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

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 Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under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

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

Applicant's Signature: Date

Type or Print name here

|  |  |  |
| --- | --- | --- |
| **1. PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL** | **Does Not Apply** | |
| Practitioner Name:(print or type) | |
| Please list any past or current professional liability claim(s) or lawsuit(s) not disclosed during previous (re)appointment/(re)credentialing, in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected PHI. Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative. | |
| Date and clinical details of the incident, with preceding events:  Date: Details: | |
|  | |
|  | |
|  | |
|  | |
| Your role and specific responsibility in the incident: | |
|  | |
|  | |
|  | |
| Subsequent events, including patient’s clinical outcome: | |
|  | |
|  | |
| Date suit or claim was filed: | |
| Name and Address of Insurance Carrier that handled the claim: | |
|  | |
| Your status in the legal action (primary defendant, co-defendant, other): | |
| Current status of suit or other action: | |
| Date of settlement, judgment, or dismissal: | |
| If case was settled out-of-court, or with a judgment, settlement amount attributed to you? **$** | |

|  |  |  |  |
| --- | --- | --- | --- |
| **2. Physician/Practitioner Health Program Disclosure**  Please complete below details if you answered yes to Question C.2 above | | **Does Not Apply** | |
| Name of Monitoring Program | | | |
| Address of Monitoring Program | | | |
| Point of Contact Name: | Phone Number | | Verification E-mail Address: |

|  |
| --- |
| **3. ATTESTATION** |
| I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A copy, or electronic PDF with signature authentication, has the same force and effect as the original. I have reviewed this information as of the most recent date listed below. |

|  |  |  |
| --- | --- | --- |
| Print Name Here: |  | |
| Signature: |  | |
| (Stamped signature is not acceptable) | |  |
| Date: |  | |

|  |
| --- |
| **Review dates and initials:** |
|  |
|  |
|  |
|  |
|  |
|  |