CREDENTIALING APPLICATION TO PARTICIPATE AS A HEALTH CARE PRACTITIONER

Please submit application to:
Credentialing@TrilliumNC.org

Trillium
HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

ACCREDITED NCQA MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION 1 YEAR

urac ACCREDITED Health Network Expires 03/01/2022

urac ACCREDITED Health Utilization Management Expires 03/01/2022

urac ACCREDITED Health Call Center Expires 03/01/2022

INSTRUCTIONS

A Licensed Practitioner must apply for and be credentialed with Trillium Health Resources to qualify for reimbursement of services provided to Trillium Health Resources members. Additionally, Practitioners must have a signed contract with Trillium Health Resources or be employed by an Organization or Group Practice that has a signed contract with Trillium Health Resources to qualify for reimbursement of services provided to Trillium Health Resources members.

THE CREDENTIALING PROCESS INCLUDES THE FOLLOWING STEPS:

1. Provider completes and signs the Credentialing Application and returns it along with the required documentation to Credentialing@TrilliumNC.org
2. A Credential Application is considered to be invalid and must be returned to the provider for correction and/or for additional information if:

- All spaces in the application have not been completed. Must put N/A or Not Applicable
- The Signatures, where required, are not original and dated within 180 days.
- The Signatures are not by the individual applicant.
- The text has been altered, highlighted, struck through, or obstructed through the use of correction fluids.
- The responses are illegible.
- The National Provider Identifier is not a valid number.
- Any of the documents or pages that comprise the Credentialing Application are missing.
- Any requested information in any of the documents that comprise the application are missing.
- NC Tracks enrollment is incomplete or missing service location, accreditation, taxonomy, or affiliations, as required.

CHECKLIST - Before submitting the Credentialing Application, ensure the necessary components are included in the following order:

- ☐ Current Valid Enrollment with NC Tracks.
- ☐ Copy of the Certificate of Insurance for your current professional liability, with coverage amounts of $1,000,000 / $3,000,000 aggregate, effective date, expiration date, and policy number. Completed, signed and dated, included Waiver regarding Auto Insurance Coverage form. Licensed Practitioners who certify in writing that they do not transport clients shall not be required to obtain Automobile Liability Insurance. Licensed Practitioners who do not employ any staff shall not be required to obtain Worker's Compensation or Employer's Liability Insurance.
- ☐ Completed Background Check Authorization Form.
- ☐ Letter(s) of reference or recommendation, and/or oversight, if required (Practitioner Evaluation Forms included in this packet). Minimum of two (2) references. Must be dated within the past 180 days. Trillium Health Resources reserves the right to contact at least one (1) reference.
- ☐ Copy of the practitioner's original state(s) license(s) and current registration.
  - ☐ If provisionally licensed, submit a current copy of your supervision contract and complete the clinical supervisor information on Item 54 of Section 1 of application. There must be an attestation from the clinical supervisor stating that the provisionally licensed practitioner is receiving supervision and that the supervisor approves the supervision contract.
- ☐ Copy of current Federal DEA certificate (for MDs/DOs, Physician Assistants and Psychiatric Nurse Practitioners). The Certificate must have a valid date and refer to current address.
- ☐ Copy of certificate from the Specialty Board, if applicable.
- ☐ Physicians who are not "Board Certified" must provide an official certified copy of educational transcripts from highest level of education.
- ☐ Copy of Educational Commission of Foreign Medical Graduate Certificate-ECFMG, if applicable.
- ☐ Copy of Curriculum Vitae or work history after graduation from Medical, Dental or other professional school.

SECTION 1: DEMOGRAPHIC AND PERSONAL DATA

Date of Application: ☐ Independent Licensed Practitioner ☐ Supplemental Licensed Practitioner

1. Name of Applicant: _____
   Last Name First Name Middle Name Maiden

2. List All Current Credentials:

3. Date of Birth:

4. Race/Ethnicity:

5. Social Security Number:

6. Sex:

7. NPI:

8. Taxonomy:

9. Type of Practice: ☐ Primary Care ☐ Specialist

10. Specialty (e.g. addiction):

11. What population(s) do you treat (e.g., geriatric, all ages)?

12. Language(s) Proficiently Spoken, including sign language:
    Are interpreters available: ☐ Yes ☐ No

13. Name of Practice:

14. Main Service Location
    Address: _____
    Street City State Zip+4

    County: Phone #: Fax #:

    Site NPI (Attach copy to application): Email:

    Site Taxonomy:

    Is this a registered business with Secretary of State? ☐ Yes ☐ No

    Accepting New Referrals: ☐ Yes ☐ No Restrictions:

    Handicapped accessible: ☐ Yes ☐ No
    If no, explain how you would accommodate members with physical disabilities:

    Days/Hours of Operation:
    Do you provide services in the community? ☐ Yes ☐ No

15. Billing Information (Only applicable if applicant is approved for a contract with Trillium Health Resources.) ☐ N/A
    Enter information to be used for submitting claims:

    Name (if different from practice name): Federal Tax ID #/SSN:

    Billing Address: _____
    Street City State Zip+4

SECTION 1: DEMOGRAPHIC AND PERSONAL DATA
Continued

Additional Office:
Address: ______________________________
Street *City* *State* *Zip+4*

Site NPI:	Site Taxonomy:	
Phone #:	Fax #:	Email:
Days/Hours of Operation:		

Handicapped accessible: ☐ Yes ☐ No
If no, explain how you would accommodate members with physical disabilities:

Additional Office:
Address: ______________________________
Street *City* *State* *Zip+4*

Site NPI:	Site Taxonomy:	
Phone #:	Fax #:	Email:
Days/Hours of Operation:		

Handicapped accessible: ☐ Yes ☐ No
If no, explain how you would accommodate members with physical disabilities:

Additional Office:
Address: ______________________________
Street *City* *State* *Zip+4*

Site NPI:	Site Taxonomy:	
Phone #:	Fax #:	Email:
Days/Hours of Operation:		

Handicapped accessible: ☐ Yes ☐ No
If no, explain how you would accommodate members with physical disabilities:

Additional Office:
Address: ______________________________
Street *City* *State* *Zip+4*

Site NPI:	Site Taxonomy:	
Phone #:	Fax #:	Email:
Days/Hours of Operation:		

Handicapped accessible: ☐ Yes ☐ No
If no, explain how you would accommodate members with physical disabilities:

SECTION 1: DEMOGRAPHIC AND PERSONAL DATA
Continued

16. Administrative Contact: _____ Title: _____

Address: _____
Street *City* *State* *Zip+4*

Phone #:	Fax #:	Email:

17. Specify the arrangements for 24 hour/7 day coverage apart from and in addition to Community Emergency Response Services (e.g. 911, Emergency Department, Mobile Crisis, etc.):

Phone #:_____

18. Name and address of practitioner(s) who share call with you.
Practitioners must have similar license or higher and be actively credentialed with Trillium Health Resources.

Name: _____ License: _____

Address: _____
Street *City* *State* *Zip+4*

Name: _____ License: _____

Address: _____
Street *City* *State* *Zip+4*

19. Are you currently affiliated with another agency or practice? ☐ Yes ☐ No
(if so, please list the name of the agency):

Agency Name: _____ Start Date: _____

Agency Name: _____ Start Date: _____

Agency Name: _____ Start Date: _____

20. DEA # (Attach copy to application):	Exp. Date:

21. Provide the following information for each state in which you are currently or were previously licensed to practice *(if necessary, please attach additional sheet)*:

State	Date of License	License Number	License Type	Status: *Active, Inactive, Suspended*	Expiration Date

******PLEASE ATTACH A COPY OF EACH STATE LICENSE CERTIFICATE******

22. If provisionally licensed, provide a copy of your current supervision contract and the name and contact information for your clinical supervisor:

Clinical Supervisor: _____

Address: _____
Street *City* *State* *Zip+4*

Phone #: Email:

SECTION 1: DEMOGRAPHIC AND PERSONAL DATA
Continued

23. Certification of Specialty Boards as applicable: ☐ N/A

If you are certified by a specialty board, indicate name of board and date of certificate.

Primary Specialty Board:_____ Date Certified _____
Expiration Date _____

Secondary Specialty Board:_____ Date Certified _____
Expiration Date _____

Are you listed in the American Board of Medical Specialists? ☐ Yes ☐ No

If you have applied to a specialty board for examination, give the name of board and the date of the scheduled examination:

Specialty Board Name: _____ Date: _____

If you have not applied to a specialty board, please explain:

24. List the dates of all current professional memberships in societies, including state and county societies: ☐ N/A

Professional Membership	From (Month/Year)	To (Month/Year)

25. List all hospitals where you currently have privileges and indicate the type and status of those privileges (physicians only, if Not Applicable please indicate):

Hospital: _____ Estimated % of Admissions: _____
Privilege and Status of Privilege:

Primary Admitting Facility:_____ Estimated % of Admissions: _____
Privilege and Status of Privilege:

If you do not have admitting privileges, who admits for you (physicians only): (Attach a copy of your Admitting Plan)

Name of Admitting Individual: _____

Address: _____
Street *City* *State* *Zip+4*

Phone #: Email:

SECTION 2: EDUCATION PRACTICE HISTORY

1. Medical, Dental or other Professional School Attended ("See Resume" is not acceptable.):

   Institution: _____

   Address: _____

   Street *City* *State* *Zip*

Degree:	Date From:	Date To:

Name as it appears on degree: _____

Please attach Educational Commission of Foreign Medical Graduate Certificate – (ECFMG) if applicable.

2. Internship: Institution: _____

   Address: _____

   Street *City* *State* *Zip*

Specialty:	Date From:	Date To:

3. Residency: Institution: _____

   Address: _____

   Street *City* *State* *Zip*

Specialty:	Date From:	Date To:

4. Other Residency/Fellowship (specify): Institution: _____

   Address: _____

   Street *City* *State* *Zip*

Specialty:	Date From:	Date To:

5. List work history since beginning of medical, dental or other professional school (last five [5] years) and explain any employment gaps longer than 6 months; please be specific:
   ("See Resume" is not acceptable.) (if necessary, please attach additional sheet)

Practice Name	From (Month/Year)	To (Month/Year)
Current Practice:		
Current Practice:		
Previous Practice:		
Previous Practice:		
Previous Practice:		
Previous Practice:		

6. List other training and/or education (including CME) within the last five (5) years:

7. Have you involuntarily or voluntarily withdrawn, or been suspended from any internship, residency or fellowship training program (Please explain):

8. Please explain any incident(s) in which you have involuntarily or voluntarily withdrawn your application for appointment, clinical privileges or reappointment before a decision was made by a hospital or healthcare facility's governing board:

SECTION 3: PRACTITIONER ATTESTATION QUESTIONS

Please check (√) **yes** or **no** for the following questions. If your answer to any of the following questions is "yes", provide details as specified on the Supplemental Form. This section must be completed and signed by the practitioner to be accepted.

A. PROFESSIONAL SANCTIONS

1. Have you ever 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 surrendered, 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? Or currently under investigation?
   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
   k. Professional employment ☐ Yes ☐ No
2. 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. Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions? ☐ Yes ☐ No
4. To your knowledge, have you ever been reported to the National Practitioner Data Bank or the North/South Carolina Board of Medical Examiners? (if applicable attach copy of NPBD report) ☐ Yes ☐ No

B. CRIMINAL HISTORY

1. Have you ever 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? Or do you have notice of any such anticipated charges? Are you currently under governmental investigation? ☐ Yes ☐ No

C. AFFIRMATION OF ABILITIES

1. Do you presently use any drugs illegally? ☐ Yes ☐ No
2. Do you have, or have you had in the last five years, any medical, physical, mental health, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance. ☐ 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

1. 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. 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. Have you ever 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
6. Have you ever practiced without liability coverage? ☐ Yes ☐ No

Signature _____ **Date** _____

***** Please provide additional detailed information on the following Supplemental Form *****

SECTION 3: PRACTITIONER ATTESTATION QUESTIONS - SUPPLEMENTAL FORM

☐ **N/A – No Supplemental Information Needed**

All spaces in the application must be completed. Additional pages can be attached in necessary. (Please indicate "N/A" or "None", if the question is not applicable)

Applicant Name:	
A. PROFESSIONAL SANCTIONS:	
List State(s) where action took place:	Date(s) of action:
Please explain:	
B. CRIMINAL HISTORY:	
Did you serve a sentence: ☐ Yes ☐ No	
If Yes, please check (√) how many years. ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Other:	
List State(s) where action took place:	Date(s) of action:
Please explain charge and verdict:	
C. AFFIRMATION OF ABILITIES:	
Please explain:	

SECTION 3: PRACTITIONER ATTESTATION QUESTIONS - SUPPLEMENTAL FORM

Continued

D. LITIGATION AND MALPRACTICE COVERAGE HISTORY:

Please list any past or current professional liability claim(s) or lawsuit(s), 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:

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?

SECTION 4: OWNERSHIP INFORMATION

1. **Do you have ownership or control interest of 5% or more in this organization?** ☐ Yes ☐ No

If yes, List all partners, managing employees and Electronic Funds Transfer (EFT) authorized individuals associated with your practice, and provide the information requested on each.

Name: **Address:**

Title: **SSN:** **License #:**

Date of birth: **% Owner:**

Check business relationship that applies:

☐ Owner ☐ Shareholder ☐ Partner ☐ Manager ☐ EFT Auth Staff

Check relationship to enrolling practitioner (if applicable).

☐ Spouse ☐ Parent ☐ Child ☐ Sibling

Name: **Address:**

Title: **SSN:** **License #:**

Date of birth: **% Owner:**

Check business relationship that applies:

☐ Owner ☐ Shareholder ☐ Partner ☐ Manager ☐ EFT Auth Staff

Check relationship to enrolling practitioner (if applicable).

☐ Spouse ☐ Parent ☐ Child ☐ Sibling

Name: **Address:**

Title: **SSN:** **License #:**

Date of birth: **% Owner:**

Check business relationship that applies:

☐ Owner ☐ Shareholder ☐ Partner ☐ Manager ☐ EFT Auth Staff

Check relationship to enrolling practitioner (if applicable).

☐ Spouse ☐ Parent ☐ Child ☐ Sibling

Name: **Address:**

Title: **SSN:** **License #:**

Date of birth: **% Owner:**

Check business relationship that applies:

☐ Owner ☐ Shareholder ☐ Partner ☐ Manager ☐ EFT Auth Staff

Check relationship to enrolling practitioner (if applicable).

☐ Spouse ☐ Parent ☐ Child ☐ Sibling

SECTION 4: OWNERSHIP INFORMATION
Continued

2. Do you have ownership or control interest of 5% or more in other organizations that bills Medicaid for services? ☐ Yes ☐ No

If yes, please fill in the following for each organization:

Organization Legal Business Name:

Employer ID #:

National Provider Identifier (NPI) #:

Organization Legal Business Name:

Employer ID #:

National Provider Identifier (NPI) #:

Organization Legal Business Name:

Employer ID #:

National Provider Identifier (NPI) #:

Organization Legal Business Name:

Employer ID #:

National Provider Identifier (NPI) #:

Organization Legal Business Name:

Employer ID #:

National Provider Identifier (NPI) #:

Organization Legal Business Name:

Employer ID #:

National Provider Identifier (NPI) #:

Organization Legal Business Name:

Employer ID #:

National Provider Identifier (NPI) #:

Organization Legal Business Name:

Employer ID #:

National Provider Identifier (NPI) #:

INSURANCE REQUIREMENTS AND ATTESTATIONS LICENSED INDEPENDENT PRACTITIONERS

CONTRACTOR shall purchase and maintain insurance as listed below from a company which is licensed and authorized to do business in the State of North Carolina by the North Carolina Department of Insurance as specified below, unless waived in writing by the LME/MCO.

i. Professional Liability: The CONTRACTOR shall purchase and maintain Professional Liability Insurance protecting the CONTRACTOR and any employee performing work under the Contract for an amount of not less than $1,000,000.00 per occurrence/$3,000,000.00 annual aggregate.

- ☐ I have provided my Certificate of Insurance showing that I meet this requirement. OR
- ☐ If I am covered by my employer's insurance, I have enclosed a statement (either from the employer or an insurance declaration page) that states I am covered.

ii. Comprehensive General Liability: If CONTRACTOR owns the building or facility where services are provided under this agreement, the CONTRACTOR shall purchase and maintain Bodily Injury and Property Damage Liability Insurance protecting the CONTRACTOR and any employee performing work under the Contract from claims of Bodily Injury or Property Damage arising from operations under the Contract for an amount of not less than $1,000,000.00 per occurrence/$3,000,000.00 annual aggregate.

- ☐ I do not own the building/facility where I provide services. OR
- ☐ I have provided my Certificate of Insurance showing that I meet this requirement.

iii. Automobile Liability: If CONTRACTOR transports recipients, the CONTRACTOR shall purchase and maintain Automobile Bodily Injury and Property Damage Liability Insurance covering all owned, non-owned, and hired automobiles for an amount not less than $500,000.00 each person and $500,0000.00 each occurrence. Policies written on a combined single limit basis shall have a minimum limit of $1,000,000.00.

- ☐ I do not transport recipients. OR
- ☐ I have provided my Certificate of Insurance showing that I meet this requirement. OR
- ☐ If I am covered by my employer's insurance, I have enclosed a statement (either from the employer or an insurance declaration page) that states I am covered.

iv. Workers' Compensation and Occupational Disease Insurance, Employer's Liability Insurance: The CONTRACTOR shall purchase and maintain Workers' Compensation and Occupational Disease Insurance as required by the statutes of the State of North Carolina. The CONTRACTOR shall purchase and maintain Employer's Liability Insurance for an amount not less than Bodily Injury by Accident $100,000.00 each Accident/ Bodily Injury by Disease $100,000.00 each Employee/Bodily Injury by Disease $500,000.00 Policy Limit. –

- ☐ Clinicians associated with my practice are independent contractors and I do not have the minimum number of employees that would require me to maintain this coverage. OR
- ☐ I have provided my Certificate of Insurance showing that I meet this requirement. OR
- ☐ N/A

v. Tail Coverage: Liability insurance may be on either an occurrence basis or on a claims-made basis. If the policy is on a claims-made basis, an extended reporting endorsement (tail coverage) for a period of not less than three (3) years after the end of the contract term, or an agreement to continue liability coverage with a retroactive date on or before the beginning of the contract term, shall also be provided.

CONTRACTOR shall:

i. Submit new COIs no later than ten (10) calendar days after the expiration of any listed policy to ensure documentation of continual coverage;
ii. Notify the LME/MCO in writing within two (2) business days of any cancellation or material change in coverage;
iii. Provide evidence to the LME/MCO of continual coverage at the levels stated above within seven (7) calendar days if CONTRACTOR changes insurance carriers during the performance period of the Contract including tail coverage as required for continual coverage; and
iv. Notify the LME/MCO in writing within two (2) business days of knowledge or notice of a claim, suit, criminal or administrative proceeding against CONTRACTOR and/or Practitioner relating to the quality of services provided under this Contract.

CONTRACTOR shall have the right to self-insure provided that CONTRACTOR's self-insurance program is licensed by the Department of Insurance of the State of North Carolina and has been actuarially determined sufficient currently to pay the insurance limits required in the Contract.

APPLICANT PRINT NAME _____ **APPLICANT SIGNATURE** _____

PRACTICE NAME _____ **DATE** _____

BACKGROUND CHECK AUTHORIZATION FORM

Name: _____ Previous Name: _____
First Middle Last

Current Address: _____
Street City State Zip Code

Number of years are residence? _____

1st Previous Address: _____
Street City State Zip Code

Number of years are residence? _____

2nd Previous Address: _____
Street City State Zip Code

Number of years are residence? _____

Social Security Number: _____ Date of Birth: _____

Driver's License # and State Issued: _____

Email Address: _____
(may be used for official correspondence)

Consumer Disclosure
I understand that Trillium Health Resources may rely on one or more consumer reporting agencies such as IntelliCorp, Inc. to obtain a consumer report(s) or investigative consumer report(s) (criminal background check, Databank, etc.) for credentialing purposes and I attest that all personal data provided is true, accurate, and complete.

Applicant Authorization
I hereby authorize Trillium Health Resources to obtain and rely upon consumer reports or investigative consumer reports for the purpose of credentialing.

_____ _____
Applicant's Signature Date

ATTESTATION STATEMENT

I certify the information submitted in this entire application, as well as any attachments or supplemental information, is complete, accurate, and current to my best knowledge and belief as of the date of signature below. I fully understand that any misstatements in or omissions from this application may constitute cause for denial of membership or termination of a resulting participation agreement. A photocopy of this application has the same force and effect as the original.

By application for membership in Trillium Health Resources, I signify my willingness to appear for interview in regard to my application. I authorize Trillium Health Resources to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to Trillium Health Resources materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of Trillium Health Resources of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of Trillium Health Resources for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to Trillium Health Resources in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to Trillium Health Resources.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Trillium Health Resources may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in Trillium Health Resources Network, I hereby consent to Trillium Health Resources for inspection of my patient records relating to Trillium Health Resources enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation. I further agree to notify Trillium Health Resources in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application.

PRINT NAME OF PRACTITIONER _____

SIGNATURE OF PRACTITIONER _____

DATE _____

PLEASE SIGN AND DATE THIS ATTESTATION STATEMENT

Submit