

Mid-Level Provider Application

I. INSTRUCTIONS

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on this application, attached additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. **Current copies of the following documents must be submitted with the application:**

- ◆ State Medical License(s)
- ◆ Face Sheet of Professional Liability Policy
- ◆ Curriculum Vitae
- ◆ Job Description for Nurse Practitioner
- ◆ Supervising Guidelines for Physician Assistant

II. IDENTIFYING INFORMATION

Last Name:	First Name:	Middle:
Is there any other name under which you have been known? Name(s):		
Home Mailing Street Address:	City:	
	State:	Zip:
Home Telephone Number: ()	E-Mail Address:	
Home Fax Number: ()	Pager Number: ()	
Birth Date:	Citizenship (If not a United States citizen, please include a copy of Alien Registration Card):	
Birth Place (City/State/Country):		
Social Security #:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Specialty:	Race/Ethnicity (Voluntary):	

III. PRACTICE INFORMATION

Supervising Physician Name(s):		
Practice Name (if applicable):		
Primary Office Street Address:	City:	
	State:	Zip:
Telephone Number: ()	Fax Number: ()	
Secondary Office Street Address:	City:	
	State:	Zip:
Telephone Number: ()	Fax Number: ()	

IV. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary)

Medical/Professional School:	Degree Received:	Date of Graduation (mm/yy):
Mailing Street Address:	City:	
	State:	Zip:
Medical/Professional School:	Degree Received:	Date of Graduation (mm/yy):
Mailing Street Address:	City:	
	State:	Zip:

V. MEDICAL LICENSURE/REGISTRATION/CERTIFICATION (Remember to attach copies)

California State License/Registration/Certification #:	Issue Date:	Expiration Date:
DEA License/Registration/Certification Number:	Type:	Expiration Date:
License/Registration/Certification Number:	Type:	Expiration Date:
National Physician Identifier (NPI):	Medi-Cal Number:	Medicare UPIN:

**VI. ALL OTHER STATE MEDICAL LICENSURE/REGISTRATION/CERTIFICATION
(List all licenses/registrations/certifications held now or previously. Remember to attach copies)**

State/Number:	Type:	Expiration Date:
State/Number:	Type:	Expiration Date:
State/Number:	Type:	Expiration Date:

VII. PROFESSIONAL LIABILITY (Remember to attach copies)

Current Insurance Carrier:	Policy #:	Original effective date:
Mailing Street Address:	City:	
	State:	Zip:
Per Claim Amount: \$	Aggregate Amount: \$	Expiration Date:
Please explain any surcharges/restrictions to your professional liability coverage: (attach additional pages if needed)		

VII. PROFESSIONAL LIABILITY (continued)

Please list all of your professional liability carriers, other than the one listed above, within the past seven years.

Name of Carrier:	Policy #:	From (mm/yy):	To (mm/yy):
Mailing Street Address:	City:		
	State:	Zip:	
Telephone Number: ()		Fax Number: ()	
Name of Carrier:	Policy #:	From (mm/yy):	To (mm/yy):
Mailing Street Address:	City:		
	State:	Zip:	
Telephone Number: ()		Fax Number: ()	

VIII. HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

A. CURRENT AFFILIATIONS (Attach additional sheets if necessary)

Name:	Appointment Date:
Mailing Street Address:	City:
	State: Zip:
Name:	Appointment Date:
Mailing Street/Address:	City:
	State: Zip:

B. PREVIOUS AFFILIATIONS During Last Ten Years. (Attach additional sheets if necessary)

Name:	From (mm/yy):	To (mm/yy):
Mailing Street Address:	City:	
	State:	Zip:
Reason for leaving:		
Name:	From (mm/yy):	To (mm/yy):
Mailing Street Address:	City:	
	State:	Zip:
Reason for leaving:		

IX. PEER REFERENCES

List two professional references, preferably from your specialty area, not including current relatives, current partners or associates in practice. If possible, include at least one Mid-Level Provider from the hospital/institution where you have privileges.

NOTE: References must be from individuals who are directly familiar with your clinical abilities, either through direct observation or through a close working relationship.

Name:	Specialty:	Telephone Number: ()
Mailing Street Address:	City:	State: Zip:
Name:	Specialty:	Telephone Number: ()
Mailing Street Address:	City:	State: Zip:

X. WORK HISTORY (Attach additional sheets if necessary)

Chronologically list all work activities for the past five years. This information must be complete. Please explain on a separate page any gaps in professional work history.

Current Practice/Employer:	Contact Name:	Telephone Number: () Fax Number: ()
Mailing Street Address	City:	State: Zip:
From (mm/yy):	To (mm/yy):	
Previous Practice/Employer	Contact Name:	Telephone Number: () Fax Number: ()
Mailing Street Address:	City:	State: Zip:
From (mm/yy):	To (mm/yy):	
Previous Practice/Employer:	Contact Name:	Telephone Number: () Fax Number: ()
Mailing Street Address:	City:	State: Zip:
From (mm/yy):	To (mm/yy):	

XVI. ATTESTATION QUESTIONS

Please answer the following questions “yes” or “no”. If your answer to questions A through L is “yes” or if your answer to M & N is “no”, please provide full details on reverse or on a separate sheet.

A.	Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?	Yes <input type="checkbox"/> No <input type="checkbox"/>
B.	Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?	Yes <input type="checkbox"/> No <input type="checkbox"/>
C.	Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?	Yes <input type="checkbox"/> No <input type="checkbox"/>
D.	Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?	Yes <input type="checkbox"/> No <input type="checkbox"/>
E.	Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?	Yes <input type="checkbox"/> No <input type="checkbox"/>
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?	Yes <input type="checkbox"/> No <input type="checkbox"/>
G.	Have you been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
H.	Have you ever been convicted of any crime (other than a minor traffic violation)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
I.	Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs?	Yes <input type="checkbox"/> No <input type="checkbox"/>
J.	Do you have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice or unable to perform those essential functions without a direct threat to the health and safety of others? If yes, please describe any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise.	Yes <input type="checkbox"/> No <input type="checkbox"/>
K.	Have any judgments been entered against you or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending?	Yes <input type="checkbox"/> No <input type="checkbox"/>
L.	Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged) or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?	Yes <input type="checkbox"/> No <input type="checkbox"/>
M.	Is your professional liability insurance valid and current?	Yes <input type="checkbox"/> No <input type="checkbox"/>
N.	Are you able to perform all the services required by your agreement with, or the professional staff bylaws of, the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?	Yes <input type="checkbox"/> No <input type="checkbox"/>

I hereby affirm that the information submitted in this Section XVI, Attestation Questions, and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material, omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name Here: _____

Mid-Level Provider’s Signature: _____
(Stamped Signature Is Not Acceptable)

Date: _____

INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance (“credentialing information”) by and between this Healthcare Organization and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and business and individuals acting as their agents) for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state¹ laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et seq. if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action taken or pending against me by any licensing, certification or registering agency, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my clinical license, certification or registration; or (ii) any adverse action taken against me by any Healthcare Organization which has resulted in the filing of an action report with any licensing, certifying or registering agency or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, non- renewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or participation agreement with the Healthcare Organization. A photocopy of this document shall be as effective as the original.

Print Name Here _____

Mid-Level Provider’s Signature _____ Date _____
(Stamped Signature Is Not Acceptable)

¹The intent of this release is to apply, at a minimum, protections comparable to those available to any regardless of where such action is brought.

MID-LEVEL PROVIDER APPLICATION

ATTACHMENT I: STATEMENT OF AGREEMENT BY SUPERVISING PROVIDER

Name: _____ Employed as: _____
Mid-Level Provider

Name: _____
Supervising Provider

I, _____, M.D./D.O. supervising Provider for the above named Mid-Level Provider, do hereby make the following statements of agreement in accordance with the policies/procedures regulating the Mid-Level Provider program:

1. I hereby accept full legal and ethical responsibility for the performance of all duties and acts performed by the above named Mid-Level Provider whom I have employed.
2. I hereby request approval to allow above named Mid-Level Provider to perform, outside my immediate supervision, the specific activities and duties, as outlined in the *attached supervising guidelines and/or job description of the Mid-Level Provider*.
3. I agree to immediately notify IPA/Medical, in writing, in the event my approval to supervise an Mid-Level Provider is removed, limited or otherwise altered by action of the Medical Board of California, or in the event of any notification of investigation of my supervision by the Board, or if there is a change in employment status of the Mid-Level Provider hereby applying.
4. I agree to inform all patients that said Mid-Level Provider will participate in the total care of the patient and agree to ensure that the Mid-Level Provider will be clearly identified by badge.
5. I agree to comply with all regulations and policies of the Medical Board of California and/or other regulating agencies and IPA/Medical with respect to the supervision of the Mid-Level Provider, specifically including such regulations and policies which have been or may, from time to time, be adopted by said Board and/or other regulating agencies and IPA/Medical with respect to:
 - a. Billing for the services of the Mid-Level Provider;
 - b. Requirements for supervision of the Mid-Level Provider with respect to the type and scope of services approved by the Medical Board of California for the Mid-Level Provider to perform; and
 - c. Requirement for identification of the Mid-Level Provider while rendering services.

It is understood that compliance with such regulations shall be considered a necessary but not sufficient condition for the continuing approval by IPA/Medical of the performance of services by the Mid-Level Provider for the health plan.

6. I understand the right of the Mid-Level Provider to render medical services under my contract shall be contingent upon my continued membership and contract with IPA/Medical. If I terminate my membership or contract, or if my membership or contract is suspended, revoked or terminated, the Mid-Level Provider's clinical activities shall automatically be changed accordingly. Similarly, if my membership or contract is restricted, the Mid-Level Provider's activities shall be restricted accordingly.
7. If applicable, a certificate issued to me by the Medical Board of California indicating my approval to supervise an Mid-Level Provider in the type and scope of practice for which this application has been made is attached.
8. I understand that the above named Mid-Level Provider shall have only such authority as is necessary to perform the duties and tasks indicated in this application. Questions of authority shall be referred to me for case by case resolution.

Provider's Signature

Date

California Participating Physician Application

Notice to Practitioners of Credentialing Rights/Responsibilities

I. Right of Review

As an applicant for credentialing/recredentialing, you have a right to review non-privileged information obtained for the purpose of evaluating your application. This includes information obtained from outside sources such as liability insurance carriers, Medical Boards, National Practitioner Data Bank. It does not include review of information that is privileged, such as references or recommendations which are protected by law from disclosure. You have a right to be informed, upon request, of the status of your credentialing application; and the right to correct erroneous information submitted by another party, provided the information is not peer-review protected.

You may request to review such information at any time by sending a written request via fax or letter to Credentialing Department at: P.O. Box 1800, Rancho Cucamonga, CA 91729-1800, fax number (909) 890-5756. Following receipt of your request, you will be contacted by the Credentialing Department, within five (5) working days in order to arrange a date and time for review of the information in the Credentialing Department.

II. Notification of Discrepancy

You will be notified in writing, by fax or letter, when information obtained by primary sources varies significantly from information provided on your application. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

III. Correction of Erroneous Information

If you believe that erroneous information has been supplied to Inland Empire Health Plan by primary sources, you may correct such information by submitting written notification to the Credentialing Department at the above cited address/fax number. Your notification, via letter or fax, must include a detailed explanation of the discrepancy and must be returned to the address above within fifteen (15) days of notification of discrepancy.

Upon receipt of your notification, Inland Empire Health Plan will re-verify the primary source information under consideration. If the primary source information has changed, an immediate correction will be made to your credentials file. You will be notified of this action. If the primary source information remains inconsistent with your notification, you will be advised of same through letter or fax. You will be requested to provide proof of correction by the primary source to the Credentialing Department via letter or fax as cited above within ten (10) days. Subsequently, a second re-verification of primary source information will be performed by Inland Empire Health Plan. If, after ten (10) working days, primary source information remains inconsistent and in dispute, you will be subject to adverse action up to administrative termination from Inland Empire Health Plan.

Print Name Here: _____

Physician Signature _____ Date _____
(Stamped signature is Not Acceptable)

California Participating Physician Application

Addendum B

Professional Liability Action Explanation

This Addendum is submitted to: _____, herein, this Healthcare Organization¹

Please complete this form for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital, or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

I. IDENTIFYING INFORMATION

Patient's Last Name	First	Middle:
Street Address:	City:	
	State:	ZIP:

II. CASE INFORMATION

City, County and State where lawsuit filed:	Court case number, if known:		
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suite Filed:	Sex of Patient:	Age of Patient
Location of Incident: <input type="checkbox"/> Hospital <input type="checkbox"/> My Office <input type="checkbox"/> Other doctor's office <input type="checkbox"/> Surgery Center <input type="checkbox"/> Other (please specify) _____			
Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consultant, etc):			
Allegation:			
Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide company name, contact person, phone number, location and carrier's claim identification number of insurance company, or other liability protection company or organization: _____ _____ _____			
If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization: Name: _____ Phone Number: _____ Name: _____ Phone Number: _____			

¹ As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

III. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (CHECK ONE)

- Lawsuit/arbitration still ongoing, unresolved.
- Judgment rendered and payment was made on my behalf. Amount paid on my behalf: _____
- Judgment rendered and I was found not liable.
- Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: _____
- Lawsuit/arbitration settled, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include 1) condition and diagnosis at time of incident, 2) dates and description of treatment rendered, and 3) condition of patient subsequent to treatment. Please print.

SUMMARY

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals, or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Physician Application. In order for participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization information about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorneys listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization".

Print Name Here: _____

Mid-level Signature: _____ Date: _____
(Stamped signature is Not Acceptable)

Verification of Qualifications *for* HIV/AIDS PHYSICIAN SPECIALIST

Health plans and healthcare organizations must implement regulations related to AB2168 (Ch. 426, 2000). This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently definite an HIV/AIDS specialist under Regulation LS-34-01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

Please check ANY and ALL of the criteria listed below that apply to you.

No, I do not wish to be designated as an HIV/AIDS Specialist

Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:

I am credentialed as a "HIV Specialist" by the American Academy of HIV Medicine (attached AAHIVM Certification);

OR

I am Board Certified in Infectious Disease **AND** in the preceding **twelve (12)** months have clinically managed a minimum of **twenty-five (25)** HIV patients **and** have successfully completed **fifteen (15)** hours of category 1 continuing medical education (CME) in HIV medicine, **five (5)** hours of which was related to antiretroviral therapy;

OR

In the past **twenty-four (24)** months, I have provided clinical management of **twenty (20)** patients; **and** in the past **twelve (12)** months completed board certification in Infectious Disease

OR

In the past **twenty-four (24)** months I have provided clinical management to **twenty (20)** HIV patients and in the past 12 months have completed 30 hours of category 1 CME in HIV Medicine;

OR

In the past **twenty-four (24)** months I have clinically managed at least 20 HIV patients and in the past **twelve (12)** months have completed 15 hours of category of 1 CME in HIV Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine (attach copies of the CME credits and Exam verification)

I attest that, to the best of my knowledge, the above information can be supported by documentation, if required.

Name of Practitioner (Please print): _____

Date: _____

Practitioner's Signature: _____

License No: _____

Office Telephone: _____

Office Fax: _____

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.	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.	
	2 Business name/disregarded entity name, if different from above	
	3 Check appropriate box for federal tax classification; check only one of the following seven boxes: <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____ Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner. <input type="checkbox"/> Other (see instructions) ▶	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <i>(Applies to accounts maintained outside the U.S.)</i>
	5 Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	6 City, state, and ZIP code	
	7 List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

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

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number																		
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> </tr> </table>																		
or																		
Employer identification number																		
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> <td style="border: 1px solid black; width: 25px; height: 20px;"></td> </tr> </table>																		

Part II Certification

Under penalties of perjury, I certify that:

- 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
- 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
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 3.

Sign Here	Signature of U.S. person ▶	Date ▶
------------------	----------------------------	--------

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.
Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at www.irs.gov/fw9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)

- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
 - Form 1099-C (canceled debt)
 - Form 1099-A (acquisition or abandonment of secured property)
- Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.
- If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.*
- By signing the filled-out form, you:
- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
 - Certify that you are not subject to backup withholding, or
 - Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
 - Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

**DELEGATION OF SERVICES AGREEMENT BETWEEN SUPERVISING PHYSICIAN
AND PHYSICIAN ASSISTANT (Title 16, CCR, Section 1399.540)**

PHYSICIAN ASSISTANT _____

(Name)

Physician assistant, graduated from the _____

(Name of PA Training Program)

physician assistant training program on _____

(Date)

He/she took (or is to take) the licensing examination for physician assistants recognized by the State of California (e.g., Physician Assistant National Certifying Examination or a specialty examination given by the State of California) on: _____

(Date)

SUPERVISION REQUIRED. The physician assistant named above (hereinafter referred to as a PA) will be supervised in accordance with the supervisor guidelines required by Section 3502 of the Business and Professions Code and Section 1399.545 if the Physician Assistant Regulations. The written supervisor guidelines are incorporated with the attached documents entitled, "Supervising Physician's Responsibility for Supervision of Physicians Assistants."

AUTHORIZED SERVICES. The PA is authorized by the physician whose name and signature appear below to perform all the tasks set forth in subsections (a), (d), (e), (f), and (g) of Section 1399.541 of the Physician Assistant Regulations, when acting under the supervision of the herein named physician. (In lieu of listing specific lab procedures, etc., the PA and *supervising* physician may state as follows: "Those procedures specified in the practice protocols or which the supervising physician specifically authorizes.")

The PA is authorized to perform the following laboratory and screening procedures:

The PA is authorized to assist in the performance of the following laboratory and screening procedures:

The PA is authorized to perform the following therapeutic procedures:

The PA is authorized to assist in the performance of the following therapeutic procedures:

The PA is authorized to function as my agent per bylaws and/or rules and regulations of (name of hospital):

The PA is authorized to perform the following laboratory and screening procedures:

a) The PA is authorized to write and sign drug orders for Schedule: II, III, IV, V without advance approval (circle authorized schedule(s)). The PA has taken and passed the drug course approved by the Board on _____ (attach certificate). DEA # _____

or

b) The PA is authorized to write and sign drug orders for Schedule II, III, IV, V with advance patient specific Approval (circle authorized schedule(s)). The PA has taken and passed the drug course approved by the Board on _____ (attach certificate). DEA # _____

CONSULTATION REQUIREMENTS. The PA is required to always and immediately seek consultation on the following types of patients and situations (e.g. patient's failure to respond to therapy; physician assistant's uncertainty of diagnosis; patient's desire to see physician; any conditions which the physician assistant feels exceeds his/her ability to manage, etc.)

(List Types of Patients and Situations)

MEDICAL DEVICES AND PHYSICIAN'S PRESCRIPTIONS. The PA may transmit by telephone to a pharmacist, and orally or in writing on a patient's medical record or a written prescription drug order, the supervising physician's prescription in accordance with Section 3502.1 of the Business and Professions Code.

The supervising physician authorizes the delegation and use of the drug order form under the established practice protocols and formulary. YES NO

The PA may also enter a drug order on the medical record of a patient at _____
(Name of Institution)
in accordance with the Physician Assistant Regulations and other applicable laws and regulations.

Any medication handed to a patient by the PA shall be authorized by the supervising physician's prescription and be prepackaged and labeled in accordance with Sections 4076 of the Business and Professions Code.

PRACTICE SITE. All approved tasks may be performed for care of patients in this office or clinic located at _____ and, in _____ Hospital(s) and _____
(Address / City) (Address / City)
_____ skilled nursing facility (facilities) for care of
(Name of Facility)
patients admitted to those insitutions by physician(s) _____
(Names)

EMERGENCY TRANSPORT AND BACK UP. In a medical emergency, telephone the 911 operator to summon an ambulance.

The _____ emergency room at _____
(Name of Hospital) (Phone Number)
is to be notified that a patient with an emergency problem is being transported to them for immediate admission. Give the name of the admitting physician. Tell the ambulance crew where to take the patient and brief them on known and suspected health condition of the patient.
Notify _____ at _____ immediately
(Name of Physician) (Phone Number/s)
(or within _____ minutes).

PHYSICIAN ASSISTANT DECLARATION

My signature below signifies that I fully understand the foregoing Delegation of Services Agreement, having received a copy of it for my possession and guidance, and agree to comply with its terms without reservations.

Date

Physician's Signature (Required)

Physician's Printed Name

Date

Physician Assistant'

Physician Assistant's Printed Name

**SUPERVISING PHYSICIANS'S RESPONSIBILITY
FOR SUPERVISION OF PHYSICIAN ASSISTANT**

SUPERVISOR _____, M.D./D.O. is licensed to practice in California as a physician and surgeon with medical license number _____. Hereinafter, the above named physician shall be referred to as the supervising physician.

SUPERVISION REQUIRED. The physician assistant (PA) named in the attached Delegation of Services Agreement will be supervised by the supervising physician in accordance with these guidelines, set forth as required by Section 3502 of the Business and Professions Code and Section 1399.545 of the Physician Assistant Regulations, which have been read by the physician whose signature appears below.

The physician shall review, countersign, and date within seven (7) days the medical record of any patient card for by the physician assistant for whom they physician's prescription for Schedule II medications was transmitted or carried out.

REPORTING OF PHYSICIAN ASSISTANT SUPERVISION. Each time the physician assistant provides care for the patient and enters his or her name, signature, initials, m or computer code on a patient's record, chart or written order, the physician assistant shall also enter the name of his or her supervising physician who is responsible for the patient. When the physician assistant transmits an oral order, he or she shall also state the name of the supervising physician responsible for the patient.

MEDICAL RECORD REVIEW. One of more of the following mechanisms, as indicated below, by a check mark (x) shall be utilized by the superivisng physician to particaly fulfill his/her obligation to adequately supervise the actions of the physician assistant named _____
(Name of PA)

_____ Examination of the patient by a supervising physician the same day as the care is given by the PA.
_____ The supervising physician shall review, audit, and countersign every medical record written by the PA within _____ of the encounter.
(Number of Days, May not Exceed 30 Days)

_____ The physician shall audit the medical records at least 5% of patients seen by the PA under any protocols Which shall be adoped by the supervising physician and the physician assistant. The physician shall select for review those cases which by diagnosis, problem, treatment, or procedure representm in his or her judgment the most significant risk to the patient.

_____ Other mechanisms approved in advance by the Physician Assistant Board may be used. Written documentation of those mechanisms is located at _____
(Give location)

_____ **INTERIM APPROVAL.** For physician assistants operating under interim approval, the supervising physician Shall review, sign, and date the medical records of all patients card for by the physician assistant within seven (7) days if the physician was on the premises when the physician assistant diagnosed or treated the patient. If the physician was not on the premises at the time, he or she shall review, sign, and date such medical records within 48 hours of the time the medical services were provided.

BACK UP PROCEDURES: In the event this supervising physician is not available when needed, the following physician(s) has (have) agreed to be a consultant(s) and/or to receive referrals:

_____ Phone: _____
(Printed Name and Specialty)
_____ Phone: _____
(Printed Name and Specialty)

PROTOCOLS NOTE: This document **does not** meet the regulation requiremetn to serve as a protocol. Protocols, if adopted by the supervising physician, must fully comply with the requirements authorized in Section 3502 (c) (1) of the Business and Professions Code

_____ (Date) _____ (Physician's Signature)

**STANDARDIZED PROCEDURE GUIDELINES
(APPLICABLE TO ALL LICENSEES UNDER THE BOARD OF REGISTERED NURSING)**

The Board of Registered Nursing and the Medical Board of California jointly promulgated the following guidelines. (Board of Registered Nursing, Title 16, California Code of Regulations (CCR) section 1474; Medical Board of California, Title 16, CCR Section 1379.)

- A. Standardized Procedures shall include a written description of the method used in developing and approving them and any revision thereof.
- B. Each standardized procedure shall:
1. Be in writing, dated and signed by the organized health care system personnel authorized to approve it.
 2. Specify which standardized procedure functions registered nurses may perform and under what circumstances
 3. State specific requirements which are to be followed by registered nurses in performing particular standardized procedure functions.
 4. Specify any experience, training, and/or education requirements for performance of standardized procedure functions.
 5. Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform standardized procedure functions.
 6. Provide for a method of maintaining a written record of those persons authorized to perform standardized procedure functions.
 7. Specify the scope of supervision required for performance of standardized procedure functions, for example, telephone contact with the physician.
 8. Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition.
 9. State the limitations on settings, if any, in which standardized procedure functions may be performed.
 10. Specify patient record-keeping requirements.
 11. Provide for a method of periodic review of the standardized procedures.

An additional safeguard for the consumer is provided by steps four and five of the guidelines which, together, form a requirement that the nurse be currently capable to perform the procedure. If a RN or NP undertakes a procedure without the competence to do so, such an act may constitute gross negligence and be subject to discipline by the Board of Registered Nursing.

Standardized procedures which reference textbooks and other written resources in order to meet the requirements of Title 16, CCR Section 1474 (3), must include book (specify edition) or article title, page numbers and sections. Additionally, the standards of care established by the sources must be reviewed and authorized by the registered nurse, physician and administrator in the practice setting. A formulary may be developed and attached to the standardized procedure. Regardless of format used, whether a process protocol or disease-specific, the standardized procedure must include all eleven required elements as outlined in Title 16, CCR Section 1474.

BEHAVIORAL HEALTH

Area(s) of Expertise Form

Provider Name: _____
Last Name
First Name
M.I.
Degree
License#

PATIENT POPULATION

- Children (age range): _____
 Adolescents (age range): _____
 Adults (age range): _____
 Geriatric Adults
 Cultural Population: _____

AREAS OF EXPERTISE IN SHORT-TERM TREATMENT

- | | |
|--|---|
| <input type="checkbox"/> 12-Step Recovery | <input type="checkbox"/> Grief / Loss |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Group Therapy |
| <input type="checkbox"/> Adjustment Disorder | <input type="checkbox"/> HIV/AIDS Issues |
| <input type="checkbox"/> Adoption Issues | <input type="checkbox"/> Hypnosis |
| <input type="checkbox"/> Adult Children of Alcoholics | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Life Transitions / Transition Issues |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Marital / Couple Counseling |
| <input type="checkbox"/> Antisocial Personality | <input type="checkbox"/> Medication Education Groups |
| <input type="checkbox"/> Anxiety Disorders | <input type="checkbox"/> Men's Group |
| <input type="checkbox"/> Anxiety Groups | <input type="checkbox"/> Men's Issues |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Military Stress |
| <input type="checkbox"/> Autism Spectrum Disorders | <input type="checkbox"/> Multiple Personality / Dissociative Identity |
| <input type="checkbox"/> Behavioral Problems / Conduct Disorders | <input type="checkbox"/> Narcissistic Personality Disorder |
| <input type="checkbox"/> Bi-Polar Disorder | <input type="checkbox"/> Obesity / Weight Loss |
| <input type="checkbox"/> Borderline Personality Disorder | <input type="checkbox"/> Obsessive Compulsive Disorder |
| <input type="checkbox"/> Cancer Survivors | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Chemical Dependency / Substance Abuse | <input type="checkbox"/> Parenting Groups / Training |
| <input type="checkbox"/> Child / Adolescent Psychiatry | <input type="checkbox"/> Parenting Issues |
| <input type="checkbox"/> Child Abuse | <input type="checkbox"/> Perinatal and Postpartum Mood Disorders |
| <input type="checkbox"/> Christian Counseling | <input type="checkbox"/> Personality Disorders |
| <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Pet Loss/ Grief |
| <input type="checkbox"/> Clinical Hypnosis | <input type="checkbox"/> Post Traumatic Stress Disorder |
| <input type="checkbox"/> Codependency | <input type="checkbox"/> Psychotherapy |
| <input type="checkbox"/> Cultural | <input type="checkbox"/> Psychotic / Schizophrenic Disorders |
| <input type="checkbox"/> Delirium, Dementia, Amnestic, and other Cognitive Disorders | <input type="checkbox"/> Reactive Attachment Disorder |
| <input type="checkbox"/> Depression Groups | <input type="checkbox"/> Sexual Abuse Groups |
| <input type="checkbox"/> Depression / Mood Disorders | <input type="checkbox"/> Sexual Addiction |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Disability Issues | <input type="checkbox"/> Sexual / Physical Abuse Perpetrators |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Sexual / Physical Abuse Victims |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> EMDR Certified | <input type="checkbox"/> Somatoform Disorders |
| <input type="checkbox"/> EMDR Certified – Severe Trauma PTSD | <input type="checkbox"/> Stress Management |
| <input type="checkbox"/> Factitious Disorders | <input type="checkbox"/> Victimization |
| <input type="checkbox"/> Family Counseling | <input type="checkbox"/> Vocational / Career |
| <input type="checkbox"/> Gambling Addiction | <input type="checkbox"/> Women's Group |
| <input type="checkbox"/> Gay / Lesbian Issues | <input type="checkbox"/> Women's Issues |
| <input type="checkbox"/> Gender Identity Issues | <input type="checkbox"/> Other |

ARE YOU ACCEPTING NEW PATIENTS? YES NO

PROVIDER SIGNATURE: _____ **DATE:** _____