Boulder Community Health

IMPORTANT CREDENTIALING INFORMATION—PLEASE READ THOROUGHLY

Thank you for your interest in applying to the Medical Staff of Boulder Community Health. To begin the application process, please provide the information listed on the attached application checklist to Boulder Community Health Medical Staff Department.

Please note that ***only complete applications will be processed***. **This means all blanks on the application form must be completed legibly, all forms and addendums signed, and all required accompanying information submitted with the application. An incomplete application will be returned to you, which will cause a delay in processing**. We understand that certain documentation may not be available immediately (i.e. state licensure, DEA certificate, etc.), please appropriately note the circumstances and submit this documentation as soon as you receive it.

The credentials verification process involves primary source verification of all the information on the application, including but not limited to education, training, peer references, past and present employers and past and present affiliations. The length of time to process your application is mainly dependent on the timely response to our requests and the accuracy of the information on your application. We encourage you to contact the sources listed on your application and ask them to return our verification requests as soon as possible. While your application is in process, **do NOT schedule yourself to begin practice or provide call coverage for the practice you are joining** because we cannot guarantee a specific date on which your file will be approved.

You must meet the minimum criteria, as stated below, for acceptance of the application:

A. Applicant is an MD, DO, DDS, DPM, PhD/PsyD or an appropriate Allied Health Professional.

B. Applicant has, within the last twenty-four months, been engaged in active clinical practice or engaged in medical related activities, e.g. residency, fellowship or masters program.

C. Applicant has established or plans to establish an office and residence within 60 miles of the hospital or has specific set arrangements made with a member of the Medical Staff of Boulder for coverage, if applicable.

D. Applicants are licensed to practice or have applied to be licensed to practice in this state, if applicable.

E. Applicants currently have professional liability insurance or have applied for professional liability insurance in the amount specified by the Governing Board.

F. Applicant has successfully completed an approved residency and/or training program.

G. Physician applicants must be currently board certified by a recognized ABMS/AOA/AAUCM/ABPS/ABPM member board or will attain such certification within the time-frame allotted by the specialty board. [ABMS-American Board of Medical Specialties; AOA-American Osteopathic association; AAUCM-American Academy of Urgent Care Medicine; ABPM (or S)-American Board of Podiatric Surgery (or Medicine)]. (MEC 4/09, 2/12)

H. Allied Health Professional applicants must be certified in the applicable specialty.

I. Applicant's privileges or right to practice at any other hospital or healthcare facility have not been revoked.*

J. Applicant's license to practice has not been revoked in any state and is not, at the time of application, under suspension.*

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K. Applicant's privileges at another hospital or health care entity are not, at the time of application, under suspension other than an administrative suspension for grounds unrelated to the practitioner's competence or professional conduct.*

L. Applicant has not been excluded, suspended, debarred or deemed ineligible to participate in any Federal health care program, nor been convicted of a criminal offense related to the provision of health care. *

Upon receipt of the application packet, the Medical Staff Department will review the application and will determine if each of the above criteria for membership and privileges are met. In the event any of the criteria for membership and privileges are not met, the potential applicant will be notified. The determination that an applicant is not eligible for membership or privileges is an administrative determination and shall not entitle the applicant to any of the procedures under the Fair Hearing Plan.

*A practitioner whose privileges or license has been revoked may be eligible for membership and/or privileges if the practitioner demonstrates that his privileges or license was subsequently reinstated by the same entity that revoked the license or privilege. Paragraphs I, J, K, and L shall not apply to a revocation or suspension of a practitioner's license or privileges which occurred prior to November 26, 1996, provided that as of that date, the practitioner is an AHP or member in good standing, as that term is defined in paragraph H, above.

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Provider Documentation Checklist

❒ **Colorado Health Care Professional Credentials Application** (linked to from www.bch.org/medstaff or re-sign saved app):

- Complete the application form with your name as listed on your Colorado license to practice.
- All blanks must be legibly completed. Full addresses, phone and fax numbers are required. Email addresses are helpful. A Curriculum Vitae is not a substitute for completing the application.
- List both month and year when completing "to/from" date blanks.
- ***Only one peer reference can be a current office associate. Peer references should be providers who have current knowledge of you skills, abilities, judgment, professional performance and clinical competence (within the last 12 months.) Peers should be the same discipline as you (MD/ DO, DDS/DDS, etc.). For Advanced Practice Practitioners, one peer needs to be a physician. No residents, fellows or family members.***
- On the insurance information page, include complete names and addresses, **retro** dates and phone numbers of all insurance companies that have provided malpractice coverage for you over the past five years.
- Explanations are required for any "yes" answers to (a) disclosure questions and (b) time gaps greater than 6 months.
- Sign and date signature pages (4 total).
- Save the application to your computer or copy and save the original before you sign the 4 signature pages, so that you can re-use the completed application for future reappointments.

❒ **Privilege Form** (linked to from www.bch.org/medstaff)**:**

- Check boxes to request only the privileges you wish to perform in a BCH facility (hospital or clinic).
- Include Procedure/activity log
- Include any other documentation required to meet competency measures as listed on the privilege form.
- If requesting any of the following, see additional Privilege Criteria (linked to from www.bch.org/medstaff): Bronchial Thermoplasty, Laparascopic & Hysteroscopic Morcellation, Port Access Catheter Placement , Robotic Surgery, Transoral Incisionless Fundoplication, Uterine Prolapse Procedures or Xtreme Lateral Interbody Fusion (XLIF)
- Proctoring
- Failure to submit required documentation will result in request for related privileges being deemed voluntarily withdrawn.
- Sign and date
- AHP's – include signed Sponsoring Medical Staff Member Agreement form

Review, complete, sign and date all Addenda (included herein)**:**

❒ Authorization for Release of Information

❒ Acknowledgement Statement

❒ Blood Borne Pathogens

❒ System Access User Agreement

❒ Signature Page

❒ W9

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Copies of:

- ❒ **Recent passport size photograph**
- ❒ **Legible copy of a government-issued photo ID** (visa if not a U.S. citizen)
- ❒ **A current Curriculum Vitae -** please make sure all the information on the CV is also on the state application (such as affiliations for the last 10 years) and that the information is the same (such as dates of affiliation).
- ❒ **Complete information concerning any professional liability claims**, complaints, or causes of action that have been lodged against you which are pending or if any judgments or settlements have been made against you. Please provide a complete explanation in your own words as well as all court documentation. This shall include but may not be limited to: the court in which the suit was filed, the caption and docket number of the case, the complete name and address of your attorney, the status or outcome of such matters and all other relevant details.
- ❒ **BLS/ACLS certificates** for all AHP's, BLS/ACLS/ATLS/PALS/NRP certificates for physicians requesting privileges for which certifications is a criterion (see privilege form)
- ❒ Current **insurance certificate**
- ❒ **DEA**, if applicable
- ❒ **CME**-Copies of certificates from continuing education courses (or specialty board summary) completed in the past 24 months. Refer to your privilege forms if additional CME's are required relevant to specific procedures requested.
- ❒ For **BCH employed** providers only: copy of diplomas and your wallet sized medical license. For **physicians** to be employed, complete Copic documents, located on the physician application webpage under #3.
- ❒ Any additional certification(s) you hold
- ❒ **Application Fee - Include a check for $500.00**, made payable to Boulder Community Health or BCH. Note: Once you are credentialed you will be charged prorated annual dues. The invoice will be included with your approval letter.

***Mail documents to*:**

BCH Medical Staff Department
PO Box 9019
Boulder, CO 80301-9019

***Credentialing Coordinators for last names starting with*:**

A-L	**Janet Magee** jmagee@bch.org	303.415.7492
M-Z	**Sarah Summers** ssummers@bch.org	303.415.7494

Additional Action Items:

- ❒ Once you have turned in your application to our department email employeehealth@bch.org to make an appointment for your health assessment. If you have documentation of your immunizations, bring to your appointment. If not, they provide testing/immunizations free of charge. They will communicate with the Medical Staff Department directly as to your fulfillment of this requirement. Your application will be deemed incomplete if this is not complete.
- ❒ Contact your credentialing coordinator (above) to schedule your new practitioner orientation.

Boulder Community Health

AUTHORIZATION FOR RELEASE OF INFORMATION FOR MEDICAL STAFF APPOINTMENT AND/OR CLINICAL PRIVILEGES

In connection with my application to the Boulder Community Health Medical Staff or Allied Health Professional Staff, I authorize BACKGROUND INFORMATION SERVICES, INC., or its agents to procure a background information report about my character or reputation, including but not limited to information as to my employment, education, driving record, social security number verification, criminal record, and/or other public records history. I authorize all persons to fully disclose information relevant to this investigation. I release from liability all persons, companies, and governmental or other agencies disclosing such information. I further authorize that a photocopy of this authorization may be considered as an original.

Additionally, I give Boulder Community Health permission to investigate any incidents of workplace misconduct of which I have been accused or for which I am alleged to have been involved during my appointment or employment with any Medical Staff(s), Allied Health Professional Staff(s), or healthcare organization(s).

I have read, understand, and authorize any person, agency or other entity contacted by BACKGROUND INFORMATION SERVICES, INC., or its agents, to furnish the above-mentioned information.

I further understand that this authorization/release is valid throughout my term of appointment.

This form will not be accepted if altered, illegible or incomplete.

Signature _____ Date _____

Type or Print Name _____ Other Names (alias, maiden, nickname) _____

Social Security # _____

Current Address _____

City _____ State _____ Zip _____ County of Resident _____

Addresses for the past seven years:

City:	State:	County or zip:	Dates lived there:

___/___/___ _____ *Date of Birth *Gender (M or F)

** without this information we may not be able to identify you in the course of our background check.*

_____ Place of Birth

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Boulder Community Health

Physician or Allied Health Practitioner Acknowledgment Statement

ORIENTATION— I acknowledge that if I am extended initial affiliation or reappointment with Boulder Community Health, I must complete a BCH/Medical staff orientation as a component of successful completion of the application process.

DISCLOSING TO BCH HUMAN RESOURCES— If I am applying for employment or am employed by BCH, I authorize the Medical Staff of BCH to obtain information from and disclose information to the BCH Human Resources Department and other appropriate BCH department acting as my employer. Such information may include information regarding my qualifications, references, professional competence, or conduct and any actions taken by the Medical Staff of BCH as my employer related thereto. This release shall remain in force so long as I am applying for employment or am employed by BCH.

SHARING OF PATIENT'S MEDICAL INFORMATION BETWEEN BCH AND THE MEDICAL STAFF OF BOULDER— I agree that if appointed as a member of the Medical Staff, I will participate in the Organized Health Care Arrangement ("OHCA") established by Boulder Community Health and the Medical Staff of Boulder to facilitate the sharing of patients' medical information for purposes of treatment, payment and health care operations of the OHCA in accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act of 1996. I agree to comply with BCH's Privacy Policies and to abide by the terms of the Joint Notice of Privacy Practices developed for the OHCA and provided to patients who receive care at BCH. I understand that the Joint Notice only applies to care provided at the Hospital and that I must provide patients with a separate notice for care provided outside the Hospital. I further agree to release BCH, its officers, directors, employees and agents from any and all claims, causes of action, liabilities, damages, costs, expenses or fees, including reasonable attorneys' fees, that may occur as a result of the physician's participation in the OHCA, except those arising from intentional misconduct on the part of BCH. I acknowledge that I am individually liable for any violation of state or federal privacy laws or regulations that occurs as a result of my own actions.

BCH MEDICAL AND ALLIED HEALTH PROFESSIONAL STAFF CREDO— I agree to abide by the following: We are physicians and allied health professionals providing the highest degree of care and commitment to patients at Boulder Community Health. To that end, we treat our patients, staff and each other with dignity, courtesy and respect at all times. We work to provide an environment of cooperation, teamwork and pride in what we do so that the needs of our patients and each other are met. We will abide by the Bylaws and Rules and Regulations of the Medical Staff of Boulder Community Health. Bylaws and Rules and Regulations are located on our page on the BCH.org website. When we see other members of our Medical Staff acting in an inappropriate manner, we are expected to remind that member about the Credo and behavioral expectations.

MEDICARE / MEDICAID / CHAMPUS PROSPECTIVE PAYMENT SYSTEM— I understand that this payment system to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment or civil penalty under applicable Federal laws.

MEDICAL STAFF CODE OF PROFESSIONAL CONDUCT— I certify that I have received, read and agree to abide by the Medical Staff Code of Professional Conduct (attached).

CALL RESPONSIBILITY- I understand that I may be obligated to provide emergency call coverage in accordance with the Medical Staff Bylaws and Rules and Regulations. INITIALS: _____

_____

Signature of Applicant (no stamps accepted) Date

_____

Printed or Typed Name

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Boulder Community Health

MEDICAL STAFF CODE OF PROFESSIONAL CONDUCT

To provide and promote quality health care, emphasizing professionalism, respect and cultural sensitivity, we, the Medical Staff[1] of Boulder Community Health, will adhere to the following Code of Professional Conduct in all interactions with patients, their families, colleagues, other health professionals, students, other trainees and the public.

The Code of Professional Conduct is a series of principles and subsidiary rules that govern professional interactions. The Code applies to all physicians at BCH involved in the clinical and administrative activities of BCH.

Failure to meet the professional obligations described below represents a violation of the Code of Professional Conduct. Items marked with an asterisk (*) indicate behaviors that also may violate federal or state laws. Alleged infractions of the professional obligations of the Code will be dealt with by the appropriate disciplinary committees and processes.

1. Respect for Persons
The basis of all human interactions at BCH will be to treat each other with respect and dignity, no matter what station, degree, race, age, sexual orientation, religion, gender, disability and/or disease. To accomplish this we resolve to:

- Treat patients, families, colleagues, other health professionals, students, and teachers with the same degree of respect and dignity we would wish them to show us.
- Treat patients with kindness and gentleness.
- Respect the privacy and modesty of patients.
- Not use offensive language, verbally or in writing, when referring to patients or their illnesses.
- Not use offensive language when interacting with any others in the community.
- Not harass others physically, verbally, psychologically, or sexually.*
- Not abuse one's power or position for sexual and/or romantic ends.
- Not discriminate on the basis of sex, religion, race, disability, age, or sexual orientation.*
- Treat all physicians, other health professionals, students, and other trainees as professionals in a professional manner.

2. Respect for Patient Confidentiality
The confidentiality of patient communication and information is the basis of professional care. To realize its achievement, we resolve to:

- Not share the medical or personal details of a patient with anyone except those health care professionals integral to the well-being of the patient or within the context of an educational endeavor.*
- Not discuss patients or their illnesses in public places where the conversation may be overheard.
- Not publicly identify patients, in spoken words or in writing, without patients' permission.
- Not invite or permit unauthorized persons into patient care areas of the hospital.
- Not share confidential passwords.
- Not look up confidential data on patients unless the information is necessary for the care of that patient.*

3. Honesty, Integrity
Honesty and integrity are the foundations of good physician-patient, professional-professional and teacher-student relationships. To this end, we resolve to:

- Be truthful in verbal and in written communications.
- Acknowledge an unanticipated outcome to colleagues and patients when the result of a treatment or procedure differs significantly from what was anticipated.
- Protect the integrity of clinical decision making, regardless of financial impact.
- Not knowingly mislead others.
- Not cheat, plagiarize, or otherwise act dishonestly.

4. Responsibility for Patient Care
To maintain our responsibility for patient care, we resolve to:

- Obtain the patient's informed consent for diagnostic tests or therapies.
- Assume 24-hour responsibility for the patients under our care; when off duty, or on vacation, assure that our patients are adequately cared for by another practitioner.
- Not abandon a patient. If unable/unwilling to continue care, we have the obligation to assist in making a referral to another competent practitioner willing to care for the patient.
- Follow up on ordered laboratory tests and complete patient record documentation conscientiously.
- Coordinate with clinical care teams about the timing of information sharing with patients and their families to present a coherent and consistent treatment plan.

[1] For the purpose of this document "medical staff" implies all credentialed practitioners (MD, DO, PA, NP, etc.)

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- Charge patients or their insurers only for clinical services provided or supervised.*
- Not document items in the medical record that were not performed.
- Not abuse alcohol or other drugs.

5. Awareness of Limitations, Professional Growth

Lifelong learning is critical to the competent practice of our profession. To achieve this end, we resolve to:

- Be aware of our personal limitations and deficiencies in knowledge and abilities and know when and whom to ask for supervision, assistance, or consultation.
- Know when and for whom to provide appropriate supervision.
- Countersign all patient workups and orders as appropriate when in a supervisory role.
- Avoid patient involvement when ill, distraught, or overcome with personal problems.

6. Deportment as a Professional

Patients and their families expect appropriate dress and identification. To fulfill this, we resolve to:

- Clearly identify ourselves, our roles and our professional levels to patients and staff and wear a name tag.
- Dress in a neat, clean, professionally appropriate manner.
- Maintain professional composure despite the stresses of fatigue, professional pressures, or personal problems.
- Not write offensive or judgmental comments in patients' charts.
- Avoid disparaging and critical comments about colleagues and their medical decisions in the presence of patients.

7. Avoiding Conflicts of Interest

Conflicts of interest are common and inevitable. To avoid conflicts of interest undermining our science, practice and teaching, we resolve to:

- Declare all conflicts when lecturing, writing or serving on professional bodies.
- Resolve all clinical conflicts of interest in favor of the patient.
- Not accept non-educational gifts of value from for-profit companies such as drug companies or medical equipment vendors or suppliers.

8. Responsibility for Peer Behavior

Peer review, reporting and monitoring is part and parcel of our role as professionals who are allowed the privilege of self-regulation. Toward this end, we resolve to:

- Take the initiative to identify and help rehabilitate impaired physicians with the assistance of the Medical Staff's Practitioner Health and Well Being Committee.
- Report serious breaches of the Code of Professional Conduct to the appropriate person.
- Report illegal* acts to the appropriate internal authorities.
- Indicate disapproval or seek appropriate intervention observing less serious breaches.

9. Respect for Personal Ethics

Each individual's beliefs and ethical principles will be respected. Toward this end, we resolve to:

- Inform patients and their families of available treatment options that are consistent with acceptable standards of medical and nursing care.
- Respect patient wishes, including advanced directive, living wills, etc., consistent with acceptable standards of care.

10. Respect for Property and Laws

Adherence to the law is integral to professional behavior. To fulfill our commitment, we resolve to:

- Adhere to the regulations and policies of Boulder Community Health as they apply to us, e.g., policies governing fire safety, hazardous waste disposal, and universal precautions.
- Adhere to local, state, and federal laws and regulations.*
- Not misappropriate, destroy, damage, or misuse property of any of BCH's components.*

Supporting Documents:

- Code of Ethics, policy #019
- Code of Conduct, policy #900
- Disruptive Behavior, and Harassment & Sexual Harassment, policy #441
- Medical Staff Bylaws & Associated Manuals
- Medical Management protocol, policy #503
- MS Professional Review Process
- Duality of Interest/Disclosure of Interest Statement

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Boulder Community Health

Blood Borne Pathogens Review

This blood borne pathogens review is an OSHA mandate. Please initial each of the following statements indicating you have read and understand it. Sign the bottom of the form and return it with your credentialing packet to the Medical Staff Office. If you have any questions please call Infection Prevention at 303-415-7664 or Employee Health at 303-415-7660. Thank you!

(initial)____Blood borne pathogens are potentially present in blood, other body fluids, unfixed tissues and organs, and cell and tissue cultures.

(initial)____The blood borne diseases of major concern to healthcare workers are HIV, Hepatitis B, and Hepatitis C.

(initial)____Hepatitis B infection is preventable with vaccinations. The series of vaccinations are free of charge through the Employee Health department.

(initial)____Breaks in the skin with contaminated sharps or needles cause the majority of exposures to blood borne diseases in healthcare.

(initial)____If exposed to HIV with a sharps injury, the risk of contracting the disease is 0.3%. If exposed to Hepatitis B with a sharps injury, the risk of contracting the disease is 0% after immunization and 5-30% with no immunization. If exposed to Hepatitis C with a sharps injury, the risk of contracting the disease is 3-10%.

(initial)____People can become infected when blood or other body fluids splash into open wounds or the mucous membranes of the eyes, nose, and mouth. The risk is much lower than with sharps injuries.

(initial)____BCH has an OSHA required Exposure Control Plan updated annually. It includes the definition of an exposure, procedures for protecting workers, the medical follow-up process for exposed workers, and methods of reviewing processes and products to prevent blood borne exposures.

(initial)____Procedures for protecting workers from exposures include the use of universal and standard precautions, immunizations for Hepatitis B, the use of personal protective equipment, and adherence to workplace safety practices.

(initial)____All physicians, allied health professionals and other healthcare workers are required to wear a surgical mask and eye protection when a splash to the face with blood or body fluids is anticipated; use of a one-way valve mask when performing mouth to mouth resuscitation; the use of a cover gown when clothing could be soiled with blood or body fluids, and the use of gloves when hands could come in contact with blood or body fluids.

(initial)____The biohazard symbol is the universal symbol placed on any container that may contain infectious waste.

(initial)____Sharps containers are for the disposal of all dirty sharps by the user. Needles must never be broken, bent, or removed from the sharps container.

(initial)____Safety devices must be used when available to prevent blood borne exposures. Safety devices include sharps disposal containers, self-sheathing needles, sharps with engineered injury protection mechanisms, and needless systems. All healthcare providers must ask for training if they have never used a safety device.

(initial)____Hand hygiene must always occur immediately after glove removal.

(initial)____If exposed to blood or other potentially infectious materials: 1) Cleanse the area immediately; 2) Flush mucous membranes with large amounts of water; 3) Wash exposed skin with soap and water; 4) Go directly to the Emergency Department and follow the directions of the charge nurse; 5) Complete the evaluation and follow-up process under the guidance of Employee Health.

(initial)____Follow-up with the Emergency Department immediately after an exposure allow the source patient to be evaluated and have stat HIV testing. This allows for timely prophylactic intervention if needed.

Signature _____ Date:_____

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BOULDER COMMUNITY HEALTH SYSTEM ACCESS USER AGREEMENT

As an employee, volunteer, contractor, or medical staff member of Boulder Community Health (BCH) or any subsidiary or affiliate thereof, I understand that access to certain information is required for me to perform my duties. Some of this information may concern patients being treated at BCH or it may concern the operations of BCH.

I understand that any patient medical information belongs to the patient. I am only permitted to access patient medical information (whether maintained electronically, on paper, or otherwise), to the extent that it is necessary to provide patient care and perform my duties and in accordance with applicable laws. I also understand that all medical and personal information regarding patients is confidential by law and may not be revealed or discussed with other patients, friends or relatives, or anyone else within or outside of BCH except as authorized by BCH or required by law.

I also understand that other information regarding the operations of BCH, whether maintained electronically, on paper, or otherwise is confidential. This information may concern, for example, employees, financial operations, strategic or business plans, quality assurance, utilization review, risk management, research, contracting, procurement, and credentialing of staff. I understand that I am only authorized to access this information if it is required for me to perform my duties. This information should not be discussed with others within or outside BCH except to the extent that this discussion is necessary to perform my duties.

I understand that I am required to protect BCH patient or operations information from loss, misuse, unauthorized access, or unauthorized modification. I also understand that my use of the system may be monitored.

I understand that I may be given a USERID/Password to the BCH network and/or computer system(s). I will safeguard the USERID/Password given to me. I acknowledge that I am strictly prohibited from disclosing my USERID/Password to anyone, including my family, friends, fellow workers, supervisors, and subordinates, for any reason. I agree to contact the Information Technology Help Desk immediately if I suspect that my password is known and/or being used by another person and that I may be required to reveal and/or relinquish my USERID/Password to the Chief Information Officer, or his/her designee. This is the only exception to the use/sharing of passwords.

I understand that I may only use my USERID/Password to perform my duties. I agree that I will not use anyone else's USERID/Password to obtain access to any BCH computer system(s). I understand that I will be held accountable for all work performed, changes made to the system or databases, or information accessed under my USERID/Password and that I am not to allow anyone else to access the BCH network/computer system using my USERID/Password.

I understand that failure to follow this policy regarding the confidentiality of information is cause for: termination of employment; termination of an independent contractor relationship; revocation of medical staff membership and privileges; revocation of access to all BCH network/computer systems; and possible legal action by any patient or other person injured by my breach of this policy.

My signature below indicates my understanding of the aforementioned mandates regarding the use of any USERID/Password I am assigned pursuant to my responsibilities with BCH, and that I have read and understand the BCH Access to Information Systems Policy (#305). In addition, users with access to the BCH electronic systems must comply with the BCH Confidentiality Policy (#401)

Printed name:_____	Signature:_____
Last 4 of SS#:_____	Date:_____

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Provider Signature Form

Printed Name:_____

Signature:_____

Initials:_____

Please sign your name and initial the way you would sign off in a patient's chart or for prescriptions.

Updated 11/11/2015

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Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

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

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:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ 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.

☐ 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) _____

(Applies to accounts maintained outside the U.S.)

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

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. 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:

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. 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
4. 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.