RBH
the road to better health

Reliant Behavioral Health, L.L.C.

1220 SW Morrison, Suite 600 • Portland, OR 97205 • 503.802.9800 • 1.877.730.5113 (Toll-free Fax)

Dear Colleague:

Enclosed is your recredentialing application. Please complete the application and return it in the enclosed envelope. Please fill the application out completely with the correct primary street address, mailing address, email address, telephone number, and fax numbers. **After filling out the application, and before signing and dating it, please make a copy of it for your records.** The following documents **must** also be included for the application to be considered complete:

- Copy of current license (s) to practice
- Copy of Federal Registration (DEA) showing expiration dates, if applicable
- Copy of current certificate of professional liability insurance, $1,000,000.00/$3,000,000.00
- Copies of any other documents which would be pertinent to the Credentials process (i.e., SAP, Board certification, continuing education, etc.)
- Copy of your W-9

We are also enclosing a flyer from PRMS about their affordable quality professional liability insurance product. This product is only available to you as a member of the RBH network. We hope it provides another reason for remaining a credentialed and contracted practitioner.

The recredentialing process can take a minimum of eight weeks depending on the length of time it takes to receive and verify all information required. This information will be kept **CONFIDENTIAL.**

Please note:

- **You have the right to know the status of your application.**
- **You have the right to review the information submitted to support your application.**
- **You have the right to correct any erroneous information on your application.**
- **You will be notified of the committees' decision in writing within 60 days of the meeting.**

If you have any questions, please contact me at 1-800-896-6642 and ProviderRelations@reliantbh.com. Thank you for your cooperation in our recredentialing process.

Sincerely,

Doug Lucas

Doug Lucas
Credentialing Representative
Reliant Behavioral Health

Enclosures: Application, Practitioner Profile, W-9, PRMS flyer, addressed envelope

Reliant Behavioral Health
Employee Assistance Program (EAP)
ReCredentialing Application Information

Important: Request for a Reliant Behavioral Health (RBH) EAP Agreement requires **completion of all information requested** on this Credentialing Information Form. The completed Form will be reviewed and verified. Applicants that are successfully approved for EAP Credentialing will be valid for a period of 3 years.
If this information does not meet credentialing criteria, the applicant will be notified.
All information given on this application is CONFIDENTIAL and will NOT be sold or released to any one with out prior authorization from you.

You **Must Enclose** the following document copies:

- **Current state license (if applicable)**
- **Current liability malpractice insurance face sheet (must carry 1m/3m coverage)**
- **DEA Certificate (if applicable)**
- **Narrative of past/current malpractice action(s)**
- **Copy of current W-9**
- **Copies of current certification (CEAP, SAP, Substance abuse)**

I. PRACTITIONER INFORMATION *Please provide the practitioner's full legal name.*

Last Name (include suffix; Jr., Sr., III):	First:	Middle:	Degree(s):

Is there any other name under which you have been known or have used since starting professional training? ☐ Yes ☐ No
Name(s) and Date(s) Used:

Birth Date:	National Practitioner Identifier (NPI) Number:	
E-Mail Address:	Social Security Number:	Gender: ☐ Male ☐ Female

II. SPECIALTY INFORMATION *This information may be included in directory listings.*

Principle clinical specialty	Do you want to be designated as a primary care practitioner (PCP)? ☐ Yes ☐ No
Additional clinical practice specialties:	

Category of professional activity, check all boxes that apply:

Clinical Practice:	Other Professional Activities:
☐ Full Time ☐ Part Time	☐ Administration ☐ Teaching
☐ Locum / Temporary	☐ Research ☐ Retired
☐ Other (explain)	☐ Other (explain)

III. PRACTICE INFORMATION

Name of Practice/Affiliation or Clinic:		Department Name (if hospital based):	
Primary Clinical Practice Street Address:			Effective Date at Location (mm/yy):
City:	County:	State:	Zip:
Primary Office Telephone Number: ( )	Primary Office Fax Number: ( )	Patient Appointment Telephone Number: ( )	
Mailing Address (**if different from above**): Attn:			
Office Manager:	Office Manager's Telephone Number: ( )	Office Manager's Fax Number: ( )	
Exchange / Answering Service Number: ( )	Pager Number: ( )	Office E-Mail Address:	
Credentialing Contact and Address (if different from above):			
Credentialing Contact's Telephone Number: ( )		Credentialing Contact's Fax Number: ( )	
Federal Tax ID Number or Social Security Number, if used for business purposes:		Name Affiliated with Tax ID Number:	
Secondary Clinical Practice Street Address:			Effective Date at Location (mm/yy):
City:	County:	State:	Zip:
Secondary Office Telephone Number: ( )	Secondary Office Fax Number: ( )	Patient Appointment Telephone Number: ( )	
Mailing Address (if different from above): Attn:			
Office Manager:	Office Manager's Telephone Number: ( )	Office Manager's Fax Number: ( )	
Exchange / Answering Service Number: ( )	Pager Number: ( )	Office E-Mail Address:	
Credentialing Contact and Address (if different from above):			
Credentialing Contact's Telephone Number: ( )		Credentialing Contact's Fax Number: ( )	
Federal Tax ID Number or Social Security Number, if used for business purposes:		Name Affiliated with Tax ID Number:	

Please list other office locations with above information on a separate sheet.

IV. PRACTICE CALL COVERAGE *Please provide the name and specialty of those practitioners who will provide call coverage for your practice or attach separate listing.*

NAME: SPECIALTY:

1. _____
2. _____
3. _____
4. _____

V. ADDITIONAL EDUCATION *If you have completed additional residencies, internships or advanced specialized education within the past three (3) years, please provide the following information. Please attach additional sheets, if necessary. .*

Complete Name and Street Address of Program:	City:	State & Zip:

Specialty:	Fax Number, if available: ( )	Month / Year of Completion:
From Month / Year:	To Month / Year:	Course of Study;

Complete Name and Street Address of Program:	City:	State & Zip:

Specialty:	Fax Number, if available: ( )	Month / Year of Completion:
From Month / Year:	To Month / Year:	Course of Study;

VI. HEALTH CARE LICENSURE, REGISTRATIONS, CERTIFICATES & ID NUMBERS *Please attach additional sheets, if necessary.*

State License or Registration Number:	Type:	Expiration Date:
UPIN: **Does Not Apply** ☐	Medicare Number:	
Drug Enforcement Administration (DEA) Registration Number (if applicable):		Expiration Date:
Controlled Substance Registration (CSR) Number (if applicable):		Date Issued:
Educational Commission for Foreign Medical Graduates (ECFMG) Number (if applicable):		Date Issued:
Other Relevant Certifications:		Expiration Date:

VII. OTHER STATE HEALTH CARE LICENSES, REGISTRATIONS & CERTIFICATES *Please include all ever held.*

Does Not Apply ☐

State / Country:		Number:	Type:	Expiration Date:
Year Obtained:	Year Relinquished:	Reason:		
State / Country:		Number:	Type:	Expiration Date:
Year Obtained:	Year Relinquished:	Reason:		
State / Country:		Number:	Type:	Expiration Date:
Year Obtained:	Year Relinquished:	Reason:		
State / Country:		Number:	Type:	Expiration Date:

VIII. PROFESSIONAL PRACTICE / WORK HISTORY

A curriculum vitae is not sufficient.

A. Please chronologically list and account for work, professional and practice history activities for the past three (3) years to present, including military service. **Please explain below in section B any gaps greater than two (2) months.** Please attach additional sheets, if necessary.

Name of Current Practice / Employer:

Contact Name:		Complete Address:
Telephone Number: ( )	Fax Number: ( )	
From (mm/yy):	To (mm/yy):	Job Title:

Name of Previous Practice / Employer:

Contact Name:		Complete Address:
Telephone Number: ( )	Fax Number: ( )	
From (mm/yy):	To (mm/yy):	Job Title:

Name of Previous Practice / Employer:

Contact Name:		Complete Address:
Telephone Number: ( )	Fax Number: ( )	
From (mm/yy):	To (mm/yy):	Job Title:

B. **<u>Please explain any gaps greater than two (2) months.</u> Include activities and/or names and dates where applicable. Please attach additional sheets, if necessary.** **Does Not Apply** ☐

Activities and/or Names:	From (mm/yy):	To (mm/yy):

IX. PROFESSIONAL LIABILITY INSURANCE

Current Insurance Carrier / Provider of Professional Liability Coverage:	Policy Number:	Type of Coverage (check one): Claims-Made ☐ Occurrence ☐
Name of Local Contact:	Mailing Address:	
Contact Telephone Number: ( )		
Per claim limit of liability: $	Aggregate amount: $	
Effective Date:	Retroactive Date, if applicable:	Expiration Date:

Please list all previous professional liability carriers within the past three (3) years. Please attach additional sheets, if necessary.

Does Not Apply ☐

Insurance Carrier / Provider of Professional Liability Coverage:	Policy Number:	Type of Coverage (check one): Claims-Made ☐ Occurrence ☐	
Name of Local Contact:	Mailing Address:		
Contact Telephone Number: ( )			
Per claim limit of liability: $	Aggregate amount: $		
Effective Date:	Expiration Date:	Retroactive Date, if applicable:	Reason for changing Ins. Co.

Insurance Carrier / Provider of Professional Liability Coverage:	Policy Number:	Type of Coverage (check one): Claims-Made ☐ Occurrence ☐	
Name of Local Contact:	Mailing Address:		
Contact Telephone Number: ( )			
Per claim limit of liability: $	Aggregate amount: $		
Effective Date:	Expiration Date:	Retroactive Date, if applicable:	Reason for changing Ins. Co.

Insurance Carrier / Provider of Professional Liability Coverage:	Policy Number:	Type of Coverage (check one): Claims-Made ☐ Occurrence ☐	
Name of Local Contact:	Mailing Address:		
Contact Telephone Number: ( )			
Per claim limit of liability: $	Aggregate amount: $		
Effective Date:	Expiration Date:	Retroactive Date, if applicable:	Reason for changing Ins. Co.

X. ATTESTATION QUESTIONS – This section to be completed by the Practitioner.

Modification to the wording or format of these Attestation Questions will invalidate the application.

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on a separate sheet. **Please sign and date each additional sheet.**

A.	**In the last three (3) years** have you had a personal/intimate relationship past or present with a patient/client or patient/client's relatives or other individuals with whom the patient/client maintains a close personal relationship? Have your ever provided treatment to a patient/client with whom you have had a prior sexual relationship?	☐ YES ☐ NO
B.	**In the last three (3) years** has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction been denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, or have you been fined or received a letter of reprimand or is any such action pending or under review?	☐ YES ☐ NO
C.	**In the last three (3) years** have you been suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	☐ YES ☐ NO
D.	**In the last three (3) years** have you been denied clinical privileges, membership, contractual participation or employment by any health care related organization*****, or have clinical privileges, membership, participation or employment at any such organization been placed on probation, suspended, restricted, revoked, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	☐ YES ☐ NO
E.	**In the last three (3) years** have you surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization***** while under investigation or potential review?	☐ YES ☐ NO
F.	**In the last three (3) years** has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization***** been withdrawn on your request prior to the organization's final action?	☐ YES ☐ NO
G.	**In the last three (3) years** has your membership or fellowship in any local, county, state, regional, national, or international professional organization been revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	☐ YES ☐ NO
H.	**In the last three (3) years** have you had board certification revoked?	☐ YES ☐ NO
I.	**In the last three (3) years** have you been the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	☐ YES ☐ NO
J.	**In the last three (3) years** have you been charged with a criminal violation (felony or misdemeanor)?	☐ YES ☐ NO
K.	Do you presently use any illegal drugs?	☐ YES ☐ NO
L.	Do you now have, or have you recently had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation, the privileges requested? If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.	☐ YES ☐ NO
M.	Are you **unable** to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	☐ YES ☐ NO
N.	**In the last three (3) years** have any professional liability claims or lawsuits been filed against you? If yes, please complete **Attachment A, Professional Liability Action Detail** for **each** past or current claim and/or lawsuit.	☐ YES ☐ NO
O.	**In the last three (3) years** has your professional liability insurance been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you been denied professional liability insurance?	☐ YES ☐ NO

e.g.** ***hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, medical school faculty position or other health delivery entity or system

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature: _____ **Date:** _____

Reliant Behavioral Health Practitioner Recredentialing Application

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this application, I understand and agree to the following:

1. I understand and acknowledge that, as an applicant for Reliant Behavioral Health panel membership indicated on this application , I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have provided peer references familiar with my professional competence and ethical character, if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.

2. I further understand and acknowledge that Reliant Behavioral Health or designated agent would investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the health care related organization(s) as a part of the verification and credentialing process.

3. I authorize all individuals, institutions, entities of other hospitals or institutions with which I 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 consult with the designated health care related 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/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 investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the health care related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the health care related organization(s) designated herein, unless revoked by me in writing.

7. 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.

Printed Name_____

Signature: _____**Date:** _____

Modification to the wording or format of the
Reliant Behavioral Health Practitioner Credentialing Application
will invalidate the application.

ATTACHMENT A

PROFESSIONAL LIABILITY ACTION DETAIL – *CONFIDENTIAL*
Practitioner's Name (print or type):
Please list any past or current professional liability claim or lawsuit, which has been filed against you in the past three (3) years. **Photocopy this page as needed and submit a separate page for EACH claim/event**. Please complete each field. Please attach additional sheet(s), if necessary.
Date and clinical details of the incident:
Your role and specific responsibilities in the incident:
Subsequent events, including patient's clinical outcome:
Month / Day / Year the suit or claim was filed:
Name and address of insurance carrier/professional liability provider that handled the claim:
Your status in the legal action (primary defendant, co-defendant, other):
Current status of suit or other action:
Month / Day / Year of settlement, judgment, or dismissal:
If case was settled out-of-court, or with a judgment, settlement amount attributed to you: **$**
I verify the information contained in this form is correct and complete to the best of my knowledge. **Signature: _____Date: _____**

Reliant Behavioral Health – PRACTITIONER PROFILE

Please complete the following form by placing a "x" in the box next to the specialty and then sub-specialty you are experienced to provide. At the end you can provide a brief description of yourself (i.e. background education etc.) to support your specialties. You may also inform RBH of any additional specialties to add to our database. Please check the **first** item yes or no indicating whether you want this data posted to RBH's website and reference guide providing healthplan members and practitioners with this profile. Enclosed is a return envelope to mail this form to RBH at 1220 SW Morrison, Suite 600, Portland, OR 97205.

☐ Yes, please post my specialties, sub-specialties and profile to the RBH website and reference guide.
☐ No, I do not want my information posted to the RBH website.

Specialty	**Age Group**						
	0-5	6-11	12-14	15-17	18-Adult	Geriatric	Group Setting
Abuse – Domestic Violence	☐	☐	☐	☐	☐	☐	☐
Abuse – Sexual Abuse	☐	☐	☐	☐	☐	☐	☐
Anger Management	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐
Assertiveness	☐	☐	☐	☐	☐	☐	☐
Attention Deficit Issues	☐	☐	☐	☐	☐	☐	☐
CBT	☐	☐	☐	☐	☐	☐	☐
CISM	☐	☐	☐	☐	☐	☐	☐
CEAP Certification	☐	☐	☐	☐	☐	☐	☐
Career Counseling				☐	☐	☐	☐
Chemical Dependency			☐	☐	☐	☐	☐
Childhood Issues							
Bed Wetting	☐	☐	☐	☐			☐
Behavioral Problems	☐	☐	☐	☐			☐
Fire Starting	☐	☐	☐	☐			☐
Learning Disability	☐	☐	☐	☐			☐
Play Therapy	☐	☐	☐	☐			☐
Soiling	☐	☐	☐	☐			☐
Co-dependency	☐	☐	☐	☐	☐	☐	☐
Couples Issues				☐	☐	☐	☐
Crime Victims	☐	☐	☐	☐	☐	☐	☐
Crisis Stabilization	☐	☐	☐	☐	☐	☐	☐
Cults	☐	☐	☐	☐	☐	☐	☐
Dementia					☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Developmental Disabilities	☐	☐	☐	☐	☐	☐	☐
DBT	☐	☐	☐	☐	☐	☐	☐
Eating Disorders - Anorexia	☐	☐	☐	☐	☐	☐	☐
Eating Disorders - Bulimia	☐	☐	☐	☐	☐	☐	☐
Evaluation Services							
Neuro Psych Testing	☐	☐	☐	☐	☐	☐	☐
Psych Testing	☐	☐	☐	☐	☐	☐	☐
SAP Evaluations/DOT certification					☐	☐	☐
Substance Abuse/Addiction		☐	☐	☐	☐	☐	☐
Workplace Conduct Evaluations				☐	☐	☐	☐
Family Issues							
Adoption		☐	☐	☐	☐	☐	☐
Blended Families		☐	☐	☐	☐	☐	☐
Communication		☐	☐	☐	☐	☐	☐
Conjoint Treatment					☐	☐	☐
Divorce		☐	☐	☐	☐	☐	☐
Life Transition		☐	☐	☐	☐	☐	☐
Mediation					☐	☐	☐
Fears/Phobias	☐	☐	☐	☐	☐	☐	☐
Female Issues	☐	☐	☐	☐	☐	☐	☐

(over)

Specialty	**Age Group**						
	0-5	6-11	12-14	15-17	18-Adult	Geriatric	Group Setting
Gambling	☐	☐	☐	☐	☐	☐	☐
Geriatrics						☐	☐
Grief/Death	☐	☐	☐	☐	☐	☐	☐
Group Therapy	☐	☐	☐	☐	☐	☐	☐
Health Issues							
AIDS/HIV	☐	☐	☐	☐	☐	☐	☐
Chronic Pain/Illness	☐	☐	☐	☐	☐	☐	☐
Disability Adjustment	☐	☐	☐	☐	☐	☐	☐
Fertility			☐	☐	☐	☐	☐
Mind/Body Problems	☐	☐	☐	☐	☐	☐	☐
Movement Disorder	☐	☐	☐	☐	☐	☐	☐
Pregnancy			☐	☐	☐	☐	☐
Hypnosis	☐	☐	☐	☐	☐	☐	☐
Male Issues	☐	☐	☐	☐	☐	☐	☐
Medication Management	☐	☐	☐	☐	☐	☐	☐
Motivation	☐	☐	☐	☐	☐	☐	☐
OCD	☐	☐	☐	☐	☐	☐	☐
Panic	☐	☐	☐	☐	☐	☐	☐
Parent Training				☐	☐	☐	☐
Procrastination	☐	☐	☐	☐	☐	☐	☐
Psychoanalysis	☐	☐	☐	☐	☐	☐	☐
PTSD	☐	☐	☐	☐	☐	☐	☐
SAD	☐	☐	☐	☐	☐	☐	☐
Sexual Issues							
Psychosexual Dysfunction			☐	☐	☐	☐	☐
Psychosexual Identity			☐	☐	☐	☐	☐
Sexual Offenders		☐	☐	☐	☐	☐	☐
Sexual Orientation							
Gay			☐	☐	☐	☐	☐
Lesbian			☐	☐	☐	☐	☐
Transsexual			☐	☐	☐	☐	☐
Solution Oriented Therapy	☐	☐	☐	☐	☐	☐	☐
Stress Management	☐	☐	☐	☐	☐	☐	☐
Trauma	☐	☐	☐	☐	☐	☐	☐
Workplace Issues							
Co-worker conflict				☐	☐	☐	☐
Workplace Aggression				☐	☐	☐	☐
Workplace Harassment				☐	☐	☐	☐
Workplace Transition Stress				☐	☐	☐	☐
Organizational Development on-site					☐		☐

Cultural Sensitivity

Bilingual/additional language fluency: ☐ Spanish ☐ Russian ☐ Vietnamese ☐ Cambodian ☐ Cantonese ☐ French ☐ German

Other language(s) you speak: _____

Cultural Competency/Concerns: ☐ African-American ☐ Hispanic-American ☐ Asian-American Other _____

Special Religious/Spiritual Focus ☐ Christian-Catholic ☐ Christian-Protestant ☐ Muslim ☐ Jewish ☐ Buddhist ☐ Hindu Other: _____

Any additional specialties/sub-specialties: _____

Profile: If you wish, please attach a paragraph or two describing your background, experience, education that can be used to develop a profile for RBH's website and reference guide. The profile will only be posted if you gave permission to do so at the beginning of this survey. Thank you.

Practitioner Name: _____ **Phone:** _____

Practice Address: _____

Substitute Form **W-9**
(Rev. February 2005)

Request for Taxpayer Identification Number and Certification

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

Please print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole Proprietor ☐ Corporation ☐ Partnership ☐ Other _____ ☐ Exempt from backup withholding

☐ LLC filing as Sole Proprietor ☐ LLC filing as Corporation ☐ LLC filing as Partnership

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 Line 1 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 3 for guidelines on whose number to enter.*

Social security number
___ ___ ___ – ___ ___ – ___ ___ ___ ___

or

Employer identification number
___ ___ – ___ ___ ___ ___ ___ ___ ___

Part II Certification

Under penalties of perjury, I certify that:

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

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 3.)

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

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.

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

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.*

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Foreign person. If you are a foreign person, do not use For W-9. Instead use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on a exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese

student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, non-employee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note: You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt from backup withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note: If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2);

2. The United States or any of its agencies or instrumentalities;

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities.

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities; or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation;

7. A foreign central bank of issue;

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States;

9. A futures commission merchant registered with the Commodity Futures Trading Commission;

10. A real estate investment trust;

11. An entity registered at all times during the tax year under the Investment Company Act of 1940;

12. A common trust fund operated by a bank under section 584(a);

13. A financial institution;

14. A middleman known in the investment community as a nominee or custodian; or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

If the payment is for…	THEN the payment is exempt for…
Interest and dividend payments	All exempt recipients except for **9**
Broker transactions	Exempt recipients **1** through **13**. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients **1** through **5**
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients **1** through **7** [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are **not exempt** from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see How to get a TIN below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see Limited liability company (LLC) on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note: See the chart on this page for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.ssa.gov/online/ss5.pdf*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses/* and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see Exempt from backup withholding on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a non-employee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The Minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole Proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.
[2] Circle the minor's name and furnish the minor's SSN.
[3] **You must show your individual name,** but you may also enter your business or "DBA" name. You may use either your SSN or your EIN (if you have one).
[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or Archer MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, or to other Federal and state agencies to enforce Federal nontax criminal laws and to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 30% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.