ADVANCED PRACTICE .com
a Jackson Healthcare company

CREDENTIALING APPLICATION

AdvancedPractice.com | 2655 Northwinds Parkway | Alpharetta, GA 30009 | phone 877.740.0404| fax 678.352.4388

General Instructions

All information requested in this application is necessary to complete the credentialing process. This information is based on the standards for credentialing established by the National Committee for Quality Assurance (NCQA) and The Joint Commission (TJC). *Failure to provide the specific requested information will result in delay in verification and approval of your credentialing file.*

- ► Type or print legibly your responses.
- ► Note that modification to the wording or format of this application or agreement will invalidate it.
- ► All questions must be answered fully and truthfully. If an answer requires an explanation, please provide it on the appropriate form provided. Make additional copies of any of the attached forms if more than one is needed and provide your name on all attachments. You may also submit narratives and/or other documentation to support your answers.
- ► Note that month/years are required for the education and work history sections of the application. All time periods during your clinical career must be accounted for.
- ► Any gap of time greater than sixty (60) days requires explanation. Please use the enclosed explanation form to provide this information.
- ► Please do not leave any blanks. If a particular section does not apply to you, write "n/a" in that section.
- ► A response of "See CV" is *not* acceptable unless you also submit a current CV containing all of the requested information.
- ► Any changes to your responses must be lined through and initialed. Use of any form of correctional fluid or tape is not acceptable.
- ► Please sign and provide a current date on the attestation and release pages of the application, the provider agreement, and any other forms completed.
- ► After the application has been completed in its entirety, make a copy of the application to retain in your files or computer for future use. Attach all documentation shown on the next page to your application prior to mailing.

Advanced Practice Initial Credentialing Checklist

_____ Completed Credentialing Application

_____ Signed and Currently Dated Attestation and Release forms

_____ Completed W-9 Federal Tax Form

_____ Completed Authorization for Direct Deposit Form

_____ Current Curriculum Vitae with complete Professional History in chronological order and no gaps
(Month and year must be included)

_____ Copy of Diploma and/or Training Certificate(s)

_____ Current Continuing Education Activity (CME/CEU activity for the past three years)

_____ Copy of Current Certification

_____ Copy of All Current Active State License Wallet Card(s) and Wall Certificate with expiration date and number

_____ Copy of current Federal DEA and current State Controlled Substance Registrations or certificate(s) – *if applicable*

_____ Copy of current BLS, ACLS, ATLS, PALS, APLS, NRP Certificate(s)

_____ Certificate of Professional Liability Insurance Coverage or Declaration Page (Face Sheet) of Policy (if applicable)

_____ Third party documentation (i.e. court documents, dismissals) for all Malpractice/Disciplinary Actions OR Completion of appropriate Explanation Form attached (if applicable)

_____ Permanent Resident Card, Green Card or Visa Status (if applicable)
All non US citizens must provide copy of green card

_____ Military Discharge Record -Form DD-214 (if applicable)

_____ 3 Written Letters of Recommendation from supervisors or peers who have directly observed you in practice within the past year. *(They must assess your clinical competence and specify the date they last observed you in practice - month/year)*

_____Recent Photograph Signed and Dated in the margin

_____ Copy of current Drivers License or Passport

_____Copies of current Immunization records and most recent TB test results (if available)

_____Copy of National Provider Identifier (NPI#) documentation and Confirmation Letter

Please return all of the above requested documents in the enclosed envelope and mail or email to:

credentialing@advancedpractice.com

AdvancedPractice.com
2655 Northwinds Parkway
Alpharetta, GA 30009
877.740.0404 toll free
678.352.4388 fax

ADVANCED PRACTICE .com
a Jackson Healthcare company

Photo / Identification Required:

ATTACH CURRENT PHOTO HERE.
INDICATE DATE TAKEN
AND SIGN IN INK ACROSS THE BOTTOM
OF PHOTO.

Note: Photo must be:

1. Original
   a. No larger than 3 by 4 inches
   b. Taken within one year of application
   c. Close-up view of self – not profile
2. Instant Polaroid photographs not acceptable

Your Signature Across the Bottom and Date

AdvancedPractice.com | 2655 Northwinds Parkway | Alpharetta, GA 30009 | phone 877.740.0404| fax 678.352.4388

ADVANCED PRACTICE .com
a Jackson Healthcare company

AdvancedPractice.com Initial Credentialing Application

Section			
Personal Information	Last Name Suffix (Jr. Sr. III) First Name Middle	Designation (ie: NP, PA, CNS, CRNA, CNM)	Social Security Number
	Home Address		Home Phone Number
	City State Zip code		Cell Phone Number
	Office Address		Office Phone Number
	City State Zip code		Office Fax Number
	Citizenship	Birthplace	Date of Birth	Email address:
	Present Position	NPI #	Medicare #
	UPIN #	Fed Tax ID	Medicaid #
	Please provide the name and address of someone who will always know your forwarding address	Contact Name and Phone	Contact Address:
Education and Training	Undergraduate School		Degree
	Dates (From mm/yy To mm/yy)	City	State
	Professional School	City	State
	Dates (From mm/yy To mm/yy)	Type of Training	
	Advanced Training / Graduate School - Facility Name	City	State
	Dates (From mm/yy To mm/yy)	Specialty	
	Fellowship Training -- Facility Name	City	State
	Dates (From mm/yy To mm/yy)	Specialty	

CERTIFICATION/RECERTIFICATION

Are you currently certified?

Yes ☐ No ☐ List all current and past board certifications

Certifying Organization	Certification #	Date Certified ___/___ (mm/yy)	Date Recertified ___/___ (mm/yy)	Date Recertified ___/___ (mm/yy)	Expiration Date ___/___ (if any)(mm/yy):
		/	/	/	/
		/	/	/	/

Please answer the following questions. Attach explanation form(s) if necessary.

A.	Have you ever been examined by any certification organization, but failed to pass? If yes, please provide name of board(s) and date(s):	Yes ☐ No ☐

Clinical Certification	BLS Certification:	ACLS Certification:	ATLS Certification:	PALS Certification:
	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
	Expiration Date: _____ / _____ / _____	Expiration Date: _____ / _____ / _____	Expiration Date: _____ / _____ / _____	Expiration Date: _____ / _____ / _____

NRP Certification:	Federal DEA Number:	Other Certification:
Yes ☐ No ☐		Type: _________________
Expiration Date: _____ / _____ / _____	Expiration Date: _____ / _____ / _____	Expiration Date: _____ / _____ / _____

LICENSURE

Please enter the information in the table below for all states in which you have held a medical license.

STATE	LICENSE NUMBER	LICENSE TYPE	LICENSE STATUS	DATE ORIGINALLY ISSUED (MM/YY)	LICENSE EXPIRATION DATE (MM/DD/YY)	STATE MEDICARE PROVIDER NUMBER	STATE MEDICAID PROVIDER NUMBER	STATE CONTROLLED SUBSTANCE PERMIT NUMBER (IF APPLICABLE)
			☐Active ☐Inactive					
			☐Active ☐Inactive					
			☐Active ☐Inactive					
			☐Active ☐Inactive					
			☐Active ☐Inactive					
			☐Active ☐Inactive					
			☐Active ☐Inactive					
			☐Active ☐Inactive					
			☐Active ☐Inactive					

☐ ***Additional licenses listed on attached sheet***

ADVANCED PRACTICE.com
a Jackson Healthcare company

REFERENCES

Please list six ***peer or supervisor*** *references that are able to comment upon your* ***current*** *clinical and professional capabilities.*

Name	Specialty	Phone # Fax # Email
Address	City State Zip code	
Name	Specialty	Phone # Fax # Email
Address	City State Zip code	
Name	Specialty	Phone # Fax # Email
Address	City State Zip code	
Name	Specialty	Phone # Fax # Email
Address	City State Zip code	
Name	Specialty	Phone # Fax # Email
Address	City State Zip code	
Name	Specialty	Phone # Fax # Email
Address	City State Zip code	

WORK HISTORY

Please list all your practice locations and employment affiliations to cover at least the past ten years of clinical practice. ***Beginning and ending month and year are required for each listing.*** Please provide a separate explanation of work gaps over 30 days in duration. If you desire the Jackson CVO not to contact these facilities, please check the appropriate box and attach a letter of explanation. You may attach an additional sheet if all required work history information will not fit in this section.

From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone	Fax:	
Do Not Contact ☐		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone	Fax:	
Do Not Contact ☐		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone	Fax:	
Do Not Contact ☐		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone	Fax:	
Do Not Contact ☐		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone	Fax:	

ADVANCED PRACTICE .com
a Jackson Healthcare company

	Do Not Contact ☐	Address	City	State	Zip Code

CURRENT HOSPITAL AND OTHER FACILITY AFFILIATIONS

Please list in reverse chronological order with the current affiliation(s) first: Include affiliations for the last 10 years. Do not list residencies, internships or fellowships. You may attach an additional sheet if needed.

CURRENT HOSPITAL AND OTHER FACILITY AFFILIATIONS DOES NOT APPLY ☐

PRIMARY FACILITY NAME:	APPOINTMENT PERIOD (MONTH/YEAR) From:____/_____ To:____/_____	CITY, STATE: Phone #: Fax #:
FACILITY NAME:	APPOINTMENT PERIOD (MONTH/YEAR) **From:____/_____** **To:____/_____**	CITY, STATE: **Phone #: Fax #:**
FACILITY NAME:	APPOINTMENT PERIOD (MONTH/YEAR) **From:____/_____** **To:____/_____**	CITY, STATE: **Phone #: Fax #:**
FACILITY NAME:	APPOINTMENT PERIOD (MONTH/YEAR) **From:____/_____** **To:____/_____**	CITY, STATE: **Phone #: Fax #:**
FACILITY NAME:	APPOINTMENT PERIOD (MONTH/YEAR) **From:____/_____** **To:____/_____**	CITY, STATE: **Phone #: Fax #:**
FACILITY NAME:	APPOINTMENT PERIOD (MONTH/YEAR) **From:____/_____** **To:____/_____**	CITY, STATE: **Phone #: Fax #:**
FACILITY NAME:	APPOINTMENT PERIOD (MONTH/YEAR)	CITY, STATE:

	From:____/_____ To:____/_____	**Phone #:** **Fax #:**
FACILITY NAME:	APPOINTMENT PERIOD (MONTH/YEAR) **From:____/_____** **To:____/_____**	CITY, STATE: **Phone #:** **Fax #:**
FACILITY NAME:	APPOINTMENT PERIOD (MONTH/YEAR) **From:____/_____** **To:____/_____**	CITY, STATE: **Phone #:** **Fax #:**
FACILITY NAME:	APPOINTMENT PERIOD (MONTH/YEAR) **From:____/_____** **To:____/_____**	CITY, STATE: **Phone #:** **Fax #:**
FACILITY NAME:	APPOINTMENT PERIOD (MONTH/YEAR) **From:____/_____** **To:____/_____**	CITY, STATE: **Phone #:** **Fax #:**
FACILITY NAME:	APPOINTMENT PERIOD (MONTH/YEAR) **From:____/_____** **To:____/_____**	CITY, STATE: **Phone #:** **Fax #:**
FACILITY NAME:	APPOINTMENT PERIOD (MONTH/YEAR) **From:____/_____** **To:____/_____**	CITY, STATE: **Phone #:** **Fax #:**

ADVANCED PRACTICE.com
a Jackson Healthcare company

DISCIPLINARY ACTIONS

If your answer to any of the following questions is "Yes", please provide a full explanation on the attached Credentialing Application Explanation Form and include any additional documentation if necessary.

Have any of the following ever been, or are currently in the process of, being: denied, revoked, suspended, reduced, limited, placed on probation, not renewed, surrendered or voluntarily relinquished? If the answer is "Yes" to any item please provide an explanation as outlined above.

1. Professional License in any state? ☐ Yes ☐ No	6. Institutional affiliation / status? ☐ Yes ☐ No
2. DEA Registration (federal or state programs)? ☐ Yes ☐ No	7. Professional society membership or fellowship / certification? ☐ Yes ☐ No
3. Other Professional Registration / License? ☐ Yes ☐ No	8. Any professional sanction (e.g. government, administrative agency or other)? ☐ Yes ☐ No
4. Clinical Privileges? ☐ Yes ☐ No	9. Participation in any private, federal, or state health insurance program (e.g. Medicare, Medicaid)? ☐ Yes ☐ No
5. Membership / Rights on any medical staff? ☐ Yes ☐ No	

10. Do you currently have any physical or mental condition including current alcohol or drug dependency that may affect your ability to practice or exercise the privileges typically associated with the specialty and position for which you are applying? ☐ Yes ☐ No

11. Are you currently using illegal drugs or legal drugs in an illegal manner? ☐ Yes ☐ No

12. Is there any reason that you are unable to perform the essential functions of the position for which you are applying safely and according to accepted standards of performance with or without reasonable accommodation? (If yes, explain on the attached form) ☐ Yes ☐ No

13. Have you ever been convicted of, pled guilty to, or pled nolo contendere for, any criminal offense (excluding parking tickets)? ☐ Yes ☐ No

14. Are any criminal charges currently pending against you in any jurisdiction? ☐ Yes ☐ No

15. Have you ever been arrested for or charged with a crime involving children? ☐ Yes ☐ No

16. Have you ever been arrested for or charged with a sexual offense including sexual harassment? ☐ Yes ☐ No

17. Have you ever been arrested for or charged with a crime involving moral turpitude? ☐ Yes ☐ No

18. Is there any other issue which should be disclosed that may have an adverse impact on your ability to deliver effective clinical health care services? ☐ Yes ☐ No

 AdvancedPractice.com | 2655 Northwinds Parkway | Alpharetta, GA 30009 | phone 877.740.0404| fax 678.352.4388

ADVANCED PRACTICE .com
a Jackson Healthcare company

PROFESSIONAL LIABILITY

1. Have you ever been denied professional liability insurance or denied renewal of an existing policy?
If the answer to the above question is "YES" please attach a brief explanation.

☐ Yes ☐ No

2. Have any malpractice claims, suits, settlements, or arbitration proceedings ever been made against you including any that have been dismissed?

☐ Yes ☐ No

3. Are you aware of any claims, suits, or settlements currently pending or of any intent to file a claim or suit?

☐ Yes ☐ No

If your answer to either of the above questions is "Yes" please provide the following information on each claim and provide a brief clinical summary of each case on the attached Professional Liability Claims Information Form.

	Plaintiff Name and Insurance Carrier	Location (County, State)	Status (Dismissed / Settled / Judgment / Pending)	Date of Incident (mm/yy)	Amount of Award or Settlement (if appropriate)
# 1					Summary Included ☐
# 2					Summary Included ☐
# 3					Summary Included ☐
# 4					Summary Included ☐

☐ Additional Malpractice Claims or incidents are listed on attached sheet

Please list your current malpractice insurance carrier and the associated information for the last 10 years. If you currently do not carry any malpractice insurance, please list the last malpractice insurance carrier which provided coverage for you. In addition, please list any malpractice insurance carrier who has been associated with any malpractice claim, suit or settlement listed below.

Malpractice Insurance Carrier	Policy Number	Policy Dates From (mm/yy)	Policy Dates To (mm/yy)	Amount of Coverage

AdvancedPractice.com | 2655 Northwinds Parkway | Alpharetta, GA 30009 | phone 877.740.0404| fax 678.352.4388

ADVANCED PRACTICE .com
a Jackson Healthcare company

Current Continuing Medical Education (CME / CEU)

Please provide CME/CEU activity completed within the last 3 years. This summary form may be submitted in lieu of sending copies of your CME/CEU certificate(s) for internal credentialing; however, some facilities may require actual copies of your certificates for privileging. Please make as many copies of this page as needed.

Program Title	Date	Sponsoring Organization	# of CMEs/CEUs

Professional Liability Claims Information Form

The following information is necessary to complete the credentialing verification process and will be kept confidential. Please print or type answers to the following for any malpractice claims reported to your malpractice insurance carrier, opened, closed, dismissed, settled or paid. Please complete a separate form for each claim. One case per sheet only (please photocopy first if additional sheets are needed)

PROVIDER'S NAME (REQUIRED):____

1. Name of Patient Involved: ______________________________ Age: ________________

   Month and Year of Occurrence: ____/_____ Month and Year of Lawsuit: ____/_____

   Event Precipitating Claim:______________________________ Insurance Carrier at Time: _____________________

2. What is/was your status: ☐ Primary Defendant ☐ Co-defendant ☐ Other

   Please list other Defendants: ____

What was the patient's outcome? ____

How were you alleged to have caused harm or injury to this patient?
____

Please provide specifics in reference to the adverse event:
____

What is/was your role in this event?
____

Current Status***: (please check one)***

☐ Still pending: as of (date) ___/___/_____

Who is handling the defense of the case?

____

☐ Trial date set, awaiting trial? ☐ Yes ☐ No Trial Date: ____/___/_____

☐ Settled out of court? ☐ Yes ☐ No Date: ____/___/_____ Amount of Total Settlement: $ _____________

Amount Paid on Your Behalf: $ ____________

☐ Dismissed: Date: ___/___/_____

☐ Defense Verdict: Date: ___/___/_____

☐ Plaintiff Verdict: Date: ___/___/_____

☐ Judgment Amount: $ ___________________ Date: ___/___/_____ Amount of Total Judgment: $ _

This professional Liability Claims Information Form is required on all claims/lawsuits. Clinical details are required for all suits, regardless of status or settlement amount.

I certify that the information contained in this form is correct and complete to the best of my knowledge.

APPLICANT'S SIGNATURE: ________________________________ ***DATE:*** ______________________

Print Name: ____

Credentialing Application Explanation Form

Please make as many copies of this page as needed to fully respond to each question for which you answered "yes". Provide your name on each page if additional sheets are used.

Identify the Section of the application that you are providing an explanation for.

Provider Name: ____

SECTION/QUESTION#:	COMMENTS:

APPLICANT'S SIGNATURE: ________________________________ ***DATE:*** ______________________

Print Name: ____

AdvancedPractice.com | 2655 Northwinds Parkway | Alpharetta, GA 30009 | phone 877.740.0404| fax 678.352.4388

Authorization, Attestation and Release
(Credentialing)

I acknowledge that AdvancedPractice.com (“AP.com”) has engaged a third-party credentialing organization (the “Jackson CVO”) or caused the Jackson CVO to be engaged to provide certain credentialing services from time to time on an on-going basis in connection with my candidacy for locum tenens or full time placement with hospitals, clinics or other healthcare clients of AP.com (the “Clients”). I understand that, as part of the credentialing application process for each such Client, the Jackson CVO must collect information from me and from third parties and share all or part of such information with the Client for a proper evaluation of my current licensure, relevant training and experience, clinical competence, health status, character, ethics, and any other criteria used by the Jackson CVO and the Client for determining my initial and ongoing eligibility to provide healthcare services to or on behalf of the Client.

I further acknowledge and understand that my cooperation in providing and assisting the Jackson CVO in obtaining information and my consent to the release of information does not guarantee that any Client will grant me clinical privileges or contract with me as a provider of services. I understand that my credentialing application is not an application for employment and that acceptance of my application by the Jackson CVO or its Clients will not in itself result in my employment.

Agreement to Provide Information
I agree to provide on a timely basis as requested by the Jackson CVO sufficient and accurate information as deemed necessary or appropriate by the Jackson CVO for the completion, submittal and support of my credentialing applications.

Authorization of Investigation Concerning Application
I authorize the Jackson CVO and the Client, and their respective employees, affiliated entities and representatives and agents (together and individually the “Agents”), to collect, hold, and investigate information, which includes both oral and written statements, records, and documents, concerning or to be included in my credentialing applications. I agree to allow the Agents to inspect and copy all records and documents relating to my credentialing applications and to disclose and share any such information among themselves in connection with their investigations.

Authorization of Third-Party Sources to Release Information
I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, promptly upon an Agent’s request to release to the Agents information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, education, training, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnoses and treatment, ethics, behavior, or any other matter having a bearing on my qualifications for credentialing with the Jackson CVO and the Clients (whether it has such a bearing may be presumed by such third parties solely by receipt of a request of information from an Agent). I authorize my current and past professional liability carrier(s) to release to Agents my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Release from Liability
I release from all liability and hold harmless the Agents and any entity responding to a request for information by an Agent as authorized hereunder, and any other third party, and their respective owners, managers, directors, officers, employees, agents and representatives, for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of such Agent or other third party in connection with the gathering, holding, use, sharing and interpretation of, and reliance upon, information which is the subject of this Authorization, Attestation and Release. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for credentialing activities.

Attestation
I certify that all information provided by me in connection with my credentialing application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify AP.com and the Jackson CVO (and its Client, if requested) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in connection with my credentialing application or authorized to be released to Agents in connection with the credentialing process.

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

APPLICANT'S SIGNATURE: ____***DATE:*** _________________________

Print Name: ____

Locum Tenens Practice Experience

List professional locum tenens experience in chronological order. Attach a separate sheet if necessary.

1. Facility	Phone	Fax
Address	City, State, Zip	
Contact	Date from	To
2. Facility	Phone	Fax
Address	City, State, Zip	
Contact	Date from	To
3. Facility	Phone	Fax
Address	City, State, Zip	
Contact	Date from	To
4. Facility	Phone	Fax
Address	City, State, Zip	
Contact	Date from	To
5. Facility	Phone	Fax
Address	City, State, Zip	
Contact	Date from	To
6. Facility	Phone	Fax
Address	City, State, Zip	
Contact	Date from	To
7. Facility	Phone	Fax
Address	City, State, Zip	
Contact	Date from	To

 AdvancedPractice.com | 2655 Northwinds Parkway | Alpharetta, GA 30009 | phone 877.740.0404| fax 678.352.4388

ADVANCED PRACTICE .com
a Jackson Healthcare company

Authorization Agreement for Ach Credits (Direct Deposit)

Name:
Address:
City, State, Zip:
Social Security #:

Please deposit my payment into the following account:

ACCOUNT TYPE   TRANSIT/ABA NUMBER   ACCOUNT NUMBER

☐ Checking Account (Attach a voided CHECK)   ☐ Savings Account (Attach a blank DEPOSIT SLIP) _______________ _________________

I hereby authorize **Advanced Practice Professionals, LLC** to deposit my check each pay period directly into my account of choice. This authorization will activate my direct deposit on the next payment date following receipt by the Accounting Department and remain in effect until I have terminated it in writing or until **Advanced Practice Professionals, LLC** has notified me that this deposit service is no longer available. If I need to make changes to my account selection, I understand that I must give advance notice to allow reasonable time for making these changes. I authorize my bank to honor **Advanced Practice Professionals, LLC** instructions to refund any amount it has deposited to my account.

Signature: ______________________________ Date: _________________________________

AdvancedPractice.com | 2655 Northwinds Parkway | Alpharetta, GA 30009 | phone 877.740.0404| fax 678.352.4388

Independent Contractor Statement

The undersigned service provider (the "Provider") states, acknowledges and agrees that he/she is an independent contractor and is not an employee of AdvancedPractice.com or any of its affiliates.

1. I am a trained healthcare provider engaged in the practice of healthcare.
2. I am solely responsible for my professional actions in providing services to patients at the contracted healthcare facilities or elsewhere.
3. AdvancedPractice.com does not have the right to direct or control the manner in which I practice my profession.
4. I independently determine the assignments I am willing to accept and the rate at which I will be paid for each assignment. I cannot be directed by AdvancedPractice.com to accept assignments.
5. AdvancedPractice.com does not direct my professional services in any manner, including the time, place, type of professional service, working conditions, quality of the professional service, my right to utilize or hire assistants or the prices charged for the services I render.
6. I am capable of performing the services required by the assignments I accept. I understand that AdvancedPractice.com does not control the working environment for the assignment and I will address any requests for assistance, accommodations or modifications necessary to perform the services directly with the healthcare facilities.
7. My contract with AdvancedPractice.com governs termination of my contractual relationship with AdvancedPractice.com and the termination of my participation in a particular assignment.
8. To my knowledge, AdvancedPractice.com has no relationship with the healthcare facilities with whom I accept assignments other than that of a contracted placement agency, and I understand that AdvancedPractice.com is not licensed to nor does engage in the practice of medicine.
9. I am not employed by AdvancedPractice.com. As an independent contractor, I agree that I am responsible for and will pay all federal, state and local income or self-employment taxes due on payments received as a result of this assignment, and I am **NOT** entitled to claim unemployment benefits or workers compensation benefits against AdvancedPractice.com.
10. To the extent I receive payments from AdvancedPractice.com in relation to this assignment, such payments are made by AdvancedPractice.com on behalf of the Client for the services I have provided to the Client.

This Declaration is a true and correct statement of the facts set forth herein.
This Declaration is executed as of _________________, 20___.

PROVIDER

____
(Signature)
____
(Print Name)

AdvancedPractice.com | 2655 Northwinds Parkway | Alpharetta, GA 30009 | phone 877.740.0404| fax 678.352.4388

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Cer

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
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation,
☐ Other (see instructions) ►

Address (number, street, and apt. or suite no.)

City, state, and ZIP code

List account number(s) here (optional)

Part I **Taxpayer Identification Number (TIN)**

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

Employer identification number

Part II **Certification**

Taxpayer Identification Number (TIN)

Social security number

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.

Certification

Under penalties of perjury, I certify that:

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

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign

Signature of

Here

U.S. person � Date �

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid,

AdvancedPractice.com | 2655 Northwinds Parkway | Alpharetta, GA 30009 | phone 877.740.0404| fax 678.352.4388

acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

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

U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien, A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

Cat. No. 10231X Form **W-9** (Rev. 10-2007) Form W-9 (Rev. 10-2007) Page **2**

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form 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 payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an 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. This is called “backup withholding.” Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee 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,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
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.
Also see *Special rules for partnerships* on page 1.

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 income tax return. 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 entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the “Name” line. You may enter your business, trade, or “doing business as (DBA)” name on the “Business name” line.

Limited liability company (LLC). Check the “Limited liability company” box only and enter the appropriate code for the tax classification (“D” for disregarded entity, “C” for corporation, “P” for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner’s name on the “Name” line. Enter the LLC’s name on the “Business name” line.

For an LLC classified as a partnership or a corporation, enter the LLC’s name on the “Name” line and any business, trade, or DBA name on the “Business name” line.

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 Payee

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

AdvancedPractice.com | 2655 Northwinds Parkway | Alpharetta, GA 30009 | phone 877.740.0404| fax 678.352.4388

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.

The following payees are exempt from backup withholding:

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:

1. A corporation,
2. A foreign central bank of issue,
   a. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
3. A futures commission merchant registered with the Commodity Futures Trading Commission,
   a. 10. A real estate investment trust,
4. An entity registered at all times during the tax year under the Investment Company Act of 1940,
5. A common trust fund operated by a bank under section 584(a),
   a. 13. A financial institution,
6. A middleman known in the investment community as a nominee or custodian, or
7. 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 payees listed above, 1 through 15.

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-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 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*. 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 Identification Number (EIN) under Starting a Business. 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. Entering "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 payees, see *Exempt Payee* 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.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 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 payees 1 through 5
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 7 [2]

 AdvancedPractice.com | 2655 Northwinds Parkway | Alpharetta, GA 30009 | phone 877.740.0404| fax 678.352.4388

Form W-9 (Rev. 10-2007) Page **4**

1. **Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.
2. **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 nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).
3. **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

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN &
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

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 disregarded entity owned by an individual	The owner [3]

For this type of account:	Give name and EIN of:
A valid trust, estate, or pension trust 6. Corporate or LLC electing corporate status on Form 8832 7. Association, club, religious, charitable, educational, or other tax-exempt organization 8. Partnership or multi-member LLC 9. A broker or registered nominee 10. 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 11. Disregarded entity not owned by an individual 12.	Legal entity [4] The corporation The organization The partnership The broker or nominee The public entity The owner

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.consumer.gov/idtheft* or 1-877-IDTHEFT(438-4338).

Visit the IRS website at *www.irs.gov* to learn more about identity theft and how to reduce your risk.

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 and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

4 List first and circle the name of the 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.) Also see *Special rules for partnerships* on page 1.

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 or HSA. 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, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% 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.