



2201 West Broad Street
Suite 205
Richmond, Virginia 23220
Phone: 804-643-2287 Fax: 804-622-8144
Website: ccvs.ramdocs.org

Credentials Application

EACH HOSPITAL/FACILITY WILL CONSIDER THIS A PRE-APPLICATION UNTIL ELIGIBILITY OF THE APPLICANT IS ESTABLISHED. UPON ESTABLISHMENT OF ELIGIBILITY, THIS WILL BECOME AN OFFICIAL APPLICATION AND WILL BE MOVED FORWARD IN THE PROCESS. IF IT IS DETERMINED THAT THE APPLICANT IS NOT ELIGIBLE FOR APPOINTMENT, THEN THE HOSPITAL/FACILITY WILL NOTIFY THE APPLICANT.

Driver's License Number & State of Issue

Name: _____

Date: _____

Complete all sections that are applicable to you.



I. PERSONAL INFORMATION

Name _____ Gender _____
Last First Initial Suffix Other Name

Date of Birth _____ Marital Status: _____ Name of Spouse: _____

Place of Birth _____ Social Security # _____ U.P.I.N. # _____

Email Address _____ Cell Phone _____

NPI # (National Provider Identifier) _____ Ethnicity _____
(Optional)

Professional Designation (MD, DO, CRNA, PA, etc.): _____

If you are not a US Citizen please complete the following:

Citizenship _____ Visa Type & Expiration _____
Foreign National Identification Number & Country Of Issue _____
Are you eligible to work in the United States? _____ Yes _____ No

II. LIST ALL ADDRESSES:

(Check preferred mailing address. If not currently at this address - **expected starting date:** _____)

___ Practice Address _____ Phone _____
Street Address
City State Zip FAX # _____

___ Mailing Address _____ Phone _____
Street Address
City State Zip FAX # _____

Email address for credentialing contact

___ Home Address _____ Phone _____
Street Address
City State Zip FAX # _____



III. PRACTICE STATUS: Group ____ Partnership ____ Individual ____

Practice Name _____ Tax ID # _____

Office Email _____ Website _____

List name of all physicians in your practice (attach separate sheet if necessary):

Office Manager/Contact Person _____ Direct Phone # _____

Billing Address _____

Answering Service # _____ Pager # _____

Name on back-up physician(s) [PCP must have at least one back-up who is also a member of the same network]:

a) _____
Name Day Phone # After Hours #
Address _____

b) _____
Name Day Phone # After Hours #
Address _____

Name of Physicians who share call if outside your group:

a) _____
Name Day Phone # After Hours #
Address _____

b) _____
Name Day Phone # After Hours #
Address _____

c) _____
Name Day Phone # After Hours #
Address _____

Please list your sponsoring physician and attach a list of any supervising physicians.

a) _____
Name Day Phone # Specialty
Address _____



IV. EDUCATION /TRAINING

COMPLETE ALL SECTIONS IN MM/YY FORMAT

UNDERGRADUATE/GRADUATE EDUCATION:

Institution: _____ **Degree:** _____

Address _____ City _____ State _____ Zip _____
 Dates: ___/___ to ___/___ **Completed** Y N*

Institution: _____ **Degree:** _____

Address _____ City _____ State _____ Zip _____
 Dates: ___/___ to ___/___ **Completed** Y N*

MEDICAL EDUCATION:

Institution: _____ **Degree:** _____

Address _____ City _____ State _____ Zip _____
 Dates: ___/___ to ___/___ **Completed** Y N*

Institution: _____ **Degree:** _____

Address _____ City _____ State _____ Zip _____
 Dates: ___/___ to ___/___ **Completed** Y N*

INTERNSHIP(S):

Institution: _____ **Dates:** ___/___ to ___/___

Address _____ City _____ State _____ Zip _____
 Program Director: _____ Specialty _____ **Completed** Y N*

Institution: _____ **Dates:** ___/___ to ___/___

Address _____ City _____ State _____ Zip _____
 Program Director: _____ Specialty _____ **Completed** Y N*

RESIDENCY(IES):

Institution: _____ **Dates:** ___/___ to ___/___

Address _____ City _____ State _____ Zip _____
 Program Director: _____ Specialty _____ **Completed** Y N*

Institution: _____ **Dates:** ___/___ to ___/___

Address _____ City _____ State _____ Zip _____
 Program Director: _____ Specialty _____ **Completed** Y N*

FELLOWSHIP(S):

Institution: _____ Dates: ____/____ to ____/____

Address _____ City _____ State _____ Zip _____
 Program Director: _____ Specialty _____ Completed Y N*

Institution: _____ Dates: ____/____ to ____/____

Address _____ City _____ State _____ Zip _____
 Program Director: _____ Specialty _____ Completed Y N*

* If answered No, please explain why: _____

LIST TEACHING OR UNIVERSITY APPOINTMENTS HELD:

Facility	City	State	Title	Department	From	To

V. LIST ALL MEDICAL AND SURGICAL EXPERIENCES IN THE ARMED SERVICES AND/OR PUBLIC HEALTH SERVICE, WITH DATES AND LOCATIONS:

Are you currently on active or reserve military duty? Yes No

If you are no longer in active Military Service, please provide a copy of your DD214.

Branch of Service: _____ Hospital/Clinic: _____
Supervisor Who Can Confirm Service: _____

Address _____ City _____ State _____ Zip _____
 Phone: _____ Fax: _____

Dates of Service: ____/____ to ____/____

Branch of Service: _____ Hospital/Clinic: _____
Supervisor Who Can Confirm Service: _____

Address _____ City _____ State _____ Zip _____
 Phone: _____ Fax: _____

Dates of Service: ____/____ to ____/____



ECFMG # _____ Date Certification Was Issued _____

FIFTH PATHWAY # _____ Date Certification Was Issued _____

Institution: _____

Address: _____

Please include a copy of your ECFMG or Fifth Pathway certificate.

VII. WORK HISTORY

Chronologically list all medical practices since training in MM/YY format. Please account for any gaps in training and/or practice. If additional space is needed, please copy this section or attach a separate sheet. Please note: "see cv" and "see attached" are not acceptable:

-Practice Name _____ Date: ____/____ to ____/____

Address City State Zip

Reason for leaving: _____

Phone: _____ Fax: _____

-Practice Name _____ Date: ____/____ to ____/____

Address City State Zip

Reason for leaving: _____

Phone: _____ Fax: _____

-Practice Name _____ Date: ____/____ to ____/____

Address City State Zip

Reason for leaving: _____

Phone: _____ Fax: _____

-Practice Name _____ Date: ____/____ to ____/____

Address City State Zip

Reason for leaving: _____

Phone: _____ Fax: _____

-Practice Name _____ Date: ____/____ to ____/____

Address City State Zip

Reason for leaving: _____

Phone: _____ Fax: _____

VIII. HOSPITAL/HEALTHCARE FACILITY AFFILIATIONS

List present and previous hospital/health care facility affiliation(s) in MM/YY format (do not list hospitals which are part of your internship(s) and residency(ies)). Please account for any gaps in practice. If additional space is needed, please copy this section or attach a separate sheet. Please note: "see cv" and "see attached" are not acceptable:

PRIMARY Facility _____ Dates: ___/___ to ___/___

Address _____ City _____ State _____ Zip _____
Phone: _____ Fax: _____

Position/Category: _____ Reason for Leaving: _____

-Facility _____ Dates: ___/___ to ___/___

Address _____ City _____ State _____ Zip _____
Phone: _____ Fax: _____

Position/Category: _____ Reason for Leaving: _____

-Facility _____ Dates: ___/___ to ___/___

Address _____ City _____ State _____ Zip _____
Phone: _____ Fax: _____

Position/Category: _____ Reason for Leaving: _____

-Facility _____ Dates: ___/___ to ___/___

Address _____ City _____ State _____ Zip _____
Phone: _____ Fax: _____

Position/Category: _____ Reason for Leaving: _____

-Facility _____ Dates: ___/___ to ___/___

Address _____ City _____ State _____ Zip _____
Phone: _____ Fax: _____

Position/Category: _____ Reason for Leaving: _____

IX. MEDICAL PRACTICE:

GIVE A NARRATIVE DESCRIPTION OF YOUR MEDICAL PRACTICE, INCLUDING SPECIFIC INTERESTS.

* Attention emergency room MDs, radiologists, pathologists and anesthesiologists: Please provide hospitals in which you render service under a contract with the facility or as an employee.

Is your practice limited to a specialty or subspecialty? If so, please indicate.

Do you place any age limitations on your type of patient population? Yes No if yes, list:

Medicaid #: _____

Medicare #: _____

Your Medigap payment should be mailed to: the provider the insured

Your FEP Medigap should be mailed to: the provider the insured

Are you fluent in languages other than English? Yes No

If yes, what languages? _____

Do you perform the following procedures or treat any of the following conditions in your office?

- | | | |
|--|--|--|
| <input type="checkbox"/> Lab | <input type="checkbox"/> Cardiac stress test | <input type="checkbox"/> X-rays |
| <input type="checkbox"/> Pulmonary functions | <input type="checkbox"/> EKGs | <input type="checkbox"/> Allergy injections |
| <input type="checkbox"/> Other _____ | | <input type="checkbox"/> Care of minor lacerations |

PROFESSIONAL FELLOWSHIPS, MEMBERSHIPS AND SOCIETIES (List all past and present, including state and county medical societies, with dates):

X. CERTIFICATION BY SPECIALTY BOARD

If you are *certified* by a specialty board, indicate the:

Name of the Board: _____

Date certification will expire: _____ Date of certification: _____

Name of the Board: _____

Date certification will expire: _____ Date of certification: _____

If you have *applied* to a specialty board for examination give the:

Name of the Board: _____

Application Date: _____ Date of Exam: _____

If you have taken and failed to pass a specialty board examination, please list the board's name and date of examination(s): _____

If status is one of eligibility, indicate date eligibility status will terminate under rules of that specific board: _____

XI. LICENSURE: Virginia Board of Medicine (include a copy of current license):

Number: _____ Issue Date: _____

Expiration Date: _____

DEA REGISTRATION: Narcotic License (include a copy of your current DEA Certificate):

Number: _____ State of Registration: _____

Issue Date: _____ Expiration Date: _____

Please list all other states or localities where you hold, or have held, a medical license. List the license number after each state or locality and provide a copy of the license.

1. ___# _____ Exp. Date _____ 4. ___# _____ Exp. Date _____

2. ___# _____ Exp. Date _____ 5. ___# _____ Exp. Date _____

3. ___# _____ Exp. Date _____ 6. ___# _____ Exp. Date _____

XII. LIABILITY INSURANCE

Please list each carrier for the last **FIVE** years and include copies of certificates. **Include** carrier(s) during residency or fellowship training, if applicable. **Make additional copies of this page as necessary.**

a. Amount of coverage _____ Retroactive Date _____

Policy # _____ Policy in force from ____/____ to ____/____

Insurance Carrier _____

Agent _____

Agent's Address _____

Phone: _____ Fax: _____

Are any specific procedures excluded from your insurance coverage? Yes No

If yes, please list _____

Type of Coverage: **(Check One)** Claims Made Occurrence Tail
 (Check One) Individual Shared

b. Amount of coverage _____ Retroactive Date _____

Policy # _____ Policy in force from ____/____ to ____/____

Insurance Carrier _____

Agent _____

Agent's Address _____

Phone: _____ Fax: _____

Are any specific procedures excluded from your insurance coverage? Yes No

If yes, please list _____

Type of Coverage: **(Check One)** Claims Made Occurrence Tail
 (Check One) Individual Shared

XIII. PROFESSIONAL REFERENCES:

List three practitioners who currently work extensively with you or have observed your work within the last two (2) years. (Please make sure that you are including a reference outside of your group. At least one reference must be in your specialty and of the same discipline as yourself.) References must be providers in your same professional discipline. *Mid Level Practitioners (e.g. NP, PA, CRNA, etc.) may use all office associates – one must be a physician. References with familial ties will not be used.

If you completed training in the past two years, please list your Program Director.

1. Name _____ Title _____
Address _____
City, State, Zip _____
Phone _____ Fax _____
Email Address _____

2. Name _____ Title _____
Address _____
City, State, Zip _____
Phone _____ Fax _____
Email Address _____

3. Name _____ Title _____
Address _____
City, State, Zip _____
Phone _____ Fax _____
Email Address _____

XIV. DISCLOSURE QUESTIONS

IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED IN THE AFFIRMATIVE, PLEASE PROVIDE A FULL EXPLANATION ON A SEPARATE SHEET OF PAPER:

Licensure

1.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your license to practice medicine in any jurisdiction ever been limited, suspended, not renewed, refused, voluntarily or involuntarily relinquished, or revoked (i.e. stipulations)?
2.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had any disciplinary actions taken by any board you have been/are licensed by (including reprimands, censures, probation, etc.)?

Hospital Privileges and Other Affiliations

3.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been refused membership on a hospital medical staff?
4.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your request for specific clinical privileges ever been denied or granted with stated limitations, or have your hospital privileges ever been voluntarily or involuntarily suspended, limited, revoked, or not renewed? If so, at which hospitals?
5.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever voluntarily or involuntarily relinquished your hospital clinical privileges or medical staff memberships? if so, which hospital(s)?
6.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been terminated for cause or not renewed for cause from participation or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?
7.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you perform any procedure in your office for which you do not have privileges at a hospital?

Education, Training and Board Certification

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

DEA or State Controlled Substance Registration

12.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your DEA number (narcotics license) or other controlled substance authorization or any state pharmaceutical certificate ever been suspended or revoked, denied, reduced or not renewed?
13.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever voluntarily or involuntarily relinquished your DEA registration?

Medicare, Medicaid or other Governmental Program Participation

14.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization or local, state, or national professional society (including Medicare, Medicaid, any third party payor, or peer review organization)?
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Other Sanctions or Investigations

15.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently, or have you ever been a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?
16.	<input type="checkbox"/> Yes <input type="checkbox"/> No	To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?
17.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g. CLIA, OSHA, etc.)?
18.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action for sexual harassment or other illegal misconduct?
19.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility or any military agency?
20.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been the subject of focused individual monitoring relating to your clinical competence or professional conduct at a hospital, healthcare facility, or managed care organization?
21.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been the subject of formal or informal review, challenges, disciplinary actions for unprofessional conduct or unethical behavior?
22.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are any actions currently pending against you by any federal or state regulatory authorities, or by any hospital or provider?

Professional Liability Insurance Information and Claims History

23.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had any professional liability cases brought against you in the last five years?
24.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have any final judgments or settlements on malpractice claims ever been paid by you or on your behalf by another entity? (If a settlement was made by your insurance carrier without your consent, please note.)
25.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently have any pending malpractice cases?
26.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your liability coverage ever been canceled?
27.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?
28.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you requesting any privileges not covered by your current liability carrier?

Criminal/Civil History

29.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently charged with or have you ever been convicted of a felony or misdemeanor (other than a minor traffic violation)?
30.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been charged with a crime or traffic offense involving alcohol or a controlled substance?
31.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been court-martialed for actions related to your duties as a medical professional?

Ability to Perform Job

32.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently engaged in the illegal use of drugs? (“Currently” means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one’s ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. “Illegal use of drugs” refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. §812.22. It does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law. The term does include, however, the unlawful use of prescription controlled substances.)
33.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use any chemical substance that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?
34.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?
35.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodations?

Health History

36.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you now or within the past five years alcohol or drug dependent?
37.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you presently have, or ever had, any physical or mental condition which would affect your ability to exercise the clinical privileges requested or would require an accommodation in order for you to exercise the privileges requested safely and competently? (Regardless of how the applicant answers this question, the application will be processed in the usual manner.)
38.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently under the care of a physician or psychologist, or have you ever participated in any physician recovery program established pursuant to a state statute?

PLEASE INDICATE INSTITUTIONS WHERE YOU WISH TO SEEK A STAFF APPOINTMENT:

<p>BON SECOURS HOSPITALS:</p> <p><input type="checkbox"/> Memorial Regional Medical Center</p> <p><input type="checkbox"/> Richmond Community Hospital</p> <p><input type="checkbox"/> St. Mary's Hospital</p> <p><input type="checkbox"/> St. Francis Medical Center</p> <p>OTHER FACILITIES:</p> <p><input type="checkbox"/> Advanced Orthopaedic Center</p> <p><input type="checkbox"/> Colonial Heights Surgery Center</p> <p><input type="checkbox"/> Hallmark Youthcare</p> <p><input type="checkbox"/> Hanover Outpatient Surgery</p> <p><input type="checkbox"/> Kindred Hospital East</p> <p><input type="checkbox"/> HealthSouth Rehab Hospital - Richmond</p>	<p>HCA HOSPITALS:</p> <p><input type="checkbox"/> CJW Medical Center</p> <p><input type="checkbox"/> Henrico Doctors' Hospital-Forest, Retreat and Parham Campus</p> <p><input type="checkbox"/> John Randolph Medical Center</p> <p><input type="checkbox"/> Parham Surgery Center</p> <p><input type="checkbox"/> Sheltering Arms Rehabilitation Hanover</p> <p><input type="checkbox"/> Sheltering Arms Rehabilitation South</p> <p><input type="checkbox"/> Urological Surgery Center</p> <p><input type="checkbox"/> Virginia Physicians for Women Surgery Center</p> <p><input type="checkbox"/> Virginia Eye Institute Surgery Center</p>
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PLEASE ATTACH ALL OF THE FOLLOWING TO YOUR COMPLETED APPLICATION

1. Copy of your current Curriculum Vitae.
2. Copy of each current License Certificates.
3. Copy of your current face sheet of your current professional liability insurance policy.
4. Copies of your degree, internship, residency and fellowship certificates.
5. Copies of ECFMG and Fifth Pathway certificates (if applicable).
6. Copy of your board certification, recertification or letter from specialty board.
7. Copies of your current DEA (Federal) certificate applicable to Virginia.
8. Copy of your DD-214 (Prior Military only).
9. Copy of Visa if not US Citizen.
10. Application fee (\$350 for Non-RAM members, \$750 for Locum Tenens, \$250 for RAM members, \$225 for Mid Level Practitioners, \$600 for complex Mid Level files, if applicable- Make check payable to: CCVS (Centralized Credentials Verification Service, Inc.)
11. Recent passport-size photograph.
12. Copies of all continuing education certificates for the past three years (should total 60).
13. Copies of expired licenses, malpractice insurances you may be able to provide.
14. Evidence of annual PPD.
15. Mid-level practitioners must include any practice agreements, written protocols or other applications submitted to appropriate board in order to practice and a copy of the approval letter obtained.

AUTHORIZATION AND RELEASE OF APPLICANT

(Please read carefully before signing)

I understand and acknowledge that, as an applicant for medical staff membership at the hospital, ambulatory care center or other health care facility ("Facilities") indicated in this Application for Appointment, and/or for participation with any third party payors indicated in this Application ("Third Party Payors"), it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, health status, character, ethics and any other criteria adopted by Facilities for medical staff membership or medical surgical privileges or by Third Party Payors for participation.

I acknowledge my pledge to provide for continuous care for my patients. I further acknowledge that I am responsible for knowing the contents of the bylaws, rules and regulations of the Facilities and their medical staffs and of the Third Party Payors, and agree to be bound by them in the application process and if granted membership or participation.

I further understand and acknowledge that Centralized Credentials Verification Service ("CCVS") will investigate the information in this Application. By submitting this Application, I agree to such investigation and to the reporting and information exchange activities of CCVS, Third Party Payors and Facilities as a part of the Centralized Credentials Verification Service program, as follows:

- 1. Authorization of Investigation and Release of Information Concerning Application.** I hereby authorize all individuals, institutions and entities (including but not limited to administrators and members of the medical staffs of other Facilities or institutions with which I have been associated; administrators, employees and participants of other Third Party Payors with which I have been associated; and all professional liability insurers with which I have had or currently have professional liability insurance) who have knowledge concerning information requested in this Application, to consult with and release relevant information to CCVS, Third Party Payors and Facilities, their medical staffs and agents. I further authorize CCVS to release all such information to all Facilities and Third Party Payors that participate in the CCVS program and with which I am affiliated.
- 2. Authorization of Release and Exchange of Disciplinary Information.** I hereby authorize any Facilities at which I have, or have had, medical staff membership and any Third Party Payors with which I participate, or have participated, to release Disciplinary Information about any disciplinary action taken against me to CCVS, its other participating Facilities, other physician- sponsored credentialing programs and their participating Facilities, and as otherwise may be required by law. I further authorize CCVS to release Disciplinary Information to all Facilities and Third Party Payors that participate in the CCVS program and with which I am affiliated. As used herein, Disciplinary Information means information concerning (i) any action taken by such Facilities, their administrators or medical staff or other committees to revoke, suspend, restrict or condition my privileges; (ii) any other denial of privileges to me; (iii) any other disciplinary action involving me; or (iv) my resignation prior to the conclusion of any disciplinary proceeding or prior to the commencement of formal charges but after I have knowledge that such formal charges are contemplated and/or in preparation.
- 3. Release from Liability.** I hereby fully, absolutely, and unconditionally release from liability Facilities (including but not limited to those participating in the CCVS program and their medical staffs), CCVS, Third Party Payors and their respective agents, and all other individuals, institutions and entities providing information in accordance with the authorizations contained herein for all their acts performed in good faith and without malice in connection with the investigation of this Application and the release and exchange of Disciplinary Information authorized above, including



but not limited to the acts of preparing or completing any verifications, evaluations, recommendations, information requests, or forms that are provided by the applicant, CCVS, Facilities, or Third Party Payors. This release shall be in addition to any other applicable immunities provided by law for peer review activities or otherwise.

I understand and agree that the authorizations and releases given by me herein shall be irrevocable so long as I am an applicant for or have medical staff privileges at any Facilities participating in CCVS's credentialing program, and/or so long as I am participating with one or more Third Party Payors designated in this Application.

I acknowledge that the investigation of information in this Application and the release and exchange of Disciplinary Information by the Facilities, CCVS and Third Party Payors and their agents are done to achieve, maintain and improve the quality of patient care.

All information provided by me in the Application is correct and complete to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the Application may constitute grounds for denial of appointment or for summary dismissal from the medical staff and/or Third Party Payors. I understand and acknowledge that the Facilities shall be solely responsible for all decisions concerning medical staff membership and the granting of medical and surgical privileges, and that Third Party Payors shall be solely responsible for all decisions concerning participation with such Third Party Payors. I further understand and acknowledge that CCVS shall have no responsibility or liability with respect to medical staff membership decisions by Facilities or participation decisions by Third Party Payors.

I further acknowledge that I have read and understand the foregoing Authorization and release.

A photocopy of this Authorization and Release shall be as effective as the original.

Name _____ Date _____
(Please Print)

Signature _____

Mail completed application to:

**CCVS, Inc.
2201 West Broad Street, Suite 205
Richmond, VA 23220**