

Provider Information Request

Montana



The information provided on this form is required for claims processing and directory listings.

Please use separate forms for additional practice locations or practitioners/organizations.

Credential new provider

CAQH # _____

Change information

Termination Date _____

Add provider to new/additional location

Reason _____

Add provider at hospital-based location only¹

Effective date at your organization _____

For current in-network providers, the effective date will be applied after the first of following month.

1. Provider information (name as shown on CMS 1500 field 31 or UB box 1)

Individual practitioner

Organizational provider

PCP

Specialist

Name _____ SSN _____ Birth date _____ Male Female

NPI _____ Degree _____

Medical license number _____ DEA number _____

Offers telehealth Yes No (If it differs from practice location, list telehealth location in section 4.)

Note: Telehealth regulations require practitioners to be licensed by the state listed in section 2.

2. Practice location information (for patient visits and directory listing)

Practice name (as it should appear in directories) _____

Address _____ City _____ State _____ ZIP _____ County _____

Practitioner specialty (as practicing at this location) _____

List this location in directories? Note: hospital-based locations will not be listed. Yes No

Location NPI _____ Tax ID number (attach matching IRS W9) _____

Contact name _____ Contact email _____

Practice phone _____ Practice fax _____

3. Billing information (as listed on CMS 1500 field 33 or UB box 2)

Same as above

Billing name (as it appears on claims) _____

Address _____ City _____ State _____ ZIP _____ County _____

Billing contact name _____ Billing contact email _____

Billing contact phone _____ Billing contact fax _____

Credentialing email address _____

4. Summary of changes/notes

Form completed by _____

Email _____ Phone _____

¹**Hospital-based providers** are those who practice exclusively in an in-patient setting; a credentialing application is not required.

Return to: 828 Great Northern Blvd, Ste. 101, Helena, MT 59601 | Fax to: 406-422-1010 | Email to: MTProvNet@PacificSource.com



Credentialing Eligibility Criteria and Provider Rights and Responsibilities

IPN maintains a Credentialing/Recredentialing Program to assist in selection and reevaluation of providers within its delivery system. To participate with IPN, providers must successfully complete the credentialing process and be approved. Information provided on this application and acquired during the credentialing process may be provided to our clients.

Credentialing Eligibility Criteria

- Complete Universal Provider Credentialing Application
- Current, unrestricted license to practice for each state, as applicable
- Current DEA and State Board of Pharmacy certificates for each state, as applicable OR written Prescription Plan
- Proof of professional liability insurance for minimum of \$1,000,000 per occurrence and \$3,000,000 aggregate

Provider Rights and Responsibilities

The provider has the right to review information obtained in the process of evaluating the credentialing and recredentialing application exclusive of peer review information.

The provider has the right, upon request and subject to policies and procedures, to be informed of the status of the application. The Credentialing Department will make every effort to provide status at the time of request and, if unable, will respond by telephone or in writing within three (3) business days.

The provider has the right to revise, supplement or correct erroneous information to the Credentialing and recredentialing applications. This may be done at the provider's discovery or if deficiencies are discovered by IPN. The provider will be notified by telephone, email or written correspondence and will have thirty (30) days to respond. After thirty (30) days without response, the application will be withdrawn from the review process. When additional information is provided by the provider within the thirty (30) days but continues to fall short of meeting criteria requirement(s) the provider will be notified by telephone, email or written correspondence allowing the provider an additional thirty (30) days to respond.

If information is not received by the Credentialing Department within sixty (60) days of request, an updated attestation may be required.

A copy of any portion of the Universal Provider Credentialing Application has the same force and effect as the original.

Credentialing and recredentialing is non-transferrable.

Universal Provider Credentials Verification Application

To use the Universal Provider Application (UPA), follow these instructions

- ❖ Complete the application in its entirety using black or blue ink. **Keep an unsigned and undated copy of the application on file for future requests.** When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate. Please sign and date pages 12 and 13. Please document any YES responses on the Attestation Question page.
- ❖ **Prior to submitting this application to any health care related organization, inquire with the organization, as you may need authorization (through a pre-application process) before the application is accepted.** Identify the health care related organization(s) to which this application is being submitted in the space provided below.
- ❖ Attach copies of requested documents each time the application is submitted.
- ❖ If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- ❖ If a section does not apply to you, please check the provided box at the top of the section.

This application is submitted to:

I. INSTRUCTIONS

This form should be **typed or legibly printed in black or blue ink**. If more space is needed than provided, attach additional sheets and reference the question being answered. **Please do not use abbreviations.** **Current copies of the following documents must be submitted with this application** (all are required for MDs, DOs; as applicable for other health providers). If not available, indicate why.

- State Professional License(s)
- DEA Certificate w/ current address
- ECFMG (if applicable)
- State Controlled Substance Certificate (if applicable)
- Passport photo (for hospitals only)
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application.)

**** All sections must be completed in their entirety****

II. PROVIDER INFORMATION

Last name (include suffix; Jr., Sr., III)			First (do not abbreviate)			Middle (do not abbreviate)			
Other name(s) under which you have been known by reference, licensing and or educational institutions?						Degree(s)			
Home telephone number			Pager number		Cell number		E-mail address		
Home mailing address			City			State		Zip code	
Birth date		Birth place (city, state, country)		Social security number			Medicare Opt-Out - §1128 of the Social Security Act <input type="checkbox"/> Yes <input type="checkbox"/> No		
Languages spoken by provider			Type of Provider <input type="checkbox"/> PCP <input type="checkbox"/> Urgent Care <input type="checkbox"/> Specialist			Opt-Out Start Date		Opt-Out End Date	
Individual NPI #		Individual Medicare Number		Individual Medicaid number(s)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female			
Specialty at the primary practice location:			Taxonomy (10-digit code identifying specialty or subspecialty) <div style="display: flex; justify-content: space-between;"> </div>					Subspecialties:	

III. PRACTICE INFORMATION

Effective Date at Primary Practice location _____			
Name of practice, affiliation or clinic name			Department name (if hospital based)
Primary office street address		City	State Zip code
Patient appointment telephone number		Fax number	Name affiliated with tax ID number Federal tax ID number
Mailing address (if different from above)		City	State Zip code

III. PRACTICE INFORMATION (CONTINUED)	Billing address (if different from above)		City	State	Zip code
	Office manager / Administrator name		Administration telephone number	Fax number	E-mail address
	Credentialing contact (if different from above)		Credentialing telephone number	Fax number	E-mail address
	Effective Date at Secondary Practice location _____				
	Name of secondary practice, affiliation or clinic name			Department name (if hospital based)	
	Secondary office street address		City	State	Zip code
	Patient appointment telephone number		Fax number	Name affiliated with tax ID number	Federal tax ID number
	Mailing address (if different from above)		City	State	Zip code
	Billing address (if different from above)		City	State	Zip code
	Office manager / Administrator name		Administration telephone number	Fax number	E-mail address
	Credentialing contact (if different from above)		Credentialing telephone number	Fax number	E-mail address
	List other office locations with above information on a separate sheet.				

IV. PROFESSIONAL LICENSURE	State professional license/registration/certificate number			Status <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Temporary	
	Issue date	Expiration date	Name of sponsor if required by licensure, (i.e. Physician's Assistant).		
	Drug Enforcement Administration (DEA) registration number		Issue date	Expiration date	
	State controlled substance certificate number		Issue date	Expiration date	
	ECFMG number (applicable to foreign medical graduates)			Date issued	

V. ALL OTHER PROFESSIONAL LICENSES	State	License/registration/certificate number		Date issued
	Expiration date	Year relinquished	Reason	
	State	License/registration/certificate number		Date issued
	Expiration date	Year relinquished	Reason	
	State	License/registration/certificate number		Date issued
	Expiration date	Year relinquished	Reason	

VI. UNDER-GRADUATE EDUCATION	Name of college or university				Does Not Apply <input type="checkbox"/>
	Degree received		Graduation date		
	Mailing address		City	State	Zip code
	Name of college or university				
	Degree received		Graduation date		
	Mailing address		City	State	Zip code

(Do not abbreviate) (Attach additional sheet if necessary)

VII. MEDICAL/PROFESSIONAL EDUCATION	Medical/Professional school								
	Start date		Graduation date		Degree received				
	Mailing address			City		State		Zip code	
				Phone		Fax			
	Medical/Professional School								
	Start date		Graduation date		Degree received				
Mailing address			City		State		Zip code		
			Phone		Fax				

(Do not abbreviate) (Attach additional sheet if necessary)

VIII. GRADUATE EDUCATION	Institution					Does Not Apply <input type="checkbox"/>			
	Program or course of study				Faculty director				
	Mailing address			City		State		Zip code	
	Dates attended (/) - (/)			Phone		Fax			

(Do not abbreviate) (Attach additional sheet if necessary)

IX. INTERNSHIP/PGYI	Institution					Does Not Apply <input type="checkbox"/>			
	Program director								
	Mailing address			City		State		Zip code	
	Start date		Completion date		Phone		Fax		
	Type of internship			Specialty					
	Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)								

(Do not abbreviate) (Attach additional sheet if necessary)

X. RESIDENCIES	Institution					Does Not Apply <input type="checkbox"/>			
	Program director								
	Mailing address			City		State		Zip code	
	Start date		Completion date		Phone		Fax		
	Type of residency			Specialty					
	Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)								
	Institution					Does Not Apply <input type="checkbox"/>			
	Program director								
	Mailing address			City		State		Zip code	
	Start date		Completion date		Phone		Fax		
	Type of residency			Specialty					
	Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)								

(Do not abbreviate) (Attach additional sheet if necessary)

XI. FELLOWSHIPS	Institution Does Not Apply <input type="checkbox"/>					
	Program director					
	Mailing address			City	State	Zip code
	Start date		Completion date	Phone		Fax
	Course of study					
	Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)					
	Institution Does Not Apply <input type="checkbox"/>					
	Program director					
	Mailing address			City	State	Zip code
	Start date		Completion date	Phone		Fax
Course of study						
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)						

(Do not abbreviate) (Attach additional sheet if necessary)

XII. PRECEPTORSHIP	Institution Does Not Apply <input type="checkbox"/>					
	Department chairman					
	Mailing address			City	State	Zip code
	Start date		Completion date	Phone		Fax
	Training					

(Do not abbreviate) (Attach additional sheet if necessary)

XIII. FACULTY APPOINTMENT	Institution Does Not Apply <input type="checkbox"/>					
	Faculty director					
	Mailing address			City	State	Zip code
	Start date		Completion date	Phone		Fax
	Position					

(Do not abbreviate) (Attach additional sheet if necessary)

XIV. BOARD CERTIFICATION	Are you board or otherwise professionally certified? Does Not Apply <input type="checkbox"/>					
	<input type="checkbox"/> Yes If "Yes", please complete below			<input type="checkbox"/> No If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.		
	Issuing Board/Entity	Certificate Number	Specialty	Date Certified	Date Recertified	Expiration Date (if any)
	Have you applied for certification other than those indicated above? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	If so, list certification and date					
	If you participate in a specialty which does not have board certification, please indicate specialty					

(Do not abbreviate) (Attach additional sheet if necessary)

XV. OTHER CERTIFICATIONS	ACLS, BLS, ATLS, PALS, NRP, NALS (i.e., Fluoroscopy, Radiography, etc. – Attach certificate if applicable)			Does Not Apply <input type="checkbox"/>
	Type	Number	Expiration date	
	Type	Number	Expiration date	
	Type	Number	Expiration date	

XVI. HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS	Does Not Apply <input type="checkbox"/>
	Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you (A) have current affiliations, (B) applications in process, (C) have had previous affiliations or, if no current affiliation, (D) have a current coverage plan. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.

(Do not abbreviate) (Attach additional sheet if necessary)

A. CURRENT AFFILIATIONS	Name of primary facility (Do you have admitting privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No)				
	Department		Department / Clinical Chair		Status (active, provisional, courtesy, temporary, etc.)
	Mailing address		City	State	Zip code
	Phone number		Fax number	Appointment date	
	Name of secondary facility (Do you have admitting privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No)				
	Department		Department / Clinical Chair		Status (active, provisional, courtesy, temporary, etc.)
	Mailing address		City	State	Zip code
	Phone number		Fax number	Appointment date	
	Name of other facility (Do you have admitting privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No)				
	Department		Department / Clinical Chair		Status (active, provisional, courtesy, temporary, etc.)
	Mailing address		City	State	Zip code
	Phone number		Fax number	Appointment date	

(Do not abbreviate) (Attach additional sheet if necessary)

B. APPLICATIONS IN PROCESS	Hospital/Institution				
	Mailing address		City	State	Zip code
	Phone number		Fax number	Date application submitted	
	Hospital/Institution				
	Mailing address		City	State	Zip code
	Phone number		Fax number	Date application submitted	

(Do not abbreviate) (Attach additional sheet if necessary)

C. PREVIOUS AFFILIATIONS	Name of facility				Does Not Apply <input type="checkbox"/>	
	Department			Department / Clinical Chair		
	Mailing address		City	State	Zip code	
	Phone number		Fax number	Previous status (active, provisional, courtesy, temporary, etc.)		
	Reason for leaving			Appointment date (from– to)		
	Name of facility					
	Department			Department / Clinical Chair		
	Mailing address		City	State	Zip code	
	Phone number		Fax number	Previous status (active, provisional, courtesy, temporary, etc.)		
	Reason for leaving			Appointment date (from– to)		
	Name of other facility					
	Department			Department / Clinical Chair		
	Mailing address		City	State	Zip code	
	Phone number		Fax number	Previous status (active, provisional, courtesy, temporary, etc.)		
	Reason for leaving			Appointment date (from– to)		

D. INPATIENT COVERAGE PLAN	This Section only applicable for those without admitting privileges	
	Provider may attach signed letter of agreement from the physician or group representative that admits and manages the inpatient care for your patients. Does Not Apply <input type="checkbox"/>	
	Name of participating admitting physician/practice/clinic/group	
	Hospital where privileged	

(Do not abbreviate) (Attach additional sheet if necessary)

XVII. WORK HISTORY	Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. A curriculum vita may be substituted as long as it is current and has exact dates of employment.				
	Name of current practice/employer				
	Contact name	Telephone number	Fax number	From (mo/year)	To (mo/year)
	Mailing address		City	State	Zip code
	Reason for leaving				
	Name of practice/employer				
	Contact name	Telephone number	Fax number	From (mo/year)	To (mo/year)
	Mailing address		City	State	Zip code
	Reason for leaving				

XVII. WORK HISTORY (CONTINUED)	Name of practice/employer				
	Contact name	Telephone number	Fax number	From (mo/year)	To (mo/year)
	Mailing address		City	State	Zip code
	Reason for leaving				
	Please account for all gaps in time between dates of medical / professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable.				
	Activity / Name		From	To	

XVIII. PROFESSIONAL AFFILIATIONS	Please list membership in all professional societies. Complete Name of Society		Date Joined	Current Member	
				Yes	No

XIX. PEER REFERENCES	List three professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. One reference must be from same discipline.				
	Name of reference		Title and specialty		
	Mailing address		City	State	Zip code
	E-mail address	Telephone number	Fax number	Cell phone number	
	Name of reference		Title and specialty		
	Mailing address		City	State	Zip code
	E-mail address	Telephone number	Fax number	Cell phone number	
	Name of reference		Title and specialty		
	Mailing address		City	State	Zip code
	E-mail address	Telephone number	Fax number	Cell phone number	

XX. PROFESSIONAL LIABILITY	Current insurance carrier			Policy number		
	Mailing address			City		State
	Phone number		Fax number		Origination (retroactive) date	
	Per claim amount		Aggregate amount		Effective date	Expiration date
	Please list ALL professional liability carriers within the past ten years					
	Name of carrier			Policy number		
	Mailing address			City		State
	Phone number		Fax number		From	To
	Name of carrier			Policy number		
	Mailing address			City		State
	Phone number		Fax number		From	To
	Name of carrier			Policy number		
	Mailing Address			City		State
Phone number		Fax number		From	To	

XXI. PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL	Provider name(print or type)		Does Not Apply <input type="checkbox"/>
	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 health information (PHI). Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed provider 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? \$			

UNIVERSAL PROVIDER ATTESTATION QUESTIONS - To be completed by the provider

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			
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 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? (Please include an explanation sheet for any "Yes" answer in this section)		
		Yes	No
a.	License to practice any profession in any jurisdiction		
b.	Other professional registration or certification in any jurisdiction		
c.	Specialty or subspecialty board certification		
d.	Membership on any hospital medical staff		
e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.		
f.	Medicare, Medicaid, FDA, governmental, national or international regulatory agency or any public program		
g.	Professional society membership or fellowship		
h.	Participation/membership in an HMO, PPO, IPA, PHO or other entity		
i.	Academic Appointment		
j.	Authority to prescribe controlled substances (DEA or other authority)		
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?		
③	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		
④	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		
B. CRIMINAL HISTORY		Yes	No
(Please include an explanation sheet for any "Yes" answers in this section)			
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?		
a.	Do you have notice of any such anticipated charges?		
b.	Are you currently under governmental investigation?		
C. AFFIRMATION OF ABILITIES		Yes	No
①	Do you presently use any drugs illegally?		
②	Do you have, or have you ever had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or could 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.		
③	Are you unable to perform any of the services/clinical privileges required by the applicable participating provider agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		
D. LITIGATION AND MALPRACTICE COVERAGE HISTORY			
(If you answer "Yes" to any of the questions in this section, please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)			
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?		
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 judgment (court-ordered damage award) in a professional lawsuit?		
③	Are there any such claims being asserted against you now?		
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)?		
⑤	Are any of the privileges that you are requesting <u>not</u> covered by your current malpractice coverage?		
E. ATTESTATION			
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.			
_____ Typed or printed name		_____ Signature	_____ Date

Universal Provider Credentials Verification Addendum

Supplemental Provider Authorization and Release of Information

XXII. PROVIDER AUTHORIZATION TO RELEASE INFORMATION	<p>I hereby authorize the presenter of this Release and/or its representatives to consult with others who have information bearing on my professional competence, character, professional practice or ethical qualifications. I authorize all malpractice carriers to release coverage and/or claims history information which may exclude direct patient identification including name, address or telephone numbers to the presenter of this Release and/or its representatives. I hereby further consent to the inspection by the presenter, and/or its representatives, of all documents, including medical records, which may be relevant to evaluation of my professional competence, character, professional practice or ethical qualifications. <i>The presenter complies with the Health Insurance Portability and Accountability Act of 1996 "HIPAA" (as defined in 45 CFR § 160 et seq.) as well as other state and federal statutes, rules and regulations relating to confidentiality and privacy.</i> I understand that I have the right to review any information submitted in support of this Provider Application.</p> <p>I hereby release from liability any and all individuals and organizations that provide information to the presenter concerning my professional competence, practices, ethics, character or ethical qualifications for participating provider status, and hereby consent to the release of such information. I further agree to release and hold harmless from any liability the presenter and/or its representatives who participate within the scope of their duties in review of any information obtained under this Release. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, professional practice or ethical qualifications for resolving any doubts regarding such qualifications. A copy of any portion/section of the Authorization and Release, Criteria Sheet and or Application has the same force and effect as the original.</p> <p>I also understand that to participate, this application must be verified and I must be notified in writing whether this application has been approved or denied. I agree to immediately notify the entity to which this authorization has been given, in accordance with executed Agreements, of any change in submitted information. Failure to notify the entity of changes in the information contained in this application may result in immediate termination from participation with the entity to which this Release is given.</p>
Medicare Opt-Out ATTESTATION	<p>I certify that I have not filed an opt-out notice with the Center for Medicare Services (CMS) in the prior two years; I understand that should I choose to opt-out of Medicare, I must file a notice with CMS and promptly notify IPN.</p>
XXIII. ATTESTATION	<p>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 photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.</p>

Print Name Here _____

Signature _____

(Stamped signature is not acceptable)

Date _____

Review dates and initials
