PRACTITIONER CREDENTIALING APPLICATION CHECKLIST

_____**Provider Data Sheet** (please review and make the necessary corrections)

_____**Attestation Questions**

_____**Addendum A – Practitioner Rights**

_____**Addendum B – Professional Liability Action Explained**

_____**Information Release/Acknowledgments**

_____**W9 Form**

_____**Current State License**

_____**Current DEA** (if applicable)

_____**Current Malpractice Insurance Certificate**

_____ **Board Certification** (if applicable)

_____**Curriculum Vitae** (must have complete practice history with no gaps from the time residency/fellowship was completed)

Submit the above documentation to the following address:

Empire Healthcare IPA

c/o All Care To You, LLC
Attn: Empire Healthcare Provider Network Department
P.O. Box 4367
Orange, CA 92863

or

Attn: Provider Network Department - Empire Healthcare
Fax: 949-396-2614
Email: ProviderNetwork@allcaretoyou.com

Type text here

HIV/AIDS SPECIALIST DESIGNATION

This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS - 34 -01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

We will use your information for internal referral procedures and for publication listing in the Provider Directory.

As always, if information about your practice changes, please notify us promptly.

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; OR

☐ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties; OR

☐ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

☐ 1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; AND

☐ 2. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; OR

☐ In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; AND

☐ 1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; OR

☐ 2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; OR

☐ 3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

APPLICANT SIGNATURE (Stamp is Not Acceptable)**:** _____

PRINTED NAME: _____

DATE: _____

ATTESTATION QUESTIONS

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "Yes", please provide full details on a separate sheet of paper.

1. Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions or have you been fined or received a letter of reprimand or is such action pending? ☐Yes ☐No

2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, or any federal program or is any such action pending? ☐Yes ☐No

3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with (public) federal programs, or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? ☐Yes ☐No

4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? ☐Yes ☐No

5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program? ☐Yes ☐No

6. Have you ever been denied certification/recertification by a specialty board? ☐Yes ☐No

7. Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation? ☐Yes ☐No

8. a. Have you ever been convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense? ☐Yes ☐No

8. b.Are any such actions pending? ☐Yes ☐No

9. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any file and served professional liability lawsuits/arbitrations against you pending? If YES, please complete Addendum B. ☐Yes ☐No

10. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? ☐Yes ☐No

11. Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If YES, please describe on a separate sheet any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise. ☐Yes ☐No

12. Have you ever rendered professional medical services as an employee of a staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center) or an academic institution. If YES, have you, in the past seven (7) years, been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)? ☐Yes ☐No ☐Yes ☐No

13. Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs? ☐Yes ☐No

14. Within the last three (3) years, has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been terminated, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs? ☐Yes ☐No

I hereby affirm that the information submitted in this Section, Attestation Questions, Application, and any addenda thereto is current, correct, and complete to the best of my knowledge and belief and in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

APPLICANT SIGNATURE (Stamp is Not Acceptable)**:**_____

PRINTED NAME: _____

DATE: _____

Continue to the Next Page for Information Release/Acknowledgements

The CPPA has been completed. Please be sure you have signed the last two pages before submission.

California Participating Practitioner Application

Addendum A

Practitioner Rights

Right to Review

The practitioner has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices, will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email or fax to the Credentialing Department of the Healthcare Organization's offices.
The provider will be notified in writing by fax, email or letter no more than seven working days of the current status of the application with respect to outstanding information required to complete the application process. Information that can be shared includes, but not limtied to, missing supporting documents, explanations for settled claims and expired licensure. Any confidential information will not be shared with individuals who are not authorized.

Notification of Discrepancy

Practitioners will be notified in writing via fax, email or certified letter, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied to Healthcare Organization by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 48 hours of the Healthcare Organization's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

Healthcare Organization's Credentialing Department Address:

Address: PO BOX 4367 City: ORANGE State: CA Zip: 92863

APPLICANT SIGNATURE (Stamp is Not Acceptable)**:** _____

PRINTED NAME:_____

DATE:_____

California Participating Physician Application

Addendum A

Health Plans and IPA's/Medical Groups

This Addendum is submitted to:_____, herein, this Healthcare Organization[1]

I. IDENTIFYING INFORMATION

Last Name:	First:	Middle:

Medical Group(s)/IPA(s) Affiliation:

Do you intend to serve as a primary care provider? ☐ Yes ☐ No

Do you intend to serve as a specialist? ☐ Yes ☐ No (If yes, please list specialty(s) _____

Please check all that apply:

☐ Solo Practice ☐ Single Specialty

☐ Group Practice ☐ Multi Specialty

II. BILLING INFORMATION – If nothing has changed WITHIN THE LAST 3 YEARS, please check here ☐

Billing Company:

Street Address:	City:	
	State:	ZIP:
Contact:	Telephone Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

III. PRACTICE INFORMATION –If nothing has changed WITHIN THE LAST 3 YEARS, please check here ☐

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? ☐ Yes ☐ No

If so, please list:

Name:	Type of Provider:	License Number:

If you are a Physician Assistant Supervisor, please indicate State License Number: _____

Do you personally employ any physicians (do not include physicians that are employed by the medical group)? ☐ Yes ☐ No

If so, please list:

Name:	Type of Provider:	License Number:

[1] As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

Physician Name:

Please list any clinical services you perform that are not typically associated with your specialty: _____

Please list any clinical services you **do not** perform that are typically associated with your specialty: _____

Is your practice limited to certain ages? ☐ Yes ☐ No
If yes, specify limitations: _____

Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council? ☐ Yes ☐ No

Do you participate in EDI (electronic data interchange? ☐ Yes ☐ No
If so, which network? _____

Do you use a practice management system/software? ☐ Yes ☐ No
If so, which one? _____

What type of anesthesia do you provide in your group/office?
☐ Local ☐ Regional ☐ Conscious Sedation ☐ General ☐ None ☐ Other (please specify) _____

Has your office received any of the following accreditations, certifications, or licensures?
☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
☐ California Department of Health Services Licensure
☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
☐ Medicare Certification
☐ The Medical Quality Commission (TMQC)
☐ Other _____

IV. OFFICE HOURS – If nothing has changed WITHIN THE LAST 3 YEARS, please check here ☐

OFFICE	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Holiday
Primary								
Secondary								X
Third								

V. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary) - If nothing has changed WITHIN THE LAST 3 YEARS, please check here ☐

Answering Service Company:	Phone Number: ( )	Fax Number: ( )
Mailing Address:		City:
		State: ZIP:

Covering Physician's Name:	Telephone Number: ( )
Covering Physician's Name:	Telephone Number: ( )
Covering Physician's Name:	Telephone Number: ( )
Covering Physician's Name:	Telephone Number: ( )

If you do not have hospital privileges, please provide written plan for continuity of care:

VI. FOREIGN LANGUAGES SPOKEN - If nothing has changed WITHIN THE LAST 3 YEARS, please check here ☐

Fluently by Physician:	Fluently by Staff: Type text here Type text here Type text here Sp Type text here Type text here Type text here

VII. LABORATORY SERVICES - If nothing has changed WITHIN THE LAST 3 YEARS, please check here ☐

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

Tax ID#:	Billing Name:	Type of Service Provided:

Do you have a CLIA certificate?	☐ Yes	☐ No
Do you have a CLIA waiver?	☐ Yes	☐ No

Certificate Number:	Certification Expiration Date:

VIII. ADDITIONAL LICENSURES/CERTIFICATES

Are you currently accepting HMO Medi-Cal patients? ☐Yes ☐No If yes, please indicate Medi-Cal #: _____

Are you CHDP (Child Health and Disability Prevention Program) certified? ☐Yes ☐No If yes, please indicate certificate #: _____

Are you CPSP (Comprehensive Perinatal Services Program) certified? ☐Yes ☐No If yes, please indicate certificate #: _____

Are you CCS (California Children Services) certified? ☐Yes ☐No If yes, please indicate certificate #: _____

Are you a certified Workers' Compensation provider? ☐Yes ☐No If yes, please indicate certificate #: _____

IX. PROFESSIONAL ORGANIZATIONS - If nothing has changed WITHIN THE LAST 3 YEARS, please check here ☐

Please list country, state or national medical societies, or other professional organizations or societies of which you are a member of applicant.

Organization Name	**Applicant**	**Member**
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

I certify that the information in this document and any attached documents is true and correct.

Print Name: _____

Physician Signature: _____
(Stamped Signature Is Not Acceptable)

Date: _____

California Participating Practitioner Application

Addendum B

Professional Liability Action Explained

This Addendum is submitted to _____ herein, this Healthcare Organization

Please complete this form for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

☐ *Please check here if there are no pending/ settled claims to report (and sign below to attest).*

I: Practitioner Identifying Information	
First Name:	Middle:

II. Case Information			
Patient's Name:	Patient's Gender: ☐ Male ☐ Female		Patient's DOB:
City, County, State where lawsuit filed:	Court Case number, if known:	Date of alleged incident serving as basis for the lawsuit/arbitration:	Date suit filed:

Location of incident:

☐ Hospital ☐ My Office ☐ Other doctor's office ☐ Surgery Center ☐ Other (specify):

Relationship to patient (Attending physician, Surgeon, Assistant, Consultant, etc.)

Allegation:

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ☐Yes ☐No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number, or other liability protection company or organization.

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name:	Telephone Number:	Fax Number:

III. Status of Lawsuit/Arbitration (check one)

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☐ Lawsuit/arbitration still ongoing, unresolved.

☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: _____

☐ Judgment rendered and I was found not liable.

☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: _____

☐ Lawsuit/arbitration settled/dismissed, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheets.

Please include:

1. Condition and diagnosis at the time of incident,
2. Dates and description of treatment rendered, and
3. Condition of patient subsequent to treatment.

SUMMARY

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Practitioner Application. In order for the participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorney(s) listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization".

APPLICANT SIGNATURE (Stamp is Not Acceptable) _____
PRINTED NAME: _____
DATE: _____

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INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health care service plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents - collectively "Healthcare Organizations,") for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of peer records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including, but not limited to, California Business and Professions Code Section 809 et seq., if applicable.
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.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.
In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, within fourteen (14) days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me, by the Medical Board of California taken or pending, including, but not limited to, any accusation filed, temporary restraining order or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization, which has resulted in the filing of a Section 805 report (or any subsections) with the Medical Board of California, appropriate licensing board or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding any minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I pledge to provide continuous care for my patients.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

A photocopy of this document shall be as effective as the original.

_____ _____ _____

APPLICANT SIGNATURE (Stamp is Not Acceptable) **PRINTED NAME** **DATE**

Addenda Submitting;

☐ Addendum B; Professional Liability Action Explanation

This application and Addenda A and B were created and are endorsed by:
- California Association of Health Plans (916) 552-2910
- California Association of Physician Groups (916) 443-2274

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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 generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II 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); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 for Part II, later.

Sign Here **Signature of U.S. person** ► **Date** ►

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*