CONFIDENTIAL/PROPRIETARY

# ALLIED HEALTH PRACTITIONER APPLICATION

**This application is submitted to:** INLAND EMPIRE FOUNDATION FOR MEDICAL CARE

## INSTRUCTIONS:

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. **Current copies of the following documents must be submitted with this application:**

- State Professional License(s)
- DEA Certificate (if applicable)
- Board Certification (if applicable)
- Face Sheet of Professional Liability Certification
- Curriculum Vitae

## IDENTIFYING INFORMATION

| | | |
|---|---|---|
| Last Name: | First: | Middle: |
| Is there any other name under which you have been known? Name (s): | | |
| Home Mailing Address: | City: | |
| | State: | ZIP: |
| Home Telephone Number: ( ) | Home Fax Number: ( ) | |
| Birth Date: | Citizenship: | |
| Social Security # | ☐ Male | ☐ Female |

## PRACTICE INFORMATION

| | | |
|---|---|---|
| Practice Name (if applicable): | | |
| Primary Office Mailing Address: | City: | |
| | State: | ZIP: |
| Telephone Number: ( ) | Fax Number: ( ) | |
| Office Manager/Administrator: | Telephone Number: ( ) | |
| | Fax Number: ( ) | |
| Name Affiliated with Tax ID Number: | Federal Tax ID Number: | |
| Secondary Office Mailing Address: | City: | |
| | State: | ZIP: |
| Name Affiliated with Tax ID Number: | Federal Tax ID Number: | |

| Medicare UPIN (if applicable) |
|---|
| Specialty: |
| Subspecialties: |

## PROFESSIONAL EDUCATION

| Professional School: | Mailing Address: | | Degree Received: |
|---|---|---|---|
| City: | State: | ZIP: | Date of Graduation: |
| Professional School: | Mailing Address: | | Degree Received: |
| City: | State: | ZIP: | Date of Graduation: |

## POST GRADUATE TRAINING

| Institution: | | | |
|---|---|---|---|
| Mailing Address: | | City: | |
| State: | ZIP: | Program Director: | |
| Type of Training: | | | |
| Specialty: | From: | To: | |
| Institution: | | Program Director: | |
| Mailing Address: | City: | State: | ZIP: |
| Type of Training: | Specialty: | From: (mm/yy) | To: (mm/yy) |

Did you successfully complete the program? ☐ Yes ☐ No (If "No," please explain on separate sheet.)

| Institution: | | | |
|---|---|---|---|
| Mailing Address: | City: | State: | ZIP: |
| Type of Training: | Specialty: | From: | To: |

Did you successfully complete the program? ☐ Yes ☐ No (If "No," please explain on separate sheet.)

| LICENSURE | |
|---|---|
| California State Professional License Number: | Expiration Date: |
| Drug Enforcement Administration (DEA) Registration Number: | Expiration Date: |
| Controlled Dangerous Substances Certificate (CDS) (if applicable): | Expiration Date: |

| ALL OTHER STATE LICENSES | | |
|---|---|---|
| State: | License Number: | Expiration Date: |
| State: | License Number: | Expiration Date: |
| State: | License Number: | Expiration Date: |

| OTHER CERTIFICATIONS (E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.) | | |
|---|---|---|
| Type: | Number: | Expiration Date: |
| Type: | Number: | Expiration Date: |

**BOARD CERTIFICATION**

Include certifications by board(s) which are duly organized and recognized :

| Name of Issuing Board | Certificate Number | Date Certified/Recertified | Expiration Date (if any) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Have you applied for board certification other than those indicated above? Yes ☐ No ☐

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for Certification on separate sheet.

**CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS**

Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B) during the past ten years. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s).

## A. CURRENT AFFILIATIONS

| | |
|---|---|
| Name, City, and State of Primary Admitting Hospital/Institution (if applicable): | Department: |
| Status (active, provisional, courtesy, temporary, etc.): | Appointment Date: |
| Name, City, and State of Secondary Admitting Hospital/Institution (if applicable): | Department: |
| Status: | Appointment Date: |
| Name, City, and State of Other Institutions: | Department: |
| Status: | Appointment Date: |

## B. PREVIOUS HOSPITAL AND OTHER INSTITUTION AFFILIATIONS

| | | |
|---|---|---|
| Name, City and State of Affiliation: | | Department: |
| From: (mm/yy) | To: (mm/yy) | Reason for Leaving: |
| Name, City and State of Affiliation: | | Department: |
| From: (mm/yy) | To: (mm/yy) | Reason for Leaving: |
| Name, City and State of Affiliation: | | Department: |
| From: (mm/yy) | To: (mm/yy) | Reason for Leaving: |

## SUPPLEMENTAL PEER REFERENCES

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Professional Staff of each facility at which you have privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

| | | |
|---|---|---|
| Name of Reference: | Title: | Telephone Number: ( ) |
| Mailing Address: | City: | State: |
| | | Zip: |
| Name of Reference: | Title: | Telephone Number: ( ) |
| Mailing Address: | City: | State: |
| | | Zip: |

| Name of Reference: | Title: | Telephone Number: (  ) |
|---|---|---|
| Mailing Address: | City: | State: |
| | | Zip: |

## WORK HISTORY

Chronologically list all work history activities since completion of training (use extra sheets if necessary). This information must be complete. A curriculum vitae is not sufficient. Please explain any gaps on a separate page.

| Current Practice: | Contact Name: | | Telephone Number: (  ) | | |
|---|---|---|---|---|---|
| | | | Fax Number: (  ) | | |
| Mailing Address: | City: | State: | ZIP: | From: (mm/yy) | To: (mm/yy) |
| Name of Practice /Employer: | Contact Name: | | Telephone Number: (  ) | | |
| | | | Fax Number: (  ) | | |
| Mailing Address: | City: | State: | ZIP: | From: (mm/yy) | To: (mm/yy) |
| Name of Practice /Employer: | Contact Name: | | Telephone Number: (  ) | | |
| | | | Fax Number: (  ) | | |
| Mailing Address: | City: | State: | ZIP: | From: (mm/yy) | To: (mm/yy) |

## ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If your answer to any of the following questions is "yes," please provide full details on separate sheet

A. Has your professional license, Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, suspended, revoked, not renewed, or subject to probationary conditions, or have you been fined or received a letter of reprimand—or is such action pending?

Yes ☐ No ☐

B. Have you ever been suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for reasons relating to possible incompetence or improper professional conduct, by Medicare, Medicaid, or any public program—or is any such action pending?

Yes ☐ No ☐

C. Have you ever been denied, for possible incompetence or improper professional conduct, 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), professional association, professional school faculty position or other health delivery entity or system) or have your clinical privileges, membership, participation or employment at any such organization ever been suspended, restricted, revoked or not renewed - or is any such action pending?

Yes ☐ No ☐

D. Have you ever surrendered 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), professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct or in return for such an investigation not being conducted or is any such action pending?

Yes ☐ No ☐

E. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, limited, or not renewed—or is any such action pending?

Yes ☐ No ☐

F. Have you been denied certification / recertification, or has your eligibility status changed with respect to certification / recertification by a specialty board?

Yes ☐ No ☐

## HEALTH STATUS

Are you able to perform all the services required by the applicable participating provider agreement, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?

Yes ☐ No ☐

## CONVICTIONS

Have you ever been convicted of a felony?

Yes ☐ No ☐

If yes, please provide full details on a separate sheet.

| PROFESSIONAL LIABILITY | | | |
|---|---|---|---|
| Insurance Carrier: | Policy Number: | | |
| Mailing Address: | City: | State: | ZIP: |
| Per claim amount :$ | Aggregate amount:$ | Expiration Date: | |

| |
|---|
| Have any judgments been made against you, or settlements been agreed to, in professional liability cases, or are there any filed and served professional liability lawsuits against you pending?<br>Yes ☐ No ☐ |
| Has your professional liability insurance ever been terminated or restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance?<br>Yes ☐ No ☐ |
| If yes to any of the above, please provide details per the attached claims information sheet. Please explain any surcharges to your professional liability coverage on a separate sheet. |

| Please list all of your professional liability carriers for the past ten years: | | | |
|---|---|---|---|
| Name of Carrier: | Mailing Address: | From:<br>(mm/yy) | To:<br>(mm/yy) |
| Policy # | City: | State: | ZIP: |
| Name of Carrier: | Mailing Address: | From:<br>(mm/yy) | To:<br>(mm/yy) |
| Policy# | City: | State: | ZIP: |
| Name of Carrier: | Mailing Address: | From:<br>(mm/yy) | To:<br>(mm/yy) |
| Policy# | City: | State: | ZIP: |
| Name of Carrier: | Mailing Address: | From:<br>(mm/yy) | To:<br>(mm/yy) |
| Policy# | City: | State: | ZIP: |

## INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications ("peer review 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 businesses and individuals acting as their agents—collectively "Healthcare Organizations,") 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 peer review information from being further disclosed.

I am informed and acknowledge that federal and state 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 peer review 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.

I also agree to notify this Healthcare Organization in writing, within five (5) days of receiving any written or oral notice of any adverse action, including, without limitation, any filed and served malpractice suit or arbitration action; any adverse action by my professional licensing board taken or pending, including but not limited to, any accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter or reprimand, public reproval, and any formal restriction, probation, suspension or revocation of licensure; any adverse action taken by any Healthcare Organization, which has resulted in the filing of a Section 805 report with my professional licensing board, or a report with the National Practitioner Data Bank; any revocation of DEA license; a conviction of any felony or a misdemeanor of moral turpitude; any action against any certification under the Medicare or Medicaid programs; or any cancellation, non-renewal or material reduction in medical liability insurance policy coverage.

I hereby affirm that the information submitted in this application and any addenda thereto is true to the best of my knowledge and belief and is furnished in good faith. I understand that significant omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or allied health practitioner participation agreement.

A photocopy of this document shall be as effective as the original.

Print Name Here: _____

Signature: _____ Date: _____

(Stamped Signature Is Not Acceptable)

# California Participating Physician Application

## *Addendum A*

## Health Plans and IPA's/Medical Groups

This Addendum is submitted to INLAND EMPIRE FOUNDATION FOR MEDICAL CARE his Healthcare Organization.[1]

| I. IDENTIFYING INFORMATION | | |
|---|---|---|
| Last Name: | First: | Middle: |
| Medical Group (s) /IPA(s) Affiliation: | | |
| Do you intend to serve as a primary care provider? ☐ Yes ☐ No<br>Do you intend to serve as a specialist? ☐ Yes ☐ No (If yes, please list specialty(s)) | | |
| Please check all that apply:<br>☐ Solo Practice ☐ Single Specialty<br>☐ Group Practice ☐ Multi specialty | | |

| II. BILLING INFORMATION | | |
|---|---|---|
| Billing Company: | | |
| Street Address: | City: | |
| | State: | ZIP: |
| Contact: | Telephone Number: ( ) | |
| Name Affiliated with Tax ID Number: | Federal Tax ID Number: | |

**III. PRACTICE INFORMATION**

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? ☐ Yes ☐ No

If so, please list:

| Name: | Type of Provider: | License Number: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

If you are a Physician Assistant Supervisor, please include State License Number:____

Do you personally employ any physicians (do not include physicians that are employed by the medal group)? ☐ Yes ☐ No

If so, please list:

| Name: | California Medical License Number: |
|---|---|
| | |
| | |

[1] The term "this Healthcare Organization" shall refer to the entity to which this Addendum is submitted as identified above.

Please list any clinical services you perform that are not typically associated with your specialty: _____

Please list any clinical services you **do not** perform that are typically associated with your specialty: _____

Is your practice limited to certain ages? ☐Yes ☐No
If yes, specify limitations: _____

Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council? ☐Yes ☐No

Do you participate in EDI (electronic data interchange)? ☐Yes ☐No
If so, which Network? _____
Do you use a practice management system/software: ☐Yes ☐No

If so, which one? _____

What type of anesthesia do you provide in your group/office?
☐ Local ☐Regional ☐Conscious Sedation ☐General ☐None ☐Other (please specify) _____

Has your office received any of the following accreditations, certifications or licensures?
☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
☐ California Department of Health Services Licensure
☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQAAAHC)
☐ Medicare Certification
☐ The Medical Quality Commission (TMQC)
☐ Other _

## IV. OFFICE HOURS - Please indicate the hours your office is open:

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday | Holidays |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

## V. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary)

| | | |
|---|---|---|
| Answering Service Company: | Phone Number: ( ) | Fax Number: ( ) |

| | | |
|---|---|---|
| Mailing Address: | City: | |
| | State: | ZIP: |
| Covering Physician's Name: | Telephone Number: ( ) | |
| Covering Physician's Name: | Telephone Number: ( ) | |
| Covering Physician's Name: | Telephone Number: ( ) | |
| Covering Physician's Name: | Telephone Number: ( ) | |

If you do not have hospital privileges, please provide written plan for continuity of care:

## VI. FOREIGN LANGUAGES SPOKEN

| Fluently by Physician: | Fluently by Staff: |
|---|---|
| | |

## VII. LABORATORY SERVICES

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

| Tax ID #: | Billing Name: | Type of Service Provided: |
|---|---|---|
| Do you have a CLIA certificate? | ☐ Yes | ☐ No |
| Do you have a CLIA waiver? | ☐ Yes | ☐ No |
| Certificate Number: | | Certificate Expiration Date: |

## VIII. PROFESSIONAL ORGANIZATIONS

Please list country, state or national medical societies, or other professional organizations or societies of which you are a member or applicant.

| Organization Name | Applicant | Member |
|---|---|---|
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |

I certify that the information in this document and any attached documents is true and correct.

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: INLAND EMPIRE FOUNDATION FOR MEDICAL CARE herein, this Healthcare organization

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

| Last Name: | First: | Middle: |
|---|---|---|
| Street Address: | City | |
| | State: | ZIP: |

### II. CASE INFORMATION

| City, County and State where lawsuits filed: | Case Number, if known: | | |
|---|---|---|---|
| Date of alleged incident serving as basis for the lawsuit/arbitration | Date Suit Filed: | Sex of patient: | Age of patient: |

**Location of Incident:**

☐ Hospital ☐ My office ☐ Other doctor's office ☐ Surgery Center

☐ 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?** ☐ Yes ☐ 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 section of this Addendum, the term "this Healthcare Organization" shall refer to the entity to which this Addendum 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 judgement 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 organization 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: _____

Physician Signature: _____ Date: _____
(Stamped Signature Is Not Acceptable)

# California Participating Physician Application

## *Addendum C*

## Practitioner Rights

### I. RIGHT OF REVIEW

As an applicant for credentialing/re-credentialing, you have the right to review information obtained by Inland Empire Foundation for Medical Care for the purpose of evaluating your credentialing or re-credentialing application. This includes non-privileged information obtained from any outside source (e.g., Malpractice insurance carriers, state licensing boards, National Practitioner Data Bank) but does not extend to review of information, references, or recommendations protected by law from disclosure. You may request to review such information at any time by sending a written request via fax or letter to the Credentialing Manager at **3993 Jurupa Ave., Riverside, CA 92506 fax number (951) 686-1363**. The Credentialing Manager, or designee, will notify you within 72 hours of the date and time when such information will be available for review at the Credentialing Department located in Riverside, California.

### II. RIGHT, UPON REQUEST, TO BE INFORMED OF STATUS OF CREDENTIALING/RECREDENTIALING APPLICATION

You have the right to be informed, upon request, of the status of your credentialing and/or re-credentialing application. You may request such information by sending a written request via fax or letter to the Credentialing Manager at the above cited address/fax number. You will be notified in writing and within no more than ten (10) working days of receiving your fax or letter, by return fax or letter, of the current status of your application with respect to outstanding information required to complete the application process.

### III. NOTIFICATION OF DISCREPANCY

Practitioners will be notified when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of a practitioner's malpractice claims history, actions taken against a practitioner's license/certification, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have **not** been reported by the practitioner on his/her application. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

### IV. CORRECTION OF ERRONEOUS INFORMATION

If a practitioner believes that erroneous information has been supplied to IPA by primary sources, the practitioner may correct such information by submitting written notification to the Director of Medical Services. Practitioners must submit a written notice (via fax or letter) along with a detailed explanation to the Director of Medical Services at **3993 Jurupa Ave., Riverside, CA 92506; fax number (951) 686-1363**. Notification to Inland Empire Foundation for Medical Care must occur within 48 hours of Inland Empire Foundation for Medical Care notification to the practitioner of a discrepancy as provided in Section II or within 24 hours of a practitioner's review of his/her credential file as provided in Section I.

Upon receipt of notification from the practitioner, Inland Empire Foundation for Medical Care will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credential file. If, upon re-review, primary source information remains inconsistent with practitioner's notification, the Director of Medical Services will so notify the practitioner via fax or letter. The practitioner may then provide proof of correction by the primary source body to Inland Empire Foundation for Medical Care via fax or letter at the address above within ten (10) working days. The Credentialing Department will re-verify primary source information if such documentation is provided. If, after ten (10) working days, primary source information remains in dispute, the practitioner will be subject to action under the Policies and Procedures of the Inland Empire Foundation for Medical Care, up to administrative denial/termination.

Print Name: _____

Signature: _____ Date: _____

(Stamped Signature is not acceptable)

Form **W-9**
(Rev. December 2011)
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.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

## Part I Taxpayer Identification Number (TIN)

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

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

Social security number
___ - ___ - ____

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).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

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

## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

## Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. 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.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.