TPQVO
Your credentialing partner
www.tpqvo.com

1st

2nd

3rd

FAX:

Application for

Dear

Please complete the attached application for medical /professional appointment or health plan network membership (Health Care facility/Agency/Employer).

Some health care organizations will consider this a pre-application form until your eligibility is established. Upon establishment of eligibility, this application becomes official and the health care organization will begin processing this as an application for membership to its staff or network. If the health care organization determines you are not eligible, it will notify you directly.

The following items must be returned with your completed application:

_X__ A one-time Initial Application setup/processing fee of **$125.00**
_X__ **A copy of your driver's license or U.S. government-issued Passport**
_X__ A copy of your current VISA/Alien Registration Card if not a U.S. Citizen
_X__ A copy of your Medical or **Dental Degree**
_X__ A copy of your **ECFMG Certificate** (if applicable)
_X__ A copy of your **Certificate of Completion** from your **Internship Program**
_X__ A copy of C**ertificate of Completion** from **Residency** Program
_X__ A copy of your Tennessee or other state current **Medical License** or wallet card showing expiration date
_X__ Your **Curriculum Vitae** or **Biography**
_X__ A copy of the face sheet or your **Professional Liability Insurance** policy (Past 5 Years)
_X__ A copy of your **ABMS** or **AOMS Board certification** (if applicable)
_X__ A copy of your current **Federal DEA Certificate**
_X__ A signed **SVMIC Authorization to Release if applicable**
_X_ A copy of **Military Discharge** (DD214) (if applicable)
_X__ **Continuing Medical Education** hours for the past two years (if applicable--see facility requirements)

Make sure you answer the questions, sign and date the application and the Authorization and Release. We cannot process your application until we receive this authorization. Please call TPQVO if you have any questions about this application for reappointment at (423) 495-1191.

For your convenience, you may email your completed and signed application with attachments to tpqvo@tpqvo.com.

1092 Chamberlain Avenue ¨ Suite B ¨ Chattanooga, TN 37404 ¨ (423) 495-1191 ¨ (423) 495-1189 FAX
tpqvo@tpqvo.com

TENNESSEE PHYSICIANS'
QUALITY VERIFICATION ORGANIZATION

UNIVERSAL APPLICATION

APPOINTMENT TO MEDICAL/PROFESSIONAL STAFF, HEALTH PLAN,

AND/OR

MEDICAL SOCIETY MEMBERSHIP

NAME:_____

DATE:_____

For what purpose do you intend to use your privileges?

☐ Establish a practice in _____ (area)

☐ As a practice associate with _____ (practice)

☐ As a contract physician with _____ (company)

☐ Other (please explain)_____

I hereby apply to the following Specialty (check below)

☐ Anesthesiology
☐ Dentistry
☐ Emergency Medicine
☐ Family/General Practice
☐ Medicine
☐ Oral & Maxillofacial Surgery
☐ Obstetrics & Gynecology
☐ Ophthalmology
☐ Orthopedic Surgery
☐ Pathology
☐ Pediatrics
☐ Podiatry
☐ Psychiatry
☐ Physical Medicine
☐ Radiology
☐ Radiation Oncology
☐ Surgery
☐ Other_____

APPLICATION FOR APPOINTMENT TO THE MEDICAL/PROFESSIONAL STAFF

(Please type or print legibly)

PERSONAL INFORMATION

First Name | Middle | Last Name | Suffix | Degree | Gender | Race/Ethnic Origin (Optional)

Social Security Number | Marital Status | Previous Name | Dates when this name was used | Spouse's Name

Birth Date | Birth Place | US Citizen? ☐ Yes ☐ No | If no, alien registration number: _____

Home address | City | State | Zip | Telephone | Your business email (required)

PRACTICE INFORMATION

Practice Name | Credentialing Contact | Credentialing Contact email

Primary Office Address | City | State | Zip | Telephone | Fax

Billing Address (if different) | City | State | Zip | Telephone | Credentialing Contact Telephone

REQUIRED: Sequence of Telephone Numbers at which you can be reached (cellphones, home phones, etc.):

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

Partner(s) You may attach brochure or list.

☐ Solo ☐ Group ☐ Partnership ☐ Corporation _____ Other (please specify) | Tax ID # | YOUR (applicant's) NPI

Specialty(ies) | Special Practice Area(s)/Subspeciality | Medicare # | Medicaid #

Call Coverage (all offices):

Do you provide call coverage 24 hours/day, 7 days a week and does this mechanism provide the ability to contact the covering medical professional? If yes, please provide the information requested below. ☐ Yes ☐ No

Physician sharing call (if outside your group) | Address | Office Telephone | After hours Telephone

Physician sharing call (if outside your group) | Address | Office Telephone | After hours Telephone

Languages Spoken/Read: Applicant : _____ Staff _____

Do you employ nurse practitioners, physicians assistants or other allied health practitioners? ☐ Yes ☐ No

Are you accepting new patients? ☐ Yes ☐ No

Do you accept Medicare assignment? ☐ Yes ☐ No

Does this office meet ADA accessibility standards? ☐ Yes ☐ No

Does this office have a CLIA certified lab? ☐ Yes ☐ No

If yes, certification number: _____ Expiration Date: _____

Reference Lab: _____

Second Office (if applicable)

Secondary Office Address | City | State | Zip | Telephone

Secondary Office Practice Name | Office Manager

Office Manager Telephone | Fax Number

Does this office meet ADA accessibility requirements? ☐ Yes ☐ No
Does this office have a CLIA certified lab? ☐ Yes ☐ No
If so, please provide certification number: _____
Expiration date: _____
Reference lab: _____

Office Hours: (You may attach a list or brochure in lieu of completing chart)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Primary Office							
Second Office							
Third Office							
Fourth Office							

MILITARY SERVICE

Military Reserves: ☐ Yes ☐ No Military Service Branch: _____

Date: Entry _____ Separation _____ Station where separated _____

Last Duty Assigned: _____ Type of Discharge _____

MEDICAL EDUCATION

Please note: "See CV" or "see attached" are not acceptable.

Institution: Dates Attended Degree conferred:

Address:

Institution: Dates Attended Degree conferred:

Address:

ECFMG Number (if applicable): _____ Issue Date: _____

INTERNSHIP

If more than one internship was begun or completed, please supply the same information on a separate sheet and attach.

Institution Type of internship Specialty Dates: From To

Address

RESIDENCIES

If more than two residencies were begun or completed, please supply the same information on a separate sheet and attach.

Institution Program Director Email Address

Address Phone Fax

Completed? ☐ Yes ☐ No

Specialty Dates: From To

RESIDENCIES, CONTINUED

Institution | Program Director | Email Address

Address | Phone | Fax

Specialty | Dates: From To | Completed? ☐ Yes ☐ No | Program Director

FELLOWSHIPS

If more than two fellowships were begun or completed, please supply the same information on a separate sheet and attach.

Institution | Program Director | Email Address

Address | Phone | Fax

Specialty | Dates: From To | Completed? ☐ Yes ☐ No

Institution | Program Director | Email Address

Address | Phone | Fax

Specialty | Dates: From To | Completed? ☐ Yes ☐ No

TEACHING APPOINTMENTS

Please list teaching or university appointments held. If additional appointments, provide additional information as an attachment.

Institution | Dates: From To | Department Chair

Address | Type of Appointment

Institution | Dates: From To | Department Chair

Address | Type of Appointment

PRACTICE HISTORY

Please provide a chronological listing of medical practice since medical training. If you need additional space, please use a separate sheet and attach to this application. See CV is not acceptable. Provide a written explanation of any gaps in dates between education and/or practice affiliations exceeding 30 days.

Practice Name	Address (include street address, city, state)	From	To

Program Director

HOSPITAL STAFF

List all current and past hospital affiliations in chronological order. If you need additional room, continue on a separate sheet and attach to this application.

Hospital Name and Address. Please check current Primary Facility.		Appointment Date	Resignation Date (if applicable)	Current Status
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			

LICENSURE

List all current and past and specify the type, i.e., MD, DO, DDS, DPM, etc. (If currently licensed in more than five states please supply the same information on a separate sheet and attach.)

State: _____ Type: _____ Number: _____ Date Issued: _____ Date Expires: _____

State: _____ Type: _____ Number: _____ Date Issued: _____ Date Expires: _____

State: _____ Type: _____ Number: _____ Date Issued: _____ Date Expires: _____

State: _____ Type: _____ Number: _____ Date Issued: _____ Date Expires: _____

State: _____ Type: _____ Number: _____ Date Issued: _____ Date Expires: _____

DRUG ENFORCEMENT ADMINISTRATION INFORMATION (DEA)

Please attach a copy of your current DEA registration(s) to this application.

Federal DEA registration number: _____ Date Issued: _____ Date Expires: _____

BOARD CERTIFICATION

Are you currently Board Certified? ☐ Yes ☐ No Have you been Recertified? ☐ Yes ☐ No

Board	Year Certified	Year Recertified Year Expires	Cert #
Board	Year Certified	Year Recertified Year Expires	Cert #
Board	Year Certified	Year Recertified Year Expires	Cert #

OTHER CERTIFICATIONS

Please check all current certifications that apply and attach a copy of your current certificate.

☐ BASIC CPR CERTIFICATION
Expires: _____
Instructor: ☐ Yes ☐ No

☐ ACLS CERTIFICATION
Expires: _____
Instructor: ☐ Yes ☐ No

☐ ATLS CERTIFICATION
Expires: _____
Instructor: ☐ Yes ☐ No

☐ PALS CERTIFICATION
Expires: _____
Instructor: ☐ Yes ☐ No

☐ NRP CERTIFICATION
Expires: _____
Instructor: ☐ Yes ☐ No

PROFESSIONAL MEMBERSHIPS

List all professional memberships and societies, past and present, including state and county medical societies, with dates. If additional space is required, please attach separate sheet of paper.

Name	Address	Currently a Member?

PEER REFERENCES

List Medical References from three (3) peers in the same specialty who can attest to your current clinical abilities, ethical character and ability to work cooperatively with others. These should be individuals who will provide specific written comments on these matters upon request. If your training was completed within the past three years, you may list your Program Director(s). If you have been out of training for more than three years, you must name individuals who have not been listed in any other part of the application.

Name _____ Telephone _____ Fax Number _____

Address (please include suite or room number) _____ City/State/Zip _____ Email Address _____

Name _____ Telephone _____ Fax Number _____

Address (please include suite or room number) _____ City/State/Zip _____ Email Address _____

Name _____ Telephone _____ Fax Number _____

Address (please include suite or room number) _____ City/State/Zip _____ Email Address _____

PROFESSIONAL LIABILITY INSURANCE

Do you currently have malpractice insurance? ☐ Yes ☐ No

List all professional liability insurance carriers for the past 5 years, beginning with the most recent:

Carrier _____ Limits _____ Occ/Claims _____ Policy Number _____ Dates _____

Address _____

Carrier _____ Limits _____ Occ/Claims _____ Policy Number _____ Dates _____

Address _____

Carrier _____ Limits _____ Occ/Claims _____ Policy Number _____ Dates _____

Address _____

PROFESSIONAL HISTORY QUESTIONS

Answer all questions. If any answer is "yes", give a full explanation on a separate attachment.

Have any of the following ever been or are currently under investigation, either on a voluntary or involuntary* basis: denied, revoked, suspended, reduced, limited, placed on probation, not renewed or relinquished for disciplinary reasons?

	Yes	No
Medical license in any state or district	☐	☐
Other professional registration/license	☐	☐
State Controlled Substance Registration	☐	☐
Federal DEA Registration	☐	☐
Membership on any hospital medical/professional staff	☐	☐
Clinical privileges	☐	☐
Participation in the Medicare/Medicaid program	☐	☐
Membership in other health care organizations or plans (PPO, PHO, MSO, HMO, ASC)	☐	☐
Professional society membership	☐	☐
Board certification	☐	☐
ECFMG certification	☐	☐

*a voluntary relinquishment or voluntary non-renewal is for disciplinary reasons when the relinquishment or non-renewal is done to avoid an adverse action, preclude an investigation, or is done while the practitioner is under investigation related to professional conduct or competence.

Have you ever been convicted of a criminal offense (other than minor traffic violations) or are you presently indicted for a felony?	☐	☐
Has any claim of sexual harassment or violation of civil rights ever been made against you that resulted in your receiving or incurring any warning, disciplinary action, or civil liability?	☐	☐
Have you ever been denied professional liability insurance or has your coverage ever been canceled?	☐	☐
Has your present professional liability insurance carrier excluded any specific procedures from your coverage or advised you that it intends to terminate, reduce, or otherwise restrict your coverage?	☐	☐
Have any professional liability suits ever been filed against you?	☐	☐
Have any professional liability suits filed against you resulted in a judgment against you or been terminated pursuant to a settlement in which you have paid damages to the plaintiff, with or without admitting liability?	☐	☐
Have you ever settled any professional liability claim against you prior to suit and admitted liability as a part of such settlement?	☐	☐
Are you currently engaged in the illegal use of drugs?	☐	☐
Do you have any physical or mental, or emotional impairment condition which would affect your ability to carry out your professional duties or to exercise the clinical privileges you have or will request, or would require an accommodation in order for you to exercise the requested privileges safely and competently?	☐	☐
Do you or a member of your family own, have an investment in, or otherwise have a direct or indirect interest in any clinical laboratory, diagnostic or testing center, hospital, surgicenter, or other business dealing with the provision of ancillary health services, equipment or supplies? If yes, complete the following:	☐	☐

Name of Organization: _____

Address: _____

Tax Identification Number: _____

Telephone Number: _____

Type and Size of Organization: _____

% of Business Invested by Applicant: _____

Nature of business interest: _____

CONTINUING EDUCATION CREDITS (CMEs)

Do you attest that you have attended CME programs in the past 2 years that relate to your area of practice, and that you will be able to provide proof of attendance and program content upon request? ☐ Yes ☐ No

Please observe the CME documentation requirements listed later in this application

HEALTH EXAMINATION

A health examination must be performed within the last two years. Please provide the name of the physician who performed the examination. (The examining physician may not be a practice associate or relative.)

Examination Date: _____ Examining Physician: _____

Address: _____ Telephone: _____ Fax: _____

MEDICAL PROFESSIONAL STAFF MEMBERSHIP

Please check the health care facilities for which you are applying for staff privileges or membership and to which you authorize the release of this application and credentials information.

- ☐ CHI Memorial Hospital Georgia (Ft Oglethorpe, GA)
- ☐ Kindred Hospital of Chattanooga
- ☐ Memorial Health System (Memorial Hospital) TN
- ☐ _____ (other)
- ☐ Parkridge Medical Center, Inc (Parkridge East, Parkridge Valley, Parkridge Medical Center, Parkridge West Hospital
- ☐ Rhea Medical Center (Dayton, TN)
- ☐ Siskin Hospital for Physical Rehabilitation
- ☐ _____ (other)

Participating health plans send us a list of physicians to be credentialed for their individual plans. You must contact them directly.

HAMILTON COUNTY EMERGENCY RESPONSE PLAN PHYSICIAN VOLUNTEER PROGRAM

The Physician Volunteer Program offers assistance to local hospitals, the medical community and the public health department in a major emergency crisis situation such as natural disasters, accidental or intentional chemical releases, acts of terrorism, and other large public health threats. Please check "yes" if you are interested in volunteering or would like the Chattanooga-Hamilton County Health Department to contact you with more information about the program. ☐ Yes ☐ No

MEDICAL SOCIETY MEMBERSHIP

Do you wish to become a member of the Medical Society and to use this application form as your application to the state and county medical society? (Only answer if you are not currently a member) ☐ Yes ☐ No

SIGNATURE AND CERTIFICATION

I certify the information in this application is true and complete.

By typing your name below, you acknowledge that it serves as a legal equivalent to your handwritten signature, signifying your agreement to the terms and conditions outlined above.

Name _____ Signature: _____ Date: _____

Send completed application to:

TPQVO, LLC
1092 CHAMBERLAIN AVE., SUITE B
CHATTANOOGA, TN 37404
(423) 495-1191
(423) 495-1190 FAX
tpqvo@tpqvo.com

The Tennessee Medical Association, county medical societies and participating facilities do not discriminate on the basis of race, color, sex, religion, age, national origin or handicap.

AUTHORIZATION AND RELEASE OF APPLICANT

PLEASE READ CAREFULLY BEFORE SIGNING

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

I further acknowledge that I am responsible for knowing the contents of the bylaws, rules and regulations of the Facilities and their medical /professional staffs and agree to be bound by them if granted membership and/or privileges.

I further understand and acknowledge that the Tennessee Physicians' Quality Verification Organization, LLC ("TPQVO") acting as a contractor for the Facilities will investigate the information in this Application. By submitting this Application, I agree and consent to such investigation activities of TPQVO and Facilities as follows:

Authorization of Investigation and Release of Information Concerning Application for Appointment. I authorize all individuals, institutions and entities, including but not limited to administrators and members of the medical/professional staffs of other Facilities 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 have knowledge concerning information requested in this Application, who have knowledge concerning information requested in this Application, to consult with and release relevant information to TPQVO and Facilities, their medical/professional staffs and agents.

Release from Liability. I hereby release from liability Facilities, TPQVO and their respective agents, and all other individuals, institutions and entities providing information in accordance with the authorizations contained herein for their acts performed in good faith and without malice in connection with the investigation of this Application for Appointment. This release shall be cumulative and in addition to any other applicable immunities provided by law for medical care review activities.

Use of Information. I acknowledge that part of the information to be provided by me is for identification purposes only and will not be used to form the basis of decisions regarding medical/professional staff membership.

I understand and agree that the authorizations I have provided are irrevocable so long as I am an applicant for or have medical/professional staff privileges at any Facilities participating in TPQVO's central verification service.

I acknowledge that the investigation of information in this Application by the Facilities, TPQVO and their agents is done to achieve, maintain and improve quality patient care.

I consent to an inspection of records and agree to an interview if requested.

I agree to provide continuous care for each of my patients and recognize my responsibilities therein.

All information provided by me in the Application is true and complete to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the Application may constitute grounds for denial of appointment or for summary dismissal from the medical/professional staff. I understand and acknowledge that the Facilities shall be solely responsible for all decisions concerning medical/professional staff membership and the granting of medical and/or surgical privileges. Medical/professional staff membership are determined independently. I further understand and acknowledge that TPQVO has no responsibility or liability with respect to medical/professional staff membership decisions by Facilities.

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

By typing your name below, you acknowledge that it serves as a legal equivalent to your handwritten signature, signifying your agreement to the terms and conditions outlined above.

Name (Please print) _____

Signature _____ Date _____

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

(Attach Photo Here)

TO: All Medical Professional Staff Members

As part of the process of applying for hospital admitting privileges to a TPQVO participating hospital/facility, the physician must complete the following acknowledgment at the time he or she is granted those privileges or before or at the time the physician admits his or her first patient to the hospital. This acknowledgment will remain in effect as long as the physician has admitting privileges to the hospital. These statement files are subject to audit by the PRO and other designees of the Director of CHAMPUS.

MEDICARE/CHAMPUS ACKNOWLEDGMENT STATEMENT
NOTICE TO PHYSICIANS

"Medicare/CHAMPUS payment to hospitals is based, in part, on each patient's principal diagnoses and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his/her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for the payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws."

By typing your name below, you acknowledge that it serves as a legal equivalent to your handwritten signature, signifying your agreement to the terms and conditions outlined above.

Name (Please Print) _____

_____ _____

Signature of Physician Date

(For Facility's Use: Do Not Complete)

Facility Name _____

Provider Number _____

PRO Contact Name _____

PRO Contact Telephone Number _____

Physician's Full Name _____

NPI _____

CONSENT AND RELEASE FOR CRIMINAL BACKGROUND CHECK

I am receiving this consent and release because the healthcare organization to which I have applied for medical staff membership or continuation of my membership requires a criminal background check as part of the medical staff screening process and that the Tennessee Physicians' Quality Verification Organization, LLC (TPQVO) is processing this check on behalf of the healthcare organization either directly or through a third party criminal background screening service.

In connection with my application for medical staff membership or my continued medical staff membership, I have been advised and I hereby consent and authorize TPQVO and its agent, at any time during my application process to conduct an investigative consumer report that may include, but not be limited to, a criminal record check. I do hereby consent and authorize TPQVO and its agent to use any information provided on this form or during the application process in performing the investigative consumer report. I have been informed that I have the right to review and challenge any negative information that would adversely affect me or adversely affect a decision to extend membership. I agree to release, indemnify and hold harmless TPQVO and any consumer reporting agency used by TPQVO with regard to any information reported by the consumer reporting agency.

I have also been informed that I have the right to review and challenge any negative information that would adversely affect a decision by the healthcare organization client to extend or continue medical staff membership. In addition, I have been informed that I will have a reasonable opportunity to clear up any mistaken information reported within a reasonable time. Under the Fair Credit Reporting Act, I have been advised that upon request I will be provided the name, address and telephone number of the reporting agency as well as the nature, substance and source of all information. In addition, upon timely written request to TPQVO the name, address and telephone number of the consumer reporting agency and the nature and scope of the investigative report will be disclosed to me.

I acknowledge that facsimile, copy or email of this document shall have the same validity, force and effect as the original. I hereby certify that all information provided in this background check disclosure notice, my application for membership or reapplication for membership to healthcare organization medical staffs or panels, and authorization form is true, correct and complete. If any information proves to be incorrect or incomplete, I understand that grounds for termination of current membership or cancellation of any and all offers of medical staff membership are at the discretion of TPQVO clients using this information.

New York Applicants Only: I acknowledge receipt of a copy of Article 23-A of New York Correction Law.

NOTICE TO CALIFORNIA CANDIDATES

You have a right to obtain a copy of any consumer report or investigative consumer report obtained by TPQVO by checking the box provided below. The report will be provided to you within three (3) business days after we receive the requested reports related to the matter investigated.

☐ I request to receive a free copy of this report by checking this box.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by GIS during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at GIS in person or by mail. You may also receive a summary of the file by telephone. The agency is required to have personnel available to explain your file to you and the agency must explain to you any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.

By typing your name below, you acknowledge that it serves as a legal equivalent to your handwritten signature, signifying your agreement to the terms and conditions outlined above.

Signature _____ Printed Name _____ Date _____

Please list addresses at which you lived for past 7 years:

_____ From _____ To _____

_____ From _____ To _____

_____ From _____ To _____

A summary of rights under the Fair Credit Reporting Act can be found at found online at http://www.ftc.gov/bcp/edu/pubs/consumer/credit/cre35.pdf

CONTINUING MEDICAL EDUCATION

I attest that all information provided on this page is true and accurate. I understand that the information provided may be subject to review at which point I will provide proof of attendance of all CME events.

Signature _____ Name _____ Date _____

Category	Meeting or Activity	Date and Place	Credit Hours
Category 1 (Accredited Sponsorship)			
Category II (Non-accredited sponsorship)			
Category III (Medical Teaching)			
Category IV (Papers, books, publications and exhibits)			
Category V (Non-supervised individual CME Activities			
Category VI (other meritorious learning experiences			

CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS

CHI Memorial Georgia	40 hours every 2 years
Kindred Hospital - Chattanooga	40 hours every 2 years
Memorial Health Care System (Memorial Hospital)	40 hours every 2 years IF RECENT GRADUATE PLEASE PROVIDE SURGERY LOG
Memorial Health Services	40 hours every 2 years IF RECENT GRADUATE PLEASE PROVIDE SURGERY LOG
Parkridge Medical Center, Inc	40 hours every 2 years IF RECENT GRADUATE PLEASE PROVIDE SURGERY LOG
Rhea Medical Center, Inc	40 hours every 2 years (with Certificates)
Siskin Rehabilitation Hospital	40 hours every 2 years (with Certificates)
Center For Sports Medicine and Orthopaedic Surgery (fka Chattanooga Surgery Center HCA)	40 hours every 2 years (with Certificates)

SVMIC
State Volunteer Mutual Insurance Company

101 Westpark Drive, Suite 300
Brentwood, TN 37027-5031
Phone 615.377.1999
www.svmic.com

AUTHORIZATION AND RELEASE FORM

From: _____ Medical License Number: _____ State _____

RELEASE OF INFORMATION TO:
(Complete Address)

TENNESSEE PHYSICIANS' QUALITY VERIFICATION ORGANIZATION, LLC
1092 CHAMBERLAIN AVE, SUITE B
CHATTANOOGA, TN 37404

State Volunteer Mutual Insurance Company ("SVMIC") is the carrier of my medical professional liability insurance, and as such SVMIC maintains certain information regarding my medical practice -- specifically the history of any malpractice claims against me. I understand that this information is extremely sensitive and confidential. I acknowledge that SVMIC is protective of this information and will only release it upon my express and unambiguous consent and direction. I have decided, for reasons related to my practice, that certain information from SVMIC be provided as requested. I authorize SVMIC to provide to the above person or organization information relating to many professional liability claims activity against me that has been reported and covered by SVMIC, but specifically limited to: a) Claims that have resulted in paid losses (settlements), and/or b) Lawsuits (open or closed).

I HEREBY RELEASE SVMIC, ITS OFFICERS DIRECTORS, EMPLOYEES AND AGENTS FROM ANY CLAIMS, LIABILITIES, ACTIONS DAMAGES OR OTHERWISE, FOR THE RELEASE OF SUCH INFORMATION IF SUCH RELEASED INFORMATION IS DELIVERED IN GOOD FAITH AND WITHOUT MALICE. I ALSO ACKNOWLEDGE THAT MISTAKES MAY OCCUR IN THE PROVISION OF SUCH INFORMATION, AND WITHOUT LIMITING THE FOREGOING, I SPECIFICALLY RELEASE SVMIC, ITS OFFICERS DIRECTORS EMPLOYEES AND AGENTS FROM ANY CLAIMS DUE TO INCORRECT, MISDELIVERED, OR OTHERWISE INAPPLICABLE INFORMATION IF SUCH ERRORS OCCURRED IN GOOD FAITH, AND UPON DISCOVERY, SVMIC TAKES REASONABLE CORRECTIVE ACTIONS.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL SPECIFICALLY REVOKED BY ME IN WRITING.

By typing your name below, you acknowledge that it serves as a legal equivalent to your handwritten signature, signifying your agreement to the terms and conditions outlined above.

_____
Print Name

_____ _____
Signature of Insured Date

Policy Number _____

For Extender Employees - Please Provide Name of Employer _____

Last revised on 10/29/2024 **Submit** **Reset**