CENTERSTONE

Credentialing Application

1.General Information

A. Provider Name _____ Degree/License _____

Past and/or current professional name _____

Social Security Number _____ Date of Birth _____

2. Primary Office Address: Street 5410 Lee Avenue

City Chattanooga State TN Zip Code 37410 County Hamilton

3. Additional Office Addresses _____

_____

4. List any other languages that you are fluent in conducting treatment. _____

5. Practitioner Information

A. School Name _____

(for highest degree)

City/ State _____

Degree _____ Major _____ Graduation Date _____

B. License N/A State N/A Expiration Date N/A

C. Residency Program

Institution Name N/A Dates of program N/A

City/ State N/A Field of Study N/A

D. DEA Number N/A Expiration Date N/A

E. Certification

Board Certified N/A YES N/A NO

Specialty N/A Date N/A

Specialty N/A Date N/A

Board Eligible N/A YES N/A NO

Specialty N/A Date N/A

F. Professional Liability Information

Carrier N/A

Address N/A

City N/A State N/A Zip Code N/A

Coverage Limits N/A (occurrence) N/A (aggregate)

Date coverage first began N/A Expiration date N/A

Type of policy: N/A Individual N/A Group

Policy Number N/A

6. Malpractice History. Please answer the following questions.

I affirm that I have maintained malpractice insurance consecutively for the past five years.

_____ YES ✓ NO If no, please explain. Not Required

A. Have you ever been named in any malpractice action? _____ YES ✓ NO
If the answer is yes please provide a copy of the complaint, current status, settlement or dismissal information and a current claims history report.

For questions B-G please provide a statement if you answer yes.

B. Have you ever been denied malpractice insurance or has your insurance ever been canceled or renewal refused? _____ YES ✓ NO

C. Has there ever been any action against or investigation relating to your:

License _____ YES _____ NO ✓ N/A

Certification _____ YES _____ NO ✓ N/A

Registration _____ YES _____ NO ✓ N/A

Privileges _____ YES _____ NO ✓ N/A

D. Have you ever been convicted of a felony, including, but not limited to, crimes involving children, fraud, or narcotics? (Misdemeanors do not need to be reported.)
_____ YES ___✓___ NO

E. Have any adverse actions been filed against you by Medicare or Medicaid?
_____ YES ___✓___ NO

F. Have you ever been sanctioned by a professional association for ethical violations?
_____ YES ___✓___ NO

G. Are you presently using illegal drugs? _____ YES ___✓___ NO

H. Are you able to perform the essential functions of seeing patients in a timely manner, complying with policies and procedures, rendering competent quality care to patients, with or without accommodations?___✓_____ YES _____ NO *If No, please provide a statement.*

7. Work History

List all previous and present work history related to clinical practice within the last five years. Please explain any gaps in employment that are longer than 6 months.

Current Position or Position Applied for Residential Caregiver

Facility Name	Title/Position	Address	From	To

I hereby certify that all information in this application and the copies of my state license(s), certificates of insurance, and professional certificates are correct and complete. I further understand that any information entered into this application which subsequently is found to be false could result in termination of any agreement I may enter into with Centerstone.

I hereby grant permission to, and consent for, Centerstone to obtain and verify information contained on my application and consent to release by any person, organization or other entity, of all information that may be reasonably relevant to an evaluation of my professional competence, ability to render clinical services in a cost-effective manner, character, moral and ethical qualification and agree to hold harmless any such person or organization or other entity from any cause of action based on the release of such information to Centerstone. I understand that participation as a provider is dependent upon review of this application and completion of the credentialing process.

Signature _____ Date _____

CENTERSTONE

Affidavit

STATE OF_____

COUNTY OF_____

Before me, the undersigned, personally appeared _____ who, after
Print Name
being by me first duly sworn, stated under oath the following:

1. That he/she is more than eighteen (18) years of age, competent to testify to the facts stated herein and the statements made herein are based upon his/her personal knowledge.

2. a. That during the period from _____ to _____
(Month/ Year) (Month/ Year)
there have been no claims, actions, damages paid, liabilities, losses, judgments or settlements as a result of claims arising out of the negligence or care rendered by him/her to any individual.

   or

   b. Prior to this date, he/she was not required in any previous position to carry malpractice insurance.

3. That at this time there are no claims of negligence or malpractice pending or threatened against him/her.

_____
Signature

Taken, sworn and subscribed this _____ day of _____.

_____
Notary Public

My commission expires: _____

Approved 9/18/2007