

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or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, limited, or not renewed—or is any such action pending?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

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?

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: (mm/yy)	To: (mm/yy)
Policy #	City:	State:	ZIP:
Name of Carrier:	Mailing Address:	From: (mm/yy)	To: (mm/yy)
Policy#	City:	State:	ZIP:
Name of Carrier:	Mailing Address:	From: (mm/yy)	To: (mm/yy)
Policy#	City:	State:	ZIP:
Name of Carrier:	Mailing Address:	From: (mm/yy)	To: (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 recertification 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 reproof, 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 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you intend to serve as a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please list specialty(s))		
Please check all that apply:		
<input type="checkbox"/> Solo Practice	<input type="checkbox"/> Single Specialty	
<input type="checkbox"/> Group Practice	<input type="checkbox"/> 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.)? <input type="checkbox"/> Yes <input type="checkbox"/> 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 medical group)? <input type="checkbox"/> Yes <input type="checkbox"/> 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
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

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

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/RE-CREDENTIALING 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)

Physician Name: _____

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: <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnerstep) ▶ _____ <input type="checkbox"/> Other (see instructions) ▶ _____	
	<input type="checkbox"/> 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.

Social security number	
	-

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

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 ▶ _____
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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.