Cenevia
Pre-Employment Verification Request Form

Organization Name _____

Individual Making Request _____

Date of Request _____ Date Information Required _____

Practitioner Name _____
First Middle Last

Practitioner Type: MD DO DC Dentist DPM NP PA Ph.D. MS Other _____

VA. License #: _____ Social Security # _____ Date of Birth _____

Please indicate practitioner's employment status:

_____ Practitioner is scheduled for interview on _____(date).

_____ Practitioner is contracted for employment pending verifications with proposed start date of_____.
(Requires completed Cenevia application.)

_____ Locum Tenens

_____ Other. Please specify _____

Recommended for pre-employment:

_____ NPDB _____ State License _____ Education and training verification See below**

If you are requesting verification of education and training for **any provider other than a MD, DO or PA, it must be completed via written request, and therefore may take as long as 2-3 weeks to be completed depending on response of the institution. **Please complete the information below.**

_____
School Name/Date of Graduation City State

_____
School Name/Date of Graduation City State

_____
School Name/Date of Graduation City State

Total Charge: $80

NPDB - $15.00

State License - $15.00

Education and Training - $50.00

Cenevia CREDENTIALS VERIFICATION AUTHORIZATION AND RELEASE

I understand and acknowledge that, as an applicant for participation with Cenevia and other third party payors who may delegate credentialing activities to Cenevia, as applicable, it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, professional competence, character, ethical qualifications and any other criteria adopted for participation, and for resolving any questions about such information.

I further understand and acknowledge that Cenevia will investigate the information provided in this application. By submitting this application, I agree to such investigation and to the reporting and information exchange activities of Cenevia, third party payors, and health care facilities as a part of the Cenevia Credentials Program, as follows:

I hereby authorize all individuals, institutions, and entities who have knowledge concerning information requested in this application to consult with and release relevant information to Cenevia, third party payors, health care facilities, their employees and agents. I further authorize Cenevia to release all such information to all health care facilities and third party payors that participate in the Cenevia Credentials Program and with which I am affiliated.

I hereby fully, absolutely, and unconditionally release from liability facilities, Cenevia, third party payors, and their employees and agents and all other individuals, institutions and entities providing information in accordance with the authorizations contained herein for all their acts performed in good faith and without malice in connection with the investigation of this application and the release and exchange of information authorized above, including but not limited to the acts of preparing or completing any verifications, evaluations, recommendations, information requests, or forms that are provided by the applicant, Cenevia, health care facilities, or third party payors. This release shall be in addition to any other applicable immunities provided by law for peer review activities or otherwise.

I consent to the release of information and I authorize release of information and copies of related records and/or documents to Cenevia to include not only the requested information for verification but information concerning each lawsuit, civil action, or other claim brought against me for malpractice or negligence; each disciplinary action under consideration or taken; any open or previously conclude investigations; and any changes in the status of a credential and all supporting documentation related to the information provided.

I understand and agree that the authorizations and releases given by me herein shall be irrevocable so long as I am an applicant for or have staff privileges at any health care facility participating in Cenevia's Credentials Program, and/or so long as I am participating with one or more third party payors delegating credentialing activities to Cenevia.

I understand and acknowledge that Cenevia is involved in querying the National Practitioner Data Bank, American Medical Association, Board of Medicine, and other entities as recommended by The National Committee for Quality Assurance.

I understand and acknowledge the principle of ethics with the American Medical Association, American Osteopathic Association, or other appropriate professional organizations.

I acknowledge that the investigation of information in this application and the release of information by the facilities, Cenevia, and third party payors and their employees and agents are done to improve the quality of patient care. I agree to notify the Cenevia credentialing department of any changes to the information provided within thirty (30) days of any such change – including ANY actions placed against my license or any certification that I hold.

All information provided by me in this application is true to the best of my knowledge and belief, and free of omissions. I understand and agree that any material misstatement in or omission from this application may constitute grounds for denial of participation or for summary dismissal from the medical staff and/or third party payors. I understand and acknowledge that participation in Cenevia applies to participation in the Network activities only, and that health care facilities shall be solely responsible for all decisions concerning medical staff membership, and that third party payors shall be solely responsible for all decisions concerning participation with such third party payors. I further understand and acknowledge that Cenevia shall have no responsibility or liability with respect to medical staff membership decisions by health care facilities or participation decisions by third party payors.

I understand and agree that I have the right to review information submitted in support of my application and to correct erroneous information provided by either myself or an outside organization.

I further acknowledge that I have read and understand the foregoing authorization and release.

A photocopy of this Authorization and Release shall be as effective as the original.

_____ _____

Signature Date

_____

Print Name