Washington Practitioner Application

To use the Washington Practitioner Application (WPA), follow these instructions:

- **Keep an <u>unsigned</u> and <u>undated</u> copy of the application on file for future requests.** When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate. Please sign and date pages 12 and 14. Please document any YES responses on the Attestation Question page.
- Identify the health care related organization(s) to which this application is being submitted in the space provided below.
- Attach copies of requested documents each time the application is submitted.
- If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- If a section does not apply to you, please check the provided box at the top of the section.
- Expect addendums from the requesting organizations for information not included on the WPA.

This application is submitted to:

1. 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. *<u>Please do not use abbreviations</u>*. **Current copies of the following documents must be submitted with this application:** (all are required for MDs, DOs; as applicable for other health practitioners).

- State Professional License(s)
- DEA Certificate
- ECFMG (if applicable)
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application.)

**** All sections must be completed in their entirety. ****

2. PRACTITIONER INFORMATION – Legal Name Required

Last Name: (include suffix; Jr., Sr., III)	First:	Middle:	Degree(s):
List any other name(s) under which you have been known by reference, licensing and or educational institutions:			
Home Mailing Address:		City:	
		State:	Zip Code:
Home Telephone Number: ( )	Pager Number: ( )	Cell Phone Number: ( )	E-Mail Address:
Birth Date: (mm/dd/yyyy)	Birth Place (city, state, country):		Citizenship:
Social Security Number:	☐ Male ☐ Female	Languages Spoken by Practitioner:	
Have you ever voluntarily opted-out of Medicare? Yes☐ No ☐			
NPI:	Medicare Number: (WA)	Medicaid (DSHS) Number(s):	L & I Number(s):
Specialty:	Sub specialties:		
Other Professional Interests in Practice, Research, etc.:			

Modification to the wording or format of the Washington Practitioner Application may invalidate the application.

3. PRACTICE INFORMATION **CHECK ALL THAT APPLY**

Effective Date at Primary Practice location (MM/YY) _____

Practice Setting

☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐ Primary Care Site ☐ Urgent Care ☐Other

Practitioner Profile

☐ PCP ☐ Specialist ☐ Check if you are both PCP & OB OB in your practice ☐ Yes ☐ No Deliveries ☐ Yes ☐ No

Name of Practice / Affiliation or Clinic Name:	Department Name (if hospital based):		
Primary Office Street Address:	City:		
	State:	Zip Code:	Org. NPI#:
Patient Appointment Telephone Number: ( )	Fax Number: ( )		
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Office Manager / Administrator Name:	Administration Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Credentialing Contact (if different from above):	Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Name Affiliated with Tax ID Number:	Federal Tax ID Number:		

Is the office wheelchair accessible? ☐Yes ☐No

Are you accepting new patients? ☐Yes ☐No

Have you limited your practice in any way (e.g. 18 years or older?)

☐Yes ☐No If yes, please explain:

_____

_____

Do you currently supervise ARNP's or PA's? ☐Yes ☐No

If yes, please provide the name and specialty below:

_____

_____

Please list languages spoken by office staff:

_____

_____

Office Hours

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Sunday:_____

Do you provide 24 hour coverage? ☐Yes ☐No

If no, please explain how your patients obtain advice and care after hours:

_____

_____

_____

A. Inpatient Coverage Plan (for those without admitting privileges) **Does Not Apply** ☐

Name of Admitting Physician/Practice/Clinic/Group:	Hospital Where privileged:

B. Covering Practitioners/Call Group **Does Not Apply** ☐

Provider Name, Degree	Specialty	Address	Phone Number

Attach a list of additional covering practitioners if needed

Effective Date at Secondary Practice location (MM/YY) _____ **CHECK ALL THAT APPLY**

Practice Setting
☐Clinic/Group ☐Solo Practice ☐Home Based ☐Hospital Based ☐ Primary Care Site ☐ Urgent Care ☐Other

Practitioner Profile
☐ PCP ☐ Specialist ☐ Check if you are both PCP & OB OB in your practice ☐ Yes ☐ No Deliveries ☐ Yes ☐ No

Name of Secondary Practice / Affiliation or Clinic Name:	Department Name (if hospital based):		
Primary Office Street Address:	City:		
	State:	Zip Code:	Org. NPI#
Patient Appointment Telephone Number: ( )	Fax Number: ( )		
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Office Manager / Administrator Name:	Administration Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Credentialing Contact (if different from above):	Telephone Number: ( )		
E-mail Address:	Fax Number: ( )		
Name Affiliated with Tax ID Number:	Federal Tax ID Number:		
Is the office wheelchair accessible? ☐Yes ☐No	Office Hours		
Are you accepting new patients? ☐Yes ☐No Have you limited your practice in any way (e.g. 18 years or older?) ☐Yes ☐No If yes, please explain: _____ _____ Do you currently supervise ARNP's or PA's? ☐Yes ☐No If yes, please provide the name and specialty below: _____ _____ Please list languages spoken by office staff: _____ _____	Monday: _____ Tuesday: _____ Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____ Sunday:_____ Do you provide 24 hour coverage? ☐Yes ☐No If no, please explain how your patients obtain advice and care after hours: _____ _____ _____		

A. Inpatient Coverage Plan (for those without admitting privileges) **Does Not Apply** ☐

Name of Admitting Physician/Practice/Clinic/Group:	Hospital Where privileged:

B. Covering Practitioners/Call Group **Does Not Apply** ☐

Provider Name, Degree	Specialty	Address	Phone Number

Attach a list of additional covering practitioners if needed

LIST OTHER OFFICE LOCATIONS WITH THE ABOVE INFORMATION ON A SEPARATE SHEET

4. PROFESSIONAL LICENSURE, REGISTRATIONS AND CERTIFICATIONS

(Attach Additional Sheet if Necessary)

Washington State Professional License/Registration/Cert Number:	Issue Date:	Expiration Date:
Name of Sponsor if required by licensure, (e.g. Physician's Assistant).		
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Date Issued:

5. ALL OTHER PROFESSIONAL LICENSES, REGISTRATIONS AND CERTIFICATIONS

State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:

6. UNDERGRADUATE EDUCATION (*Do not abbreviate*)

Does Not Apply ☐

College or University Name:	Degree Received(be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)
Mailing Address:	City:	State:	Zip Code:
College or University Name:	Degree Received(be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)
Mailing Address:	City:	State:	Zip Code:

7. MEDICAL/PROFESSIONAL EDUCATION (*Do not abbreviate*)

Medical/Professional School:	Start Date: (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:
Medical/Professional School:	Start Date (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:

8. MASTER DEGREE PROGRAM OR POST GRADUATE EDUCATION

Does Not Apply ☐

Institution:	Address	City	State	Zip Code:
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Program or Course of Study:	Faculty Director:		

9. INTERNSHIP/PGYI (Attach Additional Sheet if Necessary)

Does Not Apply ☐

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Internship:	Specialty:	From (mm/yyyy):	To (mm/yyyy):

10. RESIDENCIES (Attach Additional Sheet if Necessary) **Does Not Apply** ☐

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):

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

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Type of Residency:	Specialty:	From (mm/yyyy):	To (mm/yyyy):

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

11. FELLOWSHIPS (Attach Additional Sheet if Necessary) **Does Not Apply** ☐

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):

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

Institution:	Phone Number:	Fax Number:	Program Director:
Mailing Address:	City:	State:	Zip Code:
Course of Study:		From (mm/yyyy):	To (mm/yyyy):

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

12. PRECEPTORSHIP (Attach Additional Sheet if Necessary) **Does Not Apply** ☐

Institution:	Address:	City:	State:	Zip Code:
Telephone Number ( )	Fax Number ( )	Email Address		
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Training:	Department Chairman:		

13. FACULTY/TEACHING APPOINTMENTS **Does Not Apply** ☐
(Attach Additional Sheet if Necessary)

Institution:	Address:	City:	State:	Zip Code:
Telephone Number ( )	Fax Number ( )	Email Address		
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Position:	Faculty Director:		

14. BOARD CERTIFICATION **Does Not Apply** ☐

Are you board or otherwise professionally certified?

☐ **Yes** If "Yes", please complete below: | ☐ **No** If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.

Issuing Board/Entity and State Issued	Specialty	Date Certified	Date Recertified	Expiration Date (if any)

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

If so, list certification and date:

If you participate in a specialty which does not have board certification, please indicate specialty:

15. OTHER CERTIFICATIONS ACLS, BLS, ATLS, PALS, NALS (e.g., Fluoroscopy, Radiography, etc.)
(Attach Certificate if Applicable)

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

16. HOSPITAL, MILITARY, AND OTHER INSTITUTIONAL AFFILITATIONS **Does Not Apply** ☐

Please list in **reverse chronological order (with the current affiliation(s) first)** all institutions where you (A) have current affiliations, (B) applications in process, (C) have had previous affiliations or, if no current affiliation, (D) have a current coverage plan. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.

A. CURRENT HOSPITAL AFFILIATIONS (*Do not abbreviate*)

Name of Primary Admitting Hospital:	Department:
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date:

Can you admit / follow clients of your primary, secondary, other practice locations? **Does Not Apply** ☐
☐ **Primary practice admits only** ☐ **Secondary Practice admits only** ☐ **can admit to for all locations**

Name of Secondary Admitting Hospital:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date:

Can you admit / follow clients of your primary, secondary, other practice locations? **Does Not Apply** ☐
☐ Primary practice admits only ☐ Secondary Practice admits only ☐ Can admit to for all location**s**

Name of Other Institutions:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date:
Can you admit / follow clients of your primary, secondary, other practice locations? **Does Not Apply** ☐ ☐ Primary practice admits only ☐ Secondary Practice admits only ☐ Can admit to for all locations	

B. CURRENT MILITARY AFFILIATIONS (Do not abbreviate) Please include Military Reserves	Division
Name of Primary Base:	City, State , Zip
Mailing Address	Fax Number:
Phone number:	Appointment Date:
Status (active, provisional, courtesy, temporary, etc.):	

C. PREVIOUS MILITARY AFFILIATIONS (Do not abbreviate)	Division
Name of Primary Base:	City, State , Zip
Mailing Address	Fax Number:
Phone number:	Appointment Date:
Status (active, provisional, courtesy, temporary, etc.):	

D. APPLICATIONS IN PROCESS (*Do not abbreviate*)

Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:
Hospital/Institution:	Phone Number/Fax Number:	Date Application Submitted:	
Mailing Address:	City:	State:	Zip Code:

E. PREVIOUS HOSPITAL AFFILIATIONS (*Do not abbreviate*)

Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Phone Number:	Fax Number:	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		

Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Phone Number:	Fax Number:	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		

Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Phone Number:	Fax Number:	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		

17. WORK HISTORY (*Do not abbreviate*)(Do not list if already listed under Hospital Affiliations)

Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. A curriculum vitae is not sufficient.

Name of Practice / Employer:	Contact Name:			Telephone Number: ( )	
Reason for Leaving:	Email Address			Fax Number: ( )	
Mailing Address	City:	State:	Zip:	From (mm/yyyy)	To (mm/yyyy)
Name of Practice / Employer:	Contact Name:			Telephone Number: ( )	
Reason for Leaving:	Email Address			Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):
Name of Practice / Employer:	Contact Name:			Telephone Number: ( )	
Reason for Leaving:	Email Address			Fax Number: ( )	
Mailing Address:	City:	State:	Zip Code:	From (mm/yyyy):	To (mm/yyyy):

18. GAPS IN HISTORY Please account for all gaps between dates of medical/professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable:

	From (mm/yyyy):	To (mm/yyyy):

19. PEER REFERENCES

List at least **three** professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. If you have been out of residency for a period of less then three years, one reference must be from the Program Director. Allied Health Provider must provide at least one reference from the same discipline.

Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ( )	Fax Number: ( )	Cell Phone Number: (Optional) ( )	

20. PROFESSIONAL AFFILIATIONS (*Do not abbreviate*)

Please List Membership In All Professional Societies Complete Name of Society:	Date Joined	Current Member
	/ / .	☐ YES ☐ NO
	/ / .	☐ YES ☐ NO

21. PROFESSIONAL LIABILITY (*Do not abbreviate*)

A. Current Insurance Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: $	Aggregate amount: $	Date Began:	Expiration Date:

B. PREVIOUS PROFESSIONAL LIABILITY CARRIERS WITHIN THE LAST TEN YEARS (Do not abbreviate)

Name of Carrier:			
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Policy Number:		From (mm/yyyy):	To (mm/yyyy):

Modification to the wording or format of the Washington Practitioner Application may invalidate the application.

Name of Carrier:			
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:		
Policy Number:	From (mm/yyyy):	To (mm/yyyy):	
Name of Carrier:			
Mailing Address:	City:	State:	Zip Code:
Phone Number:	Fax Number:		
Policy Number:	From (mm/yyyy):	To (mm/yyyy):	

WASHINGTON PRACTITIONER ATTESTATION QUESTIONS - *To be completed by the practitioner*

Please answer all of the following questions. If your answer to any of the following questions is 'Yes", provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

A.	**PROFESSIONAL SANCTIONS**			
1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?			
	a.	License to practice any profession in any jurisdiction	YES ☐	NO☐
	b.	Other professional registration or certification in any jurisdiction	YES ☐	NO☐
	c.	Specialty or subspecialty board certification	YES ☐	NO☐
	d.	Membership on any hospital medical staff	YES ☐	NO☐
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	YES ☐	NO☐
	f.	Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program	YES ☐	NO☐
	g.	Professional society membership or fellowship	YES ☐	NO☐
	h.	Participation/membership in an HMO, PPO, IPA, PHO or other entity	YES ☐	NO☐
	i.	Academic Appointment	YES ☐	NO☐
	j.	Authority to prescribe controlled substances (DEA or other authority)	YES ☐	NO☐
2.	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		YES ☐	NO☐
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		YES ☐	NO☐
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		YES ☐	NO☐
B.	**CRIMINAL HISTORY**			
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		YES ☐	NO☐
	a.	Do you have notice of any such anticipated charges?	YES ☐	NO☐
	b.	Are you currently under governmental investigation?	YES ☐	NO☐
C.	**AFFIRMATION OF ABILITIES**			
1.	Do you presently use any drugs illegally?		YES ☐	NO☐
2.	Do you have, or have you had in the last five years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.		YES ☐	NO☐
3.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		YES ☐	NO☐
D.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section,** please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)			
1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?		YES ☐	NO☐
2.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgement (court-ordered damage award) in a professional lawsuit?		YES ☐	NO☐
3.	Are there any such claims being asserted against you now?		YES ☐	NO☐
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?		YES ☐	NO☐
5.	Are any of the privileges that you are requesting not covered by your current malpractice coverage?		YES ☐	NO☐

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Applicant's Signature:_____ Date_____

Type or Print name here_____

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22. PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL	**Does Not Apply** ☐
Practitioner Name:(print or type)	
Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected PHI. Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.	
Date and clinical details of the incident, with preceding events: Date: Details:	
Your role and specific responsibility in the incident:	
Subsequent events, including patient's clinical outcome:	
Date suit or claim was filed:	
Name and Address of Insurance Carrier that handled the claim:	
Your status in the legal action (primary defendant, co-defendant, other):	
Current status of suit or other action:	
Date of settlement, judgment, or dismissal:	
If case was settled out-of-court, or with a judgment, settlement amount attributed to you? **$**	

23. ATTESTATION

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name Here: _____

Signature: _____

(Stamped signature is not acceptable)

Date: _____

Review dates and initials:

_____

_____

_____

_____

_____

_____

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Healthcare Organization:
And/or Designated Agent:

WASHINGTON PRACTITIONER APPLICATION AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this authorization and release of information form in conjunction with the Washington Practitioner Application (WPA) and/or the Washington Practitioner Attestation or Credentials Update (CU) form, I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership and/or participating status with the Healthcare Organization(s)* indicated on the WPA for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and or other qualifications in a timely manner. I understand that the application will not be processed until the application is deemed complete by the healthcare organization.
2. I further understand and acknowledge that the Healthcare Organization(s) or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to information exchange activities of the Healthcare Organization(s) as part of the verification and credentialing process.
3. I authorize all individuals, institutions and entities or organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated Healthcare Organization(s), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.
5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with providing information, investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the Healthcare Organization(s) or their respective agent(s) who act in good faith and without malice in connection with the investigation of this application.
6. I acknowledge that I have been informed of, and hereby agree to abide by, the bylaws, rules, regulations, contractual agreements, and policies of the Healthcare Organization.
7 I acknowledge that I am responsible for notifying the Healthcare Organization of any changes/challenges to licensure, DEA, malpractice claims, criminal convictions, hospital privileges or other disciplinary actions.
8. I attest to the accuracy, currency and completeness of the information provided. I understand and agree that any misstatements in or omissions from the CU, WPA, Washington Practitioner Attestation and attachments hereto may constitute cause for denial of the application or summary dismissal or termination of membership/clinical privileges/participation agreement.
9. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Healthcare Organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.
10. I understand that completion and submission of the Authorization and Release does not automatically grant me membership or clinical privileges/participating status with the Healthcare Organization(s)* indicated on the WPA/CU or Attestation.
11. I hereby further authorize and consent to the release of information and/or reporting by the Healthcare Organization(s) to medical associations, licensing boards, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, and other similar organizations regarding any pertinent information which the Healthcare Organization(s) may have concerning me as long as such release of information and/or reporting is done in good faith and without malice, and I hereby release from liability Healthcare Organization(s) and its staff and representatives for so doing.
12. 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 and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation.

Print Name Here: _____

Signature: _____

(Stamped signature is not acceptable)

Date: _____

Healthcare Organization (e.g. hospital, medical staff, medical group, independent practice association, professional review organization health plan, health maintenance organization, preferred provider organization, physician hospital organization, medical society, credentials verification organization, professional association, medical school faculty position or other health delivery entity or system).