.3 Force Majeure:** Neither party shall be deemed to be in violation of this Agreement if such party is prevented from performing any of its obligations there under for any reason beyond its reasonable control, including without limitation, acts of God, acts of any public enemy, flood, strikes, statutory or other laws, regulations, rules, or orders of the federal, state, or local government or any agency thereof.
- 10.4 Governing Law:** This Agreement shall be governed by and construed in accordance with the laws of the State of Texas.
- 10.5 Venue:** Venue for any cause of action arising under this agreement shall be in Travis County, Texas.
- 10.6 Intent of the Parties:** It is the intent of the parties that this Agreement is to be effective only in regards to their rights and obligations with respect to each other, the Covered Individual(s) and the **Pool's** stop loss carrier(s).
- 10.7 Non-Exclusive Participation:** None of the provisions of this Agreement shall prevent the **Pool** or the **Provider** from participating in or contracting with any other organization, health maintenance organization, or any other health delivery or insurance program.
- 10.8 Notice:** Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be hand delivered or sent postage prepaid by certified or registered mail, return receipt requested, to the parties at the addresses set forth on the signature page. Such address may be changed from time to time by written notice to the other party.
- 10.9 Severability:** In case any one or more of the provision of this Agreement shall be determined to be invalid, illegal, or unenforceable in any respect by a court of competent jurisdiction, the remaining provisions shall be construed liberally in order to effectuate the purposes of this Agreement, and the validity, legality and enforceability of the remaining provision shall not in any way be affected or impaired thereby.

- 10.10 Waiver:** Failure by either of the parties following notice of a breach or a default, to enforce any of the provisions of this Agreement, shall not thereafter be construed as a waiver of any subsequent breach or default of any of the provisions of this Agreement.
- 10.11 Appeal:** If any of the parties who receive a copy of the utilization management department's determination disagree with the decision, they may appeal in writing to the **Pool** utilization management department within 30 days of the date of the initial date of the denial letter but, prior to the completion of the procedure or discharge from the hospital. The available medical information must be provided to the utilization management department at no cost to The Plan. The utilization management department's determination will be reviewed by an appropriate physician specialist who has not previously reviewed the case. When all medical information necessary to render a determination is received, all parties who were notified of the original recommendation will be notified of the reconsideration decision within five (5) working days.
- 10.12 Right to Cure: Both** parties agree to meet and confer in good faith to resolve any problems, disputes or issues of breach that may arise under this Agreement. The non-conforming party is entitled to ten (10) days right to cure the alleged defect after receiving notice pursuant to Section 10.8 herein. Said notice shall include reasonable detail of the event(s) which constitutes the alleged problem, dispute or issue of breach.

Each party to this Agreement warrants that it has the full power and authority to enter into this Agreement and the Individual signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

TML Intergovernmental Employee Benefits Pool ("Pool")  
1821 Rutherford Lane  
Austin, TX 78754

\_\_\_\_\_  
Signature

Susan Smith, Executive Director  
\_\_\_\_\_  
Name & Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name & Title

\_\_\_\_\_  
Tax Identification Number

\_\_\_\_\_  
Date

# FEE SCHEDULE

## TML INTERGOVERNMENTAL EMPLOYEE BENEFITS POOL

Payment for Covered Services shall be reimbursed at 125% of current year Medicare (RBRVS) which includes the office visit co-pay according to the applicable Geographic Zip Code Description. CPT Codes not identified on the RBRVS table shall be reimbursed at eighty percent (80%) of billed charges. J Codes shall be reimbursed at AWP + 10%. AWP shall be based on Red Book 2003 pricing for mean for all products. Lab Services shall be reimbursed per the non-preferred lab fee schedule. The reimbursement rate for services provided by the Physician pursuant to participation with Pool's preferred provider network, including, but not limited to, inpatient and outpatient services shall be at the above mentioned reimbursement, or billed charges, whichever is less. Provider's billed charges shall be subject to Reasonable & Customary when reimbursed at a percentage off of billed charges.

By: \_\_\_\_\_  
Name (Signature) Title

Printed: \_\_\_\_\_  
Name Title

Address: \_\_\_\_\_  
City State Zip

## TML INTERGOVERNMENTAL EMPLOYEE BENEFITS POOL

By: \_\_\_\_\_  
Name (Signature) Title

Printed: Susan Smith \_\_\_\_\_  
Name Title Executive Director

Address: 1821 Rutherford Lane, Suite 300 \_\_\_\_\_  
City State Zip Austin, TX 78754

Tax ID#: \_\_\_\_\_

Effective Date: \_\_\_\_\_

**TML Intergovernmental  
Employee Benefits Pool**

**ACKNOWLEDGE, CONSENT, AND RELEASE**

By completing the initial information packet, I hereby authorized the TML Intergovernmental Employee Benefits Pool, its staff, and their representatives to consult with administrators and Medical Staff of hospitals or institution with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence character and ethical qualifications.

I hereby further consent to the inspection by TML Intergovernmental Employee Benefits Pool, its staff and its representatives of records and documents, including medical records at hospitals that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested, as well as my moral and ethical qualifications for staff membership.

I hereby release from liability all representatives of the Intergovernmental Employees Benefits Pool and its staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the TML Intergovernmental Employee Benefits Pool, or its staff, in good faith and without malice, concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I hereby further authorize and consent to the release by TML Intergovernmental Employee Benefits Pool or its staff to hospitals and their Medical Staffs and to medical associates, any information the hospital and Medical Staff may have concerning my professional competence, ethics, character, and other professional qualifications, as long as such release of information is done in good faith and without malice, and I hereby release TML Intergovernmental Employee Benefits Pool and its Board of Directors and staff for doing so.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**PHOTOCOPIES OF THIS DOCUMENT WILL BE AS BINDING AS THE ORIGINAL.**

**TML INTERGOVERNMENTAL EMPLOYEE BENEFITS POOL**

*Credentialed Specialty List for Medical Doctors (MD)*

**Name of Applicant:** \_\_\_\_\_

Please check your major specialty area in which you have documented education and training (i.e. board certification/board eligibility, residency training, fellowship programs, etc.) **Copies of your certification or training MUST be included in your application packet. You will be listed in the directory and website under your approved documented specialty(ies).**

	<i>(CREDENTIAL COMMITTEE ONLY)</i>		
	REQUESTED	AGREE	DISAGREE
<b>Allergy &amp; Immunology</b>			
Allergy & Immunology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical & Laboratory Immunology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Anesthesiology</b>			
Anesthesiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Critical Care Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Colon &amp; Rectal Surgery</b>			
Colon & Rectal Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Dermatology</b>			
Clinical & Lab Dermatological Immunology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dermatology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dermatopathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Emergency Medicine</b>			
Emergency Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Toxicology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Emergency Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Family Practice</b>			
Family Practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Geriatric Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Internal Medicine</b>			
Adolescent Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Cardiac Electrophysiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical & Laboratory Immunology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Critical Care Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrinology, Diabetes & Metabolism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastroenterology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Geriatric Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hematology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Internal Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interventional Cardiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Oncology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nephrology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(CREDENTIAL COMMITTEE ONLY)

REQUESTED

AGREE

DISAGREE

**Medical Genetics**

- Clinical Biochemical Genetics
- Clinical Cytogenetics
- Clinical Genetics
- Clinical Molecular Genetics
- Molecular Genetic Pathology




**Neurological Surgery**

- Neurological Surgery

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**Nuclear Medicine**

- Nuclear Medicine

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**Obstetrics & Gynecology**

- Critical Care Medicine
- Gynecologic Oncology
- Maternal & Fetal Medicine
- Obstetrics & Gynecology
- Reproductive Endocrinology




**Ophthalmology**

- Ophthalmology

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**Orthopedic Surgery**

- Hand Surgery
- Orthopedic Surgery




**Otolaryngology**

- Otolaryngology
- Otology/Neurotology
- Pediatric Otolaryngology
- Plastic Surgery w/in Head & Neck




**Pathology**

- Anatomic Pathology & Clinical Pathology
- Anatomic Pathology
- Clinical Pathology
- Blood Banking/Transfusion Medicine
- Chemical Pathology
- Cytopathology
- Dermatopathology
- Forensic Pathology
- Hematology
- Immunopathology
- Medical Microbiology
- Molecular Genetic Pathology
- Neuropathology
- Pathology
- Pediatric Pathology




**Pediatrics**

- Adolescent Medicine
- Clinical & Laboratory Immunology
- Developmental-Behavioral Pediatrics
- Medical Toxicology
- Neonatal-Perinatal Medicine
- Neurodevelopmental Disabilities




**(CREDENTIAL COMMITTEE ONLY)**

**REQUESTED**

**AGREE**

**DISAGREE**

**Pediatrics**

Pediatric Cardiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Critical Care Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Emergency Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Endocrinology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Gastroenterology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Hematology-Oncology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Nephrology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Pulmonology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Rheumatology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatrics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Physical Medicine and Rehabilitation**

Pain Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Rehabilitation Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Medicine and Rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Cord Injury Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Plastic Surgery**

Hand Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plastic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plastic Surgery w/in Head & Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Preventive Medicine**

Aerospace Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public Health & General Preventive Med.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Toxicology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Undersea & Hyperbaric Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Psychiatry & Neurology**

Addiction Psychiatry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Neurophysiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forensic Psychiatry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Geriatric Psychiatry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurodevelopmental Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurology w/Spec. Quals Child Neuro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Radiology**

Diagnostic Radiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Oncology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuroradiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nuclear Radiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Radiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vascular & Interventional Radiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**(CREDENTIAL COMMITTEE ONLY)**

**REQUESTED**

**AGREE**

**DISAGREE**

**Surgery**

General Vascular Surgery

Pediatric Surgery

Surgery (General)

Surgery of the Hand

Surgical Critical Care




**Thoracic Surgery**

Thoracic Surgery

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**Urology**

Urology

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**Non Board Certification Specialties**

General Practice

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**Other** \_\_\_\_\_

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**TML INTERGOVERNMENTAL EMPLOYEE BENEFITS POOL**

*Credentialed Specialty List for Doctors of Osteopathy (DO)*

**Name of Applicant:** \_\_\_\_\_

Please check your major specialty area in which you have documented education and training (i.e. board certification/board eligibility, residency training, fellowship programs, etc.) **Copies of your certification or training MUST be included in your application packet. You will be listed in the directory and website under your approved documented specialty(ies).**

	<i>(CREDENTIAL COMMITTEE ONLY)</i>		
	REQUESTED	AGREE	DISAGREE
<b>Anesthesiology</b>			
Addiction Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anesthesiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Critical Care Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Dermatology</b>			
Dermatology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dermatopathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MOHS-Micrographic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Emergency Medicine</b>			
Emergency Medical Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Toxicology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Family Physicians</b>			
Addiction Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adolescent/Young Adult Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Geriatric Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Internal Medicine</b>			
Addiction Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy/Immunology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Cardiac Electrophysiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Critical Care Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrinology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastroenterology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Geriatric Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hematology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infectious Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Internal Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nephrology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oncology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(CREDENTIAL COMMITTEE ONLY)

	REQUESTED	AGREE	DISAGREE
<b>Neurology and Psychiatry</b>			
Addiction Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child/Adolescent Psychiatry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child/Adolescent Neurology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuromusculoskeletal Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neuromusculoskeletal Medicine</b>			
Special Proficiency in Neuro Med	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Nuclear Medicine</b>			
In Vivo and In Vitro Nuclear Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nuclear Cardiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nuclear Imaging and Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nuclear Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Obstetrics &amp; Gynecology</b>			
Gynecologic Oncology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternal & Fetal Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obstetrics and Gynecology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obstetrics & Gynecologic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reproductive Endocrinology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ophthalmology &amp; Otolaryngology-Head and Neck Surgery</b>			
Facial Plastic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ophthalmology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Otolaryngology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Otolaryngology/Facial Plastic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Orthopedic Surgery</b>			
Orthopedic Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pathology</b>			
Anatomic Pathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anatomic Pathology & Lab. Pathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Banking/Transfusion Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Pathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cytopathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dermatopathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forensic Pathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hematology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunopathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Microbiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuropathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pediatrics</b>			
Adolescent/Young Adult Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neonatology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Allergy/Immunology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pediatric Cardiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(CREDENTIAL COMMITTEE ONLY)

	REQUESTED	AGREE	DISAGREE
<b>Pediatrics</b>			
Pediatric Endocrinology			
Pediatric Hematology/Oncology			
Pediatric Infectious Diseases			
Pediatric Intensive Care			
Pediatric Nephrology			
Pediatric Pulmonary			
Pediatrics			
Sports Medicine			
<b>Preventive Medicine</b>			
Occupational Medicine			
PM/Aerospace Medicine			
PM/Occupational-Environmental Medicine			
PM/Public Health			
PM/Occupational			
<b>Proctology</b>			
Proctology			
<b>Radiology</b>			
Angiography & Interventional Radiology			
Body Imaging			
Diagnostic Radiology			
Diagnostic Ultrasound			
Neuroradiology			
Pediatric Radiology			
Radiology			
<b>Rehabilitation Medicine</b>			
Rehabilitation Medicine			
Sports Medicine			
<b>Special Proficiency In Osteopathic Manipulative Medicine</b>			
Sports Medicine			
<b>Surgery</b>			
Neurological Surgery			
Plastic & Reconstructive Surgery			
Surgery, General			
Thoracic Cardiovascular Surgery			
Urological Surgery			
Vascular Surgery, General			
<b>Non-Board Specialties</b>			
General Practice			
<b>Other</b> _____			

**TML INTERGOVERNMENTAL EMPLOYEE BENEFITS POOL**

*Credentialed Specialty List for Non MD/DO Degrees*

**Name of Applicant:** \_\_\_\_\_

**Degree:** \_\_\_\_\_

Please check your major specialty area in which you have documented education and training or license. Copies of your certification, training, or license **MUST** be included in your application packet. **You will be listed in the directory and website under your approved documented specialty(ies).**

	<i>(CREDENTIAL COMMITTEE ONLY)</i>		
	REQUESTED	AGREE	DISAGREE
Audiology Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Certified Registered Nurse Anesthetist (CRNA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General Dentistry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuropsychology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurse Midwife	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurse Practitioner _____ (provide specialty of practice/clinic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Optometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontics/Prosthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peridontics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Assistant _____ (provide specialty of practice/clinic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Podiatry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychoanalysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychology, Clinical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Registered Dietician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech Pathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



# Texas Standardized Credentialing Application

(Please type or print)

## Section I-Individual Information

TYPE OF PROFESSIONAL			
LAST NAME		FIRST	MIDDLE (JR., SR., ETC.)
MAIDEN NAME	YEARS ASSOCIATED (YYYY-YYYY)	OTHER NAME	YEARS ASSOCIATED (YYYY-YYYY)
HOME MAILING ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
HOME PHONE NUMBER	SOCIAL SECURITY NUMBER	<input type="checkbox"/> Female <input type="checkbox"/> Male	
CORRESPONDENCE ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX NUMBER	E-MAIL	
DATE OF BIRTH (MM/DD/YYYY)	PLACE OF BIRTH	CITIZENSHIP	
IF NOT AMERICAN CITIZEN, VISA NUMBER & STATUS			ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES? <input type="checkbox"/> Yes <input type="checkbox"/> No
U.S. MILITARY SERVICE/PUBLIC HEALTH <input type="checkbox"/> Yes <input type="checkbox"/> No	DATES OF SERVICE (MM/DD/YYYY) TO (MM/DD/YYYY)	LAST LOCATION	
BRANCH OF SERVICE	ARE YOU CURRENTLY ON ACTIVE OR RESERVE MILITARY DUTY? <input type="checkbox"/> Yes <input type="checkbox"/> No		

## Education

<b>PROFESSIONAL DEGREE</b> (MEDICAL, DENTAL, CHIROPRACTIC, ETC.) Issuing Institution:			
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
DEGREE		ATTENDANCE DATES (MM/YYYY TO MM/YYYY)	
<input type="checkbox"/> Please check this box and complete and submit Attachment A if you received other professional degrees.			
<b>POST-GRADUATE EDUCATION</b>		SPECIALTY	
<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Teaching Appointment			
INSTITUTION			
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
<input type="checkbox"/> Program successfully completed		ATTENDANCE DATES (MM/YYYY TO MM/YYYY)	
PROGRAM DIRECTOR		CURRENT PROGRAM DIRECTOR (IF KNOWN)	
<b>POST-GRADUATE EDUCATION</b>		SPECIALTY	
<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Teaching Appointment			
INSTITUTION			
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE

<b>Education - continued</b>		
<b>POST-GRADUATE EDUCATION</b> <input type="checkbox"/> Program successfully completed		ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
PROGRAM DIRECTOR		CURRENT PROGRAM DIRECTOR (IF KNOWN)
<input type="checkbox"/> Please check this box and complete and submit Attachment B if you received additional postgraduate training.		
<b>OTHER GRADUATE-LEVEL EDUCATION</b> Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE		ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
<b>Licenses and Certificates</b> - Please include all license(s) and certifications in all States where you are currently or have previously been licensed.		
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? <input type="checkbox"/> Yes <input type="checkbox"/> No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? <input type="checkbox"/> Yes <input type="checkbox"/> No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> DEA Number:	ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
<input type="checkbox"/> DPS Number:	ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
<b>OTHER CDS</b> (PLEASE SPECIFY)	NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? <input type="checkbox"/> Yes <input type="checkbox"/> No
UPIN	NATIONAL PROVIDER IDENTIFIER (WHEN AVAILABLE)	
ARE YOU A PARTICIPATING MEDICARE PROVIDER? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Provider Number:	ARE YOU A PARTICIPATING MEDICAID PROVIDER? <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Provider Number:	
EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES (ECFMG) <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No ECFMG Number:		ECFMG ISSUE DATE (MM/DD/YYYY)
<b>Professional/Specialty Information</b>		
<b>PRIMARY SPECIALTY</b>	BOARD CERTIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)
IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.		
<input type="checkbox"/> I have taken exam, results pending for _____ Board.		
<input type="checkbox"/> I have taken Part I and am eligible for Part II of the _____ Exam.		
<input type="checkbox"/> I am intending to sit for the Boards on _____ (date)		
<input type="checkbox"/> I am not planning to take Boards.		
DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY? HMO: <input type="checkbox"/> Yes <input type="checkbox"/> No PPO: <input type="checkbox"/> Yes <input type="checkbox"/> No POS: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>SECONDARY SPECIALTY</b>	BOARD CERTIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

<b>Professional/Specialty Information</b> -continued		
IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.		
<input type="checkbox"/> I have taken exam, results pending for _____		Board.
<input type="checkbox"/> I have taken Part I and am eligible for Part II of the _____		Exam.
<input type="checkbox"/> I am intending to sit for the Boards on _____		(date)
<input type="checkbox"/> I am not planning to take Boards.		
DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY? HMO: <input type="checkbox"/> Yes <input type="checkbox"/> No    PPO: <input type="checkbox"/> Yes <input type="checkbox"/> No    POS: <input type="checkbox"/> Yes <input type="checkbox"/> No		
ADDITIONAL SPECIALTY	BOARD CERTIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> No    Name of Certifying Board: _____	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)
IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.		
<input type="checkbox"/> I have taken exam, results pending for _____		Board.
<input type="checkbox"/> I have taken Part I and am eligible for Part II of the _____		Exam.
<input type="checkbox"/> I am intending to sit for the Boards on _____		(date)
<input type="checkbox"/> I am not planning to take Boards.		
DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY? HMO: <input type="checkbox"/> Yes <input type="checkbox"/> No    PPO: <input type="checkbox"/> Yes <input type="checkbox"/> No    POS: <input type="checkbox"/> Yes <input type="checkbox"/> No		
PLEASE LIST OTHER AREAS OF PROFESSIONAL PRACTICE INTEREST OR FOCUS (HIV/AIDS, ETC.)		
<b>Work History</b> - Please provide a chronological work history for the past 5 years. You may submit a Curriculum Vitae as a supplement. Please explain all gaps in employment that lasted more than six months.		
<b>CURRENT PRACTICE/EMPLOYER NAME</b>		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
<b>PREVIOUS PRACTICE/EMPLOYER NAME</b>		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
<b>PREVIOUS PRACTICE/EMPLOYER NAME</b>		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
<b>PREVIOUS PRACTICE/EMPLOYER NAME</b>		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PLEASE PROVIDE AN EXPLANATION FOR ANY GAPS GREATER THAN SIX MONTHS (MM/YYYY TO MM/YYYY) IN WORK HISTORY.		
Gap Dates:	Explanation:	
Gap Dates:	Explanation:	

**Work History – continued**

Gap Dates: Explanation:

Gap Dates: Explanation:

Please check this box and complete and submit Attachment C if you have additional work history

**Hospital Affiliations**-Please include all hospitals where you currently have or have previously had privileges.

DO YOU HAVE HOSPITAL PRIVILEGES?  Yes  No IF YOU DO NOT HAVE ADMITTING PRIVILEGES, WHAT ADMITTING ARRANGEMENTS DO YOU HAVE?

PRIMARY HOSPITAL WHERE YOU HAVE ADMITTING PRIVILEGES START DATE (MM/YYYY)

ADDRESS

CITY STATE/COUNTRY POSTAL CODE

PHONE NUMBER FAX E-MAIL

FULL UNRESTRICTED PRIVILEGES?  Yes  No TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) ARE PRIVILEGES TEMPORARY?  Yes  No

OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO PRIMARY HOSPITAL?

OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES START DATE (MM/YYYY)

ADDRESS

CITY STATE/COUNTRY POSTAL CODE

PHONE NUMBER FAX E-MAIL

FULL UNRESTRICTED PRIVILEGES?  Yes  No TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) ARE PRIVILEGES TEMPORARY?  Yes  No

OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?

Please check this box and complete and submit Attachment D if you have additional current hospital affiliations.

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES AFFILIATION DATES (MM/YYYY TO MM/YYYY)

ADDRESS

CITY STATE/COUNTRY POSTAL CODE

FULL UNRESTRICTED PRIVILEGES?  Yes  No TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.) WERE PRIVILEGES TEMPORARY?  Yes  No

REASON FOR DISCONTINUANCE

Please check this box and complete and submit Attachment E if you have additional previous hospital affiliations.

**References**-Please provide three peer references from the same field and/or specialty who are not partners in your own group practice and are not relatives. All peer references should have firsthand knowledge of your abilities.

1 NAME/TITLE PHONE NUMBER

ADDRESS

CITY STATE/COUNTRY POSTAL CODE

**References** - continued

<b>2</b> NAME/TITLE	PHONE NUMBER	
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
<b>3</b> NAME/TITLE	PHONE NUMBER	
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE

**Professional Liability Insurance Coverage**

SELF-INSURED? <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME OF CURRENT MALPRACTICE INSURANCE CARRIER OR SELF-INSURED ENTITY		
ADDRESS			
CITY	STATE/COUNTRY	POSTAL CODE	
PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
AMOUNT OF COVERAGE PER OCCURRENCE	AMOUNT OF COVERAGE AGGREGATE	TYPE OF COVERAGE <input type="checkbox"/> Individual <input type="checkbox"/> Shared	LENGTH OF TIME WITH CARRIER
NAME OF PREVIOUS MALPRACTICE INSURANCE CARRIER IF WITH CURRENT CARRIER LESS THAN 5 YEARS			
ADDRESS			
CITY	STATE/COUNTRY	POSTAL CODE	
PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
AMOUNT OF COVERAGE PER OCCURRENCE	AMOUNT OF COVERAGE AGGREGATE	TYPE OF COVERAGE <input type="checkbox"/> Individual <input type="checkbox"/> Shared	LENGTH OF TIME WITH CARRIER

**Call Coverage**

See attached list of hospital staff within my department I utilize for call coverage.

PLEASE LIST NAMES OF COLLEAGUE(S) PROVIDING REGULAR COVERAGE AND HIS OR HER SPECIALTIES.

Name:	Specialty:
Name:	Specialty:
Name:	Specialty:
Name:	Specialty:
Name:	Specialty:

PLEASE LIST FULL NAMES OF ALL PARTNERS IN YOUR PRACTICE.  CHECK THIS BOX AND ATTACH LIST FOR LARGE GROUP.

Name:	Name:
Name:	Name:
Name:	Name:
Name:	Name:

<b>Practice Location Information</b> - Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.		<b>PRACTICE LOCATION</b> of	
TYPE OF SERVICE PROVIDED <input type="checkbox"/> Solo Primary Care <input type="checkbox"/> Solo Specialty Care <input type="checkbox"/> Group Primary Care <input type="checkbox"/> Group Single Specialty <input type="checkbox"/> Group Multi-Specialty			
GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY		GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9	
<b>PRACTICE LOCATION ADDRESS</b> <input type="checkbox"/> Primary			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX NUMBER	E-MAIL	
BACK OFFICE PHONE NUMBER		SITE-SPECIFIC MEDICAID NUMBER	TAX ID NUMBER
GROUP NUMBER CORRESPONDING TO TAX ID NUMBER		GROUP NAME CORRESPONDING TO TAX ID NUMBER	
ARE YOU CURRENTLY PRACTICING AT THIS LOCATION? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF NO, EXPECTED START DATE? (MM/DD/YYYY)	DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY? <input type="checkbox"/> Yes <input type="checkbox"/> No
OFFICE MANAGER OR STAFF CONTACT		PHONE NUMBER	FAX NUMBER
<b>CREDENTIALING CONTACT</b>			
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX NUMBER	E-MAIL	
<b>BILLING COMPANY'S NAME</b> (IF APPLICABLE)		BILLING REPRESENTATIVE	
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX NUMBER	E-MAIL	
DEPARTMENT NAME IF HOSPITAL-BASED		CHECK PAYABLE TO	CAN YOU BILL ELECTRONICALLY? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>HOURS PATIENTS ARE SEEN</b>			
Monday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon: Evening:
Tuesday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon: Evening:
Wednesday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon: Evening:
Thursday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon: Evening:
Friday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon: Evening:
Saturday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon: Evening:
Sunday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon: Evening:
DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE? <input type="checkbox"/> Answering Service <input type="checkbox"/> Voice mail with instructions to call answering service <input type="checkbox"/> Voice mail with other instructions <input type="checkbox"/> None			
THIS PRACTICE LOCATION ACCEPTS <input type="checkbox"/> all new patients <input type="checkbox"/> existing patients with change of payor <input type="checkbox"/> new patients with referral <input type="checkbox"/> new Medicare patients <input type="checkbox"/> new Medicaid patients			
IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION.			
<b>PRACTICE LIMITATIONS</b> <input type="checkbox"/> Male only <input type="checkbox"/> Female only    Age: <input type="checkbox"/> Other:			
DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, SOCIAL WORKERS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, provide the following information for each staff member:			
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER	
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER	

<b>Practice Location Information - continued</b>		
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER
NON-ENGLISH LANGUAGES SPOKEN BY HEALTH CARE PROVIDERS		NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL
ARE INTERPRETERS AVAILABLE? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify languages:		
DOES THIS PRACTICE LOCATION MEET ADA ACCESSIBILITY STANDARDS? <input type="checkbox"/> Yes <input type="checkbox"/> No		WHICH OF THE FOLLOWING FACILITIES ARE HANDICAPPED ACCESSIBLE? <input type="checkbox"/> Building <input type="checkbox"/> Parking <input type="checkbox"/> Restroom <input type="checkbox"/> Other:
DOES THIS LOCATION HAVE OTHER SERVICES FOR THE DISABLED? <input type="checkbox"/> Text Telephony-TTY <input type="checkbox"/> American Sign Language-ASL <input type="checkbox"/> Mental/Physical Impairment Services <input type="checkbox"/> Other:		
IS THIS LOCATION ACCESSIBLE BY PUBLIC TRANSPORTATION? <input type="checkbox"/> Bus <input type="checkbox"/> Subway <input type="checkbox"/> Regional Train <input type="checkbox"/> Other:		
DOES THIS LOCATION PROVIDE CHILDCARE SERVICES? <input type="checkbox"/> Yes <input type="checkbox"/> No		DOES THIS LOCATION QUALIFY AS A MINORITY BUSINESS ENTERPRISE? <input type="checkbox"/> Yes <input type="checkbox"/> No
WHO AT THIS LOCATION HAVE THE FOLLOWING CURRENT CERTIFICATIONS? (PLEASE LIST ONLY THE APPLICANT'S CERTIFICATION EXPIRATION DATES.)		
Basic Life Support	<input type="checkbox"/> Staff <input type="checkbox"/> Provider Exp:	Advanced Life Support in OB
Advanced Trauma Life Support	<input type="checkbox"/> Staff <input type="checkbox"/> Provider Exp:	Cardio-Pulmonary Resuscitation
Advanced Cardiac Life Support	<input type="checkbox"/> Staff <input type="checkbox"/> Provider Exp:	Pediatric Advanced Life Support
Neonatal Advanced Life Support	<input type="checkbox"/> Staff <input type="checkbox"/> Provider Exp:	Other (please specify)
DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? <input type="checkbox"/> Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE):		
<input type="checkbox"/> X-ray; please list all certifications:		
<b>OTHER SERVICES</b>		
<input type="checkbox"/> Radiology Services	<input type="checkbox"/> EKG	<input type="checkbox"/> Care of Minor Lacerations
<input type="checkbox"/> Allergy Injections	<input type="checkbox"/> Allergy Skin Tests	<input type="checkbox"/> Routine Office Gynecology
<input type="checkbox"/> Age Appropriate Immunizations	<input type="checkbox"/> Flexible Sigmoidoscopy	<input type="checkbox"/> Tympanometry/Audiometry Tests
<input type="checkbox"/> Osteopathic Manipulations	<input type="checkbox"/> IV Hydration /Treatments	<input type="checkbox"/> Cardiac Stress Tests
<input type="checkbox"/> Other:		<input type="checkbox"/> Pulmonary Function Tests
		<input type="checkbox"/> Drawing Blood
		<input type="checkbox"/> Asthma Treatments
		<input type="checkbox"/> Physical Therapies
PLEASE LIST ANY ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)		
IS ANESTHESIA ADMINISTERED AT THIS PRACTICE LOCATION? <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify the classes or categories:		WHO ADMINISTERS IT?
<input type="checkbox"/> Please check this box and complete and submit Attachment F if you have other practice locations.		

**Section II-Disclosure Questions** - Please provide an explanation for any question answered yes-except 19-on page on page 10.

**Licensure**

- 1 Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?  Yes  No
- 2 Have you ever received a reprimand or been fined by any state licensing board?  Yes  No

**Hospital Privileges and Other Affiliations**

- 3 Have your clinical privileges or Medical Staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?  Yes  No
- 4 Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?  Yes  No
- 5 Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?  Yes  No

**Education, Training and Board Certification**

- 6 Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?  Yes  No
- 7 Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?  Yes  No
- 8 Have any of your board certifications or eligibility ever been revoked?  Yes  No
- 9 Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?  Yes  No

**DEA or DPS**

- 10 Have your Federal IDEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?  Yes  No

**Medicare, Medicaid or other Governmental Program Participation**

- 11 Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?  Yes  No

**Other Sanctions or Investigations**

- 12 Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, IDEA or DPS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?  Yes  No

**Section II - Disclosure Questions - continued**

**Other Sanctions or Investigations**

- 13 To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?  Yes  No
- 14 Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?  Yes  No
- 15 Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency?  Yes  No

**Malpractice Claims History**

- 16 Have you ever had any malpractice actions within the past 5 years (pending, settled, arbitrated, mediated or litigated)?  Yes  No
- If yes, please check this box and complete and submit Attachment G.

**Criminal**

- 17 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional?  Yes  No
- 18 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony including an act of violence, child abuse or a sexual offense?  Yes  No
- 19 Have you been court-martialed for actions related to your duties as a medical professional?  Yes  No

**Ability to Perform Job**

- 20 Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)  Yes  No
- 21 Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?  Yes  No

**Ability to Perform Job**

- 22 Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?  Yes  No
- 23 Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation?  Yes  No

*Please use the space on page 10 to explain yes answers to any question except 16.*



**Section III – Standard Authorization, Attestation and Release (Not for Use for Employment Purposes)**

I understand and agree that, as part of the credentialing application process for participation and/or clinical privileges (hereinafter, referred to as "Participation") at or with

(PLEASE INDICATE MANAGED CARE COMPANY(S) OR HOSPITAL(S) TO WHICH YOU ARE APPLYING) (HEREINAFTER, INDIVIDUALLY REFERRED TO AS THE "ENTITY")

and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

**For Hospital Credentialing.** I consent to appear for an interview with the credentials committee, medical staff executive committee, or other representatives of the medical staff, hospital administration or the governing board, if required or requested. As a medical staff member, I pledge to provide continuous care for my patients. I have been informed of existing hospital bylaws, rules and regulations, and policies regarding the application process, and I agree that as a medical staff member, I will be bound by them.

**Authorization of Investigation Concerning Application for Participation.** I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

**Authorization of Third-Party Sources to Release Information Concerning Application for Participation.** I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

**Authorization of Release and Exchange of Disciplinary Information.** I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning: (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

**Release from Liability.** I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third

\_\_\_\_\_  
APPLICANT'S INITIALS AND DATE (MM/DD/YYYY)

**Section III – Standard Authorization, Attestation and Release – continued**

party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities.

In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity’s medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s).

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
NAME (PLEASE PRINT OR TYPE)

\_\_\_\_\_  
SOCIAL SECURITY NUMBER

\_\_\_\_\_  
DATE (MM/DD/YYYY)

**Required Attachments or Supplemental Information – Please attach hard copy or scanned documents of the following:**

- Copy of DEA or state DPS Controlled Substances Registration Certificate
- Copy of other Controlled Dangerous Substances Registration Certificate(s)
- Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and applicant’s name
- Copies of IRS W-9s for verification of each tax identification number used
- Copy of workers compensation certificate of coverage, if applicable
- Copy of CLIA certifications, if applicable
- Copies of radiology certifications, if applicable
- Copy of DD214, record of military service, if applicable

Reproduction of this form without any changes is allowed.

**Notice About Certain Information Laws and Practices Pertaining to State Governmental Bodies (i.e. State Hospitals)**

With few exceptions, you are entitled to be informed about the information that a state governmental body collects about you (i.e. a state hospital). Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However the state governmental body may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that the state governmental body correct information that it has about you that is incorrect. For information about the procedure and costs for obtaining information, please contact the appropriate state governmental body to which you have submitted this application.

**OTHER PROFESSIONAL DEGREE**

Issuing Institution:

ADDRESS

CITY

STATE/COUNTRY

POSTAL CODE

DEGREE

ATTENDANCE DATES(MM/YYYY TO MM/YYYY)

<b>OTHER PROFESSIONAL DEGREE</b>		
Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
<b>OTHER PROFESSIONAL DEGREE</b>		
Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
<b>OTHER PROFESSIONAL DEGREE</b>		
Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
<b>OTHER PROFESSIONAL DEGREE</b>		
Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
<b>OTHER PROFESSIONAL DEGREE</b>		
Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	

<b>OTHER POST-GRADUATE EDUCATION</b>		SPECIALTY
<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Teaching Appointment		
INSTITUTION		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
<input type="checkbox"/> Program successfully completed	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)	



**Texas Standardized Credentialing Application**

**Attachment B - Other Post-Graduate Education**

PROGRAM DIRECTOR		CURRENT PROGRAM DIRECTOR (IF KNOWN)
<b>OTHER POST-GRADUATE EDUCATION</b>		SPECIALTY
<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Teaching Appointment		
INSTITUTION		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
<input type="checkbox"/> Program successfully completed		ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
PROGRAM DIRECTOR		CURRENT PROGRAM DIRECTOR (IF KNOWN)
<b>OTHER POST-GRADUATE EDUCATION</b>		SPECIALTY
<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Teaching Appointment		
INSTITUTION		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
<input type="checkbox"/> Program successfully completed		ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
PROGRAM DIRECTOR		CURRENT PROGRAM DIRECTOR (IF KNOWN)
<b>OTHER POST-GRADUATE EDUCATION</b>		SPECIALTY
<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Teaching Appointment		
INSTITUTION		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
<input type="checkbox"/> Program successfully completed		ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
PROGRAM DIRECTOR		CURRENT PROGRAM DIRECTOR (IF KNOWN)
<b>OTHER POST-GRADUATE EDUCATION</b>		SPECIALTY
<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Teaching Appointment		
INSTITUTION		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
<input type="checkbox"/> Program successfully completed		ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
PROGRAM DIRECTOR		CURRENT PROGRAM DIRECTOR (IF KNOWN)
<b>OTHER POST-GRADUATE EDUCATION</b>		SPECIALTY
<input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Teaching Appointment		
INSTITUTION		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
<input type="checkbox"/> Program successfully completed		ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
PROGRAM DIRECTOR		CURRENT PROGRAM DIRECTOR (IF KNOWN)

<b>PREVIOUS PRACTICE/EMPLOYER NAME</b>	START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS	
CITY	STATE/COUNTRY POSTAL CODE
REASON FOR DISCONTINUANCE	



**Texas Standardized Credentialing Application**

**Attachment C - Other Work History**

PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		

OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES		START DATE (MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL



**Texas Standardized Credentialing Application Attachment D - Other Current Hospital Affiliations**

FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No		TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)		ARE PRIVILEGES TEMPORARY? <input type="checkbox"/> Yes <input type="checkbox"/> No	
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?					
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES				START DATE (MM/YYYY)	
ADDRESS					
CITY		STATE/COUNTRY		POSTAL CODE	
PHONE NUMBER		FAX		E-MAIL	
FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No		TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)		ARE PRIVILEGES TEMPORARY? <input type="checkbox"/> Yes <input type="checkbox"/> No	
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?					
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES				START DATE (MM/YYYY)	
ADDRESS					
CITY		STATE/COUNTRY		POSTAL CODE	
PHONE NUMBER		FAX		E-MAIL	
FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No		TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)		ARE PRIVILEGES TEMPORARY? <input type="checkbox"/> Yes <input type="checkbox"/> No	
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?					
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES				START DATE (MM/YYYY)	
ADDRESS					
CITY		STATE/COUNTRY		POSTAL CODE	
PHONE NUMBER		FAX		E-MAIL	
FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No		TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)		ARE PRIVILEGES TEMPORARY? <input type="checkbox"/> Yes <input type="checkbox"/> No	
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?					
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES				START DATE (MM/YYYY)	
ADDRESS					
CITY		STATE/COUNTRY		POSTAL CODE	
PHONE NUMBER		FAX		E-MAIL	
FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No		TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)		ARE PRIVILEGES TEMPORARY? <input type="checkbox"/> Yes <input type="checkbox"/> No	
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?					
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES				START DATE (MM/YYYY)	
ADDRESS					
CITY		STATE/COUNTRY		POSTAL CODE	
PHONE NUMBER		FAX		E-MAIL	
FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No		TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)		ARE PRIVILEGES TEMPORARY? <input type="checkbox"/> Yes <input type="checkbox"/> No	
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?					

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)	
ADDRESS			
CITY		POSTAL CODE	
STATE/COUNTRY			
FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No		WERE PRIVILEGES TEMPORARY? <input type="checkbox"/> Yes <input type="checkbox"/> No	
TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)			



**Texas Standardized Credentialing Application Attachment E - Other Previous Hospital Affiliations**

REASON FOR DISCONTINUANCE		
PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? <input type="checkbox"/> Yes <input type="checkbox"/> No
REASON FOR DISCONTINUANCE		
PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? <input type="checkbox"/> Yes <input type="checkbox"/> No
REASON FOR DISCONTINUANCE		
PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? <input type="checkbox"/> Yes <input type="checkbox"/> No
REASON FOR DISCONTINUANCE		
PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? <input type="checkbox"/> Yes <input type="checkbox"/> No
REASON FOR DISCONTINUANCE		
PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? <input type="checkbox"/> Yes <input type="checkbox"/> No
REASON FOR DISCONTINUANCE		
PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? <input type="checkbox"/> Yes <input type="checkbox"/> No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? <input type="checkbox"/> Yes <input type="checkbox"/> No
REASON FOR DISCONTINUANCE		

<b>Practice Location Information</b> - Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.		<b>PRACTICE LOCATION</b> of
TYPE OF SERVICE PROVIDED <input type="checkbox"/> Solo Primary Care <input type="checkbox"/> Solo Specialty Care <input type="checkbox"/> Group Primary Care <input type="checkbox"/> Group Single Specialty <input type="checkbox"/> Group Multi-Specialty		
GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY	GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9	



Texas Standardized Credentialing Application

Attachment F - Other Practice Locations

<b>PRACTICE LOCATION ADDRESS</b>			
<input type="checkbox"/> Primary			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX NUMBER	E-MAIL	
BACK OFFICE PHONE NUMBER		SITE-SPECIFIC MEDICAID NUMBER	TAX ID NUMBER
GROUP NUMBER CORRESPONDING TO TAX ID NUMBER		GROUP NAME CORRESPONDING TO TAX ID NUMBER	
ARE YOU CURRENTLY PRACTICING AT THIS LOCATION? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF NO, EXPECTED START DATE? (MM/DD/YYYY)	DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY? <input type="checkbox"/> Yes <input type="checkbox"/> No
OFFICE MANAGER OR STAFF CONTACT		PHONE NUMBER	FAX NUMBER
<b>CREDENTIALING CONTACT</b>			
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX NUMBER	E-MAIL	
<b>BILLING COMPANY'S NAME</b> (IF APPLICABLE)			BILLING REPRESENTATIVE
ADDRESS			
CITY		STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX NUMBER	E-MAIL	
DEPARTMENT NAME IF HOSPITAL-BASED		CHECK PAYABLE TO	CAN YOU BILL ELECTRONICALLY? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>HOURS PATIENTS ARE SEEN</b>			
Monday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon: Evening:
Tuesday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon: Evening:
Wednesday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon: Evening:
Thursday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon: Evening:
Friday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon: Evening:
Saturday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon: Evening:
Sunday	<input type="checkbox"/> No Office Hours	Morning:	Afternoon: Evening:
DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE?			
<input type="checkbox"/> Answering Service <input type="checkbox"/> Voice mail with instructions to call answering service <input type="checkbox"/> Voice mail with other instructions <input type="checkbox"/> None			
THIS PRACTICE LOCATION ACCEPTS			
<input type="checkbox"/> all new patients <input type="checkbox"/> existing patients with change of payor <input type="checkbox"/> new patients with referral <input type="checkbox"/> new Medicare patients <input type="checkbox"/> new Medicaid patients			
IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION.			
<b>PRACTICE LIMITATIONS</b>			
<input type="checkbox"/> Male only <input type="checkbox"/> Female only Age: <input type="checkbox"/> Other:			
DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, SOCIAL WORKERS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION?			
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the following information for each staff member:			
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER	
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER	

Practice Location Information - continued

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NUMBER
NON-ENGLISH LANGUAGES SPOKEN BY HEALTH CARE PROVIDERS		NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL
ARE INTERPRETERS AVAILABLE? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify languages:		
DOES THIS PRACTICE LOCATION MEET ADA ACCESSIBILITY STANDARDS? <input type="checkbox"/> Yes <input type="checkbox"/> No		WHICH OF THE FOLLOWING FACILITIES ARE HANDICAPPED ACCESSIBLE? <input type="checkbox"/> Building <input type="checkbox"/> Parking <input type="checkbox"/> Restroom <input type="checkbox"/> Other:
DOES THIS LOCATION HAVE OTHER SERVICES FOR THE DISABLED? <input type="checkbox"/> Text Telephony-TTY <input type="checkbox"/> American Sign Language-ASL <input type="checkbox"/> Mental/Physical Impairment Services <input type="checkbox"/> Other:		
IS THIS LOCATION ACCESSIBLE BY PUBLIC TRANSPORTATION? <input type="checkbox"/> Bus <input type="checkbox"/> Subway <input type="checkbox"/> Regional Train <input type="checkbox"/> Other:		
DOES THIS LOCATION PROVIDE CHILDCARE SERVICES? <input type="checkbox"/> Yes <input type="checkbox"/> No		DOES THIS LOCATION QUALIFY AS A MINORITY BUSINESS ENTERPRISE? <input type="checkbox"/> Yes <input type="checkbox"/> No
WHO AT THIS LOCATION HAVE THE FOLLOWING CURRENT CERTIFICATIONS? (PLEASE LIST ONLY THE APPLICANT'S CERTIFICATION EXPIRATION DATES.)		
Basic Life Support	<input type="checkbox"/> Staff <input type="checkbox"/> Provider Exp:	Advanced Life Support in OB
Advanced Trauma Life Support	<input type="checkbox"/> Staff <input type="checkbox"/> Provider Exp:	Cardio-Pulmonary Resuscitation
Advanced Cardiac Life Support	<input type="checkbox"/> Staff <input type="checkbox"/> Provider Exp:	Pediatric Advanced Life Support
Neonatal Advanced Life Support	<input type="checkbox"/> Staff <input type="checkbox"/> Provider Exp:	Other (please specify)
DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? <input type="checkbox"/> Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE):		
<input type="checkbox"/> X-ray; please list all certifications:		
<b>OTHER SERVICES</b>		
<input type="checkbox"/> Radiology Services	<input type="checkbox"/> EKG	<input type="checkbox"/> Care of Minor Lacerations
<input type="checkbox"/> Allergy Injections	<input type="checkbox"/> Allergy Skin Tests	<input type="checkbox"/> Routine Office Gynecology
<input type="checkbox"/> Age Appropriate Immunizations	<input type="checkbox"/> Flexible Sigmoidoscopy	<input type="checkbox"/> Tympanometry/Audiometry Tests
<input type="checkbox"/> Osteopathic Manipulations	<input type="checkbox"/> IV Hydration /Treatments	<input type="checkbox"/> Cardiac Stress Tests
<input type="checkbox"/> Other:		<input type="checkbox"/> Pulmonary Function Tests
		<input type="checkbox"/> Drawing Blood
		<input type="checkbox"/> Asthma Treatments
		<input type="checkbox"/> Physical Therapies
PLEASE LIST ANY ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)		
IS ANESTHESIA ADMINISTERED AT THIS PRACTICE LOCATION? <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify the classes or categories:		WHO ADMINISTERS IT?
<input type="checkbox"/> <b>Please check this box and complete and submit Attachment F if you have other practice locations.</b>		

INCIDENT DATE (MM/DD/YYYY)	DATE CLAIM WAS FILED (MM/DD/YYYY)	CLAIM/CASE STATUS
PROFESSIONAL LIABILITY CARRIER INVOLVED		
ADDRESS		



# 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	
	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 ▶ .....	
	<input type="checkbox"/> Exempt from backup withholding	
	Address (number, street, and apt. or suite no.)	
City, state, and ZIP code		
List account number(s) here (optional)		
Requester's name and address (optional)		

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. 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.

Social security number							
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> </tr> </table>							
or							
Employer identification number							
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> <td style="width: 15%; border: 1px solid black;"> </td> </tr> </table>							

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

## 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.)

<b>Sign Here</b>	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.

**Foreign person.** If you are a foreign person, use the appropriate Form W-8 (see **Pub. 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 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 30% of such payments (29% after December 31, 2003; 28% after December 31, 2005). 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.

**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 <b>9</b>
Broker transactions	Exempt recipients <b>1</b> through <b>13</b> . 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 <b>1</b> through <b>5</b>
Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup>	Generally, exempt recipients <b>1</b> through <b>7</b> <sup>2</sup>

<sup>1</sup> See **Form 1099-MISC**, Miscellaneous Income, and its instructions.  
<sup>2</sup> 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 on-line at [www.ssa.gov/online/ss5.html](http://www.ssa.gov/online/ss5.html). 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 get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS Web Site at [www.irs.gov](http://www.irs.gov).

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, 3, 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 or Archer MSA 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 <sup>1</sup>
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee <sup>1</sup>
b. So-called trust account that is not a legal or valid trust under state law	The actual owner <sup>1</sup>
5. Sole proprietorship or single-owner LLC	The owner <sup>3</sup>
For this type of account:	Give name and EIN of:
6. Sole proprietorship or single-owner LLC	The owner <sup>3</sup>
7. A valid trust, estate, or pension trust	Legal entity <sup>4</sup>
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

<sup>1</sup> 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.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> **You must show your individual name**, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

<sup>4</sup> 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. 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, or to Federal and state agencies to enforce Federal nontax criminal laws and to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 30% 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.

