20098 Ashbrook Place, Suite 250 Ashburn, VA 20147
Phone: 1-800-274-7526 Fax: 1-888-492-1026

WHOLEHEALTH NETWORKS, INC.

PRACTITIONER APPLICATION

INSTRUCTIONS

This form must be typed or printed legibly in blue or black ink. Below is a list of the items that must be submitted along with this application:

- ❑ Copy of license(s) if applicable
- ❑ Copy of insurance face sheet for professional and business liability policy
- ❑ Copy of educational or training certificates, diploma, or specialty training documentation letter(s)
- ❑ Signed release and attestation statement, with professional liability form if applicable.

Please return this application along with the necessary documentation to the address listed at the top of the page to the attention of the Credentialing Department.

PRACTITIONER NAME

Name:_____ **Male/Female:** _____

PRACTITIONER SPECIALTIES

Please check all specialties for which you are applying for network participation. **You must include the credentials for a specialty in order for it to be added to your profile. You must meet credentialing criteria for each specialty** (please refer to the Practitioner Specialty

____ Acupuncture
____ Acupuncture, MD/DO
____ Acupuncture, DC/ND
____ Behavioral Health
____ Biofeedback
____ Childbirth Educators
____ Chinese Herbal Medicine
____ Chiropractic Physician
____ Dietician - Registered/Licensed
____ Doulas
____ Energy Healing Practitioner
____ Feldenkrais
____ Guided Imagery/Hypnotherapy
____ Hellerwork
____ Herbal Consultant
____ Holistic Nurse Practitioner
____ Homeopathy
____ Hypnotist, non-clinical
____ Integrative Holistic Physician (MD/DO)
____ Massage Therapy
____ Massage Therapy – Clinical
____ Mind-Body Skills Instructor
____ Mindfulness-Based Stress Reduction Teacher
____ Music Therapy
____ Naturopathic Physician
____ Nutritional Counselor
____ Occupational Therapist
____ Asian/Oriental Bodywork Therapist
____ Pain Practitioner
____ Personal Trainer/Exercise Specialist
____ Physical Therapy
____ Pilates Instructor
____ Post Birthing & Lactation Counselor
____ Qi Gong Instructor
____ Reflexologist
____ Tai Chi Instructor
____ Yoga Instructor

OFFICE LOCATION(S)

Primary Location:

Clinic Name: _____
Address: _____
City, State, Zip: _____

TIN: _____ TIN Owner: _____

Phone: _____ Office Fax: _____

Office Contact: _____ Title: _____

Website Address: _____ E-Mail Address: _____

Do you receive mail at your physical or billing address? Physical or Billing or Both

Primary Billing Address:

*this address should match your W9

City, State, Zip: _____

_____

Phone: Office Fax:

Group NPI:	
Secondary Location:	
Clinic Name:	
Address:	
City, State, Zip: TIN:	
Phone:	TIN Owner:
Website Address:	Office Fax:
Secondary Billing Address:	E-Mail Address:
City, State, Zip:	
Phone:	Office Fax:
Group NPI:	

Social Security No:	State License #:
Medicare Number:	State License Expiration Date:
Year Started Practicing:	Malpractice Carrier (attach current face sheet):
Years at current location:	Malpractice Limits:
Date of Birth:	Malpractice Policy #:
Individual NPI:	Malpractice Expiration:
Colleges/Specialty Institutions:	Board Certifications:
	DEA Number (for physicians):
Graduation Date(s):	DEA Expiration (for physicians):

**** If you have additional addresses, please include an additional sheet of paper with this application***

1. **LIMITATIONS** (Please fill in the blanks or circle the correct answer when completing the questions below.)

A. Have you ever been involved in a malpractice claim?	YES	NO
B. Have you ever been before a peer review board?	YES	NO
C. Do you have any pending claims?	YES	NO
D. Do you have any state sanctions and/or complaints?	YES	NO
E. Do you have any Medicare sanctions and/or complaints?	YES	NO

If you answered YES to questions A or C above, please complete the attached Liability Form for each claim.
If you answered YES to questions B, D, or E above, please attach a detailed explanation and indicate if you have made any changes in your practice as a result of this incident.

2. Have you ever had your membership in any professional organization refused, suspended, or revoked? If YES, please attach details.	YES	NO
3. Have you ever received any formal criticism, disciplinary action, or reprimand? If YES, please attach details.	YES	NO
4. Have you ever voluntarily surrendered or had any license to practice refused, restricted, suspended, or revoked? If YES, attach details.	YES	NO
5. Are you currently using illegal chemical substances, or abusing alcohol? If YES, explain fully in a sworn statement.	YES	NO

6. Are you currently taking any prescription medications that could potentially affect your job performance? If YES, explain fully in a sworn statement. YES NO

7. Have you ever been convicted of a crime or felony (other than a violation of traffic laws) in any state or country? If YES, please explain fully. YES NO

8. Are there reasons you are unable to perform the essential functions involved in delivering safe, efficient, quality care, with or without reasonable accommodation? If YES, explain fully in a sworn statement. YES NO

9. Are you a member of any national professional associations? If YES, please attach names and dates. YES NO

10. Do you hold licenses in any other states? YES NO

If YES, please complete.

State	Type of License	Date of Licensure	License Number	Active
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

11. How many continuing education credits have you obtained in the past 12 months? _____

12. Do you hold any specialty certificates? YES NO
If YES, please attach a copy of the certificate.

13. Do you currently have hospital privileges? YES NO Do you have a history of loss or limitation of hospital privileges? YES NO If YES, explain fully in a sworn statement.
Please list your primary admitting facility. _____

14. If you completed a residency, internship, or fellowship for your specialty please include the following:

Type	Dates	Facility Name	Location
_____	_____	_____	_____
_____	_____	_____	_____

15. What languages do you and your office staff speak fluently? Please list. _____ _____

16. Please give three (3) professional references, at least one should be a person with whom you have close referral relationships (include phone numbers).

Referral Practitioner	Specialty	Phone
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

17. **WORK HISTORY (REQUIRED)** Please list chronologically your employment history for the **past five (5) years**, with explanations for gaps of six (6) months or more. **(This should include ALL employment including self employment, schooling, military service & relevant work history.)** All practitioners are required to have a minimum of 12 months experience in the practice specialty. Exception can be made if practitioner is co-located with a mentor of the same practitioner type who is an in-network practitioner with WHN and a mentor letter is attached.

Current work place: _____

Time in this employment: From:_____**to** _____
(mm/yy) (mm/yy)

Previous work place:_____

Time in this employment: From:_____**to** _____
(mm/yy) (mm/yy)

Previous work place:_____

Time in this employment: From:_____**to** _____
(mm/yy) (mm/yy)

Previous work place: _____

Time in this employment: From:_____**to** _____
(mm/yy) (mm/yy)

Previous work place: _____

Time in this employment: From:_____**to** _____
(mm/yy) (mm/yy)

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18. Do you have referral relationships with conventional medical doctors for patient evaluation and care? If YES, please explain. YES NO _____

_____

19. Practice Philosophy _____

_____

_____

Practitioner Specific Information:

20. The following pages list criteria that are practitioner specific. Please check the information that applies to you for your specialty(s).

Primary Specialty	**a.**	
Other Specialties	**a.**	**b.**

PRACTITIONER SPECIALTY SPECIFIC CREDENTIALS REQUIREMENTS

***Please check the information that applies to your specialty (ies)**.You will be listed in the directories by these categories.*

Acupuncture	❑ Graduation from a National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) accredited program ❑ Hold a valid unrestricted state license and/or NCCAOM certification **OR** ❑ Physician Acupuncturists (**MD/DO**) must hold a valid unrestricted license to practice medicine Including acupuncture, and either be a member of the Am Academy of Medical Acupuncture (AAMA), or be certified by the Am Board of Medical Acupuncture ❑ **NDs and DCs** need to have 200 hours of acupuncture training and meet ND or DC state scope of practice criteria ❑ Professional liability insurance limits of 1M/3M are required for all MD's and DO's as well as ND's and DC's who practice acupuncture **OR** liability insurance limits of at least $200,000 / $500,000 for licensed acupuncturists only
Behavioral Health	❑ Hold a valid unrestricted state license in a behavior health discipline, i.e. Psychologists, Social Worker etc. ❑ Professional liability insurance limits of at least $200,000 / $500,000
Biofeedback	❑ Certification from the Biofeedback Certification Institute of America (BCIA) ❑ Professional liability insurance limits of at least $200,000 / $500,000
Childbirth Educator	Applicants may qualify as a Childbirth Educator, with documented training and certification under the auspices of at least **one** of the following programs: ❑ International Childbirth Education Association (ICEA) ❑ Childbirth and Postpartum Professional Association (CAPPA) ❑ American Academy of Husband Coached Childbirth (AAHCC – Bradley ® Method) ❑ ASPO/Lamaze – Lamaze Certified Childbirth Educator ❑ Prepared Childbirth Educators (PCE) ❑ The Academy of Certified Birth Educators & Labor Support Professionals (ACBE) ❑ Birth & Beginnings Education (BABE)
Chinese Herbal Medicine	❑ National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Herbal Practitioner certification, or state license exam for Chinese Herbal Medicine ❑ Credentialed as a licensed acupuncturist or other licensed profession ❑ Professional liability insurance limits of at least $200,000 / $500,000
Chiropractic	❑ Graduation from an accredited college ❑ Hold a valid unrestricted state license ❑ Professional liability insurance limits of at least $200,000 / $500,000
Dietician	❑ Hold a valid unrestricted state license and/or American Dietetic Association/Commission on Dietetic Registration (ADA/CDR) accreditation ❑ Professional liability insurance limits of at least $200,000 / $500,000
Doulas	Documented training and certification as a prenatal, labor/birth, or postpartum Doulas under the auspices of at least **one** of the following programs: ❑ International Childbirth Education Association (ICEA) ❑ Doulas of North America (DONA) ❑ Childbirth and Postpartum Professional Association (CAPPA) ❑ National Association of Postpartum Care Services **PLUS** ❑ Current professional liability insurance policy of $200,000/$500,000 minimum
Energy Healing Practitioner	❑ Credentialed with WholeHealth Networks, Inc. in another licensed specialty ❑ Professional liability insurance limits of at least $200,000 / $500,000 ❑ Reiki Certified as a Third Degree Reiki (Reiki Master) or as a Reiki Master Teacher **OR** ❑ Healing Touch Certified as a practitioner or teacher by Healing Touch International
Feldenkrais	❑ Guild Certified Feldenkrais Practitioner or Teacher certificate from the Feldenkrais Guild of North America ❑ Professional liability insurance limits of at least $200,000 / $500,000
Guided Imagery/ Hypnotherapy	❑ Meet WholeHealth Networks, Inc. credentialing criteria in Behavioral Health ❑ Documented training in clinical Guided Imagery or Hypnotherapy ❑ Professional liability insurance limits of at least $200,000 / $500,000
Hellerwork Practitioner	❑ Certified by Hellerwork International as a Certified Hellerwork Practitioner ❑ Professional liability insurance of at least $200,000 / $500,000
Herbal Consultant	❑ Professional current member of the American Herbalists Guild and a minimum of 200 hours education in herbal medicine
Holistic Nurse Practitioner	❑ Hold a valid unrestricted state license as an advanced nurse or nurse practitioner ❑ 200 or more hours course work in alternative medicine or another credentialed CAM specialty ❑ Professional liability insurance of at least $200,000 / $500,000
Homeopath	❑ Certified in Classical Homeopathy by the Council for Homeopathic Certification **OR** ❑ A licensed independent prescribing health practitioner (DC, ND, MD, DO, NP, etc.) otherwise credentialed by examination with a recognized state, national or international certificate of primary care or specialty care homeopathic expertise ❑ One year of practice experience as a homeopathic practitioner ❑ Business or professional liability insurance of at least $200,000 / $500,000 or $1M/ $3M based on license level
Hypnotist (non clinical)	❑ Active Certified members of the National Guild of Hypnotists, Inc. ❑ Professional liability insurance limits of at least $200,000 / $500,000
Integrative Holistic Physician	❑ A minimum of 200 hours course work in alternative medicine or osteopathic principles, or be certified by the American Board of Holistic Medicine ❑ Hold a valid unrestricted state license to practice medicine ❑ Professional liability insurance of $1,000,000 / $3,000,000

Massage Therapy	❑ Hold a valid unrestricted state massage license **OR**
	❑ Current jurisdictional (city/county, etc.) license. **PLUS** either of the following:
	  ❑ Certificate of NCBTMB exam passage (National Certification Board of Therapeutic Massage & Bodywork **OR**
	  ❑ Certificate of active professional AMTA or ABMP membership (requires 500 hrs training) **OR**
	  ❑ Meet WholeHealth Networks, Inc. qualifications for alternative bodywork training and certification (Rolfing, Myotherapy, Reiki, Hellerwork, Oriental Body Work, etc.)
	❑ Professional liability insurance of at least $200,000 / $500,000

Massage Therapy-Clinical	❑ Hold a valid unrestricted state massage license ❑ Certification by the National Certification Board for Massage or Therapeutic Bodywork (NCBMTB) or an equivalent State licensing exam ❑ Evidence of professional continuing education in massage totaling at least **60 hours** of course work in the past four years ❑ Copy of Certificate of Completion of at least one advanced massage modality practice training program of 25 hours or more ❑ Documentation of at least two calendar years in active clinic practice ❑ **Two Letters** of Reference from health professionals attesting to personal and clinical practice characteristics, at least one of which must be from a referring or supervising MD, DO, DC, PT, RN or WholeHealth Networks, Inc. credentialed clinical massage practitioner who has supervised your practice **PLUS:** ❑ Documentation of **supervised contact hours** performing clinical massage: ❑ 500 contact hours required for applicants with only a basic 500 hour massage education **OR**

	❑	250 contact hours required for applicants with 1000 hour basic massage education that Includes clinical assessment, clinical pathology, and clinical charting **OR**
	❑	Postgraduate clinical training equivalent to 250 contact hours after their basic 500 hour education
	❑	Professional liability insurance of $200,000/$600,000 or $500,000/$500,000
Mind-Body Skills Instructor	❑	Certification by Peggy Huddleston of satisfactory completion of training in administering the "Prepare for Surgery, Heal Faster" program **OR**
	❑	Written documentation of completion of training in the MindBodySpirit Professional Training Program, offered by the Center for MindBody Medicine in Washington,DC O**R**
	❑	Documentation of status as a Certified Middendorf Practitioner by completion of the three year (three block) professional training offered by Middendorf Breath Institute in Berkeley,CA **OR**
	❑	Written Documentation of completion of training as a meditation Instructor in a formal or apprenticeship training program **PLUS**
	❑	Attestation of a minimum of 200 hours or training and/or practice teaching
Mindfulness Based Stress Reduction Teachers	❑	MBSR Teacher Certification evidenced by a Certification by the Center for Mindfulness A at the University of MA **OR**
	❑	Copy of Attestation to 200 hours of experience teaching Mindfulness-Based Stress Reduction (MBSR) **PLUS**
	❑	Written Documentation of completion *of Mindfulness-Based Stress Reduction in Mind/Body Medicine A 5- or 7-Day Residential Training Retrea*t offered by the Center for Mindfulness at University of Massachusetts Medical School **OR**
	❑	Written Documentation of completion of *Practicum in MBSR* (formerly the *Internship Program*) and/or *Teacher Development Intensive in MBSR* and/or *Supervision in MBSR* conducted by CFM or a CFM affiliated training program **PLUS**
	❑	Letter of Reference from an MBSR Instructor-trainer approved by the Center for Mindfulness (contact CFM or WholeHealth Networks, Inc. for list of approved professionals)
Music Therapy	❑	A listing of current certification as MT-BC by the Certification Board for Music Therapists (CBMT) **OR**
	❑	A listing as a Registered Music Therapist (RMT), Certified Music Therapist (CMT) or Advanced Certified Music Therapist (ACMT), as listed with the National Music Therapy Registry **PLUS**
	❑	Current membership in the American Music Therapy Association (AMTA)
Naturopathic Physician	❑	Graduation from a naturopathic medical college with a minimum four-year graduate degree
	❑	Hold a valid unrestricted state license If licensure is not available by the state the practitioner must pass the Naturopathic Physicians License Exam (NPLEX) and have a valid out-of-state ND license
	❑	Professional liability insurance of at least $200,000/$500,000
Nutritional Counselor	❑	Hold a valid unrestricted state license as a nutritionist **OR (if non-licensed state)**
	❑	Certified as a Certified Clinical Nutritionist (CCN) by the Clinical Nutrition Certification Board **OR**
	❑	Certified as a Certified Nutritionist (CN) by the National Institute of Nutritional Education
	❑	Professional liability insurance limits of at least $200,000/$500,000
Occupational Therapist	❑	Graduation from an accredited college or formal training program
	❑	Hold a valid unrestricted state license
	❑	NBCOT certification (not required but recommended)
	❑	Professional liability insurance limits of at least $200,000 / $500,000
Asian/Oriental Bodywork	❑	Hold a valid unrestricted state or local license **PLUS**
	❑	Written documentation of Massage training program, Including Oriental body work, of 500 class hours and a National Certification Board for Therapeutic Massage and Bodywork (NCBTMB) certification **OR**
	❑	Certification in Asian Bodywork Therapy by the Nat Cert Commission for Acupuncture and Oriental Med (NCCAOM)
	❑	Professional liability insurance of at least $200,000 / $500,000
Pain Practitioner	❑	Hold a current, valid, unrestricted license/registration as a health care practitioner (MD, DO, DC, PT, ND, LAc, Nurse practitioner or behavioral health) in the state in which he/she will participate
	❑	Graduation from an accredited college or formal training program for the primary license recognized by the state licensing agency
	❑	Current professional liability insurance policy meeting primary specialty requirements, or at least $200,000 / $500,000
	❑	Certification as a Diplomat, Fellow or Clinical Associate in Pain Management by exam of the American Academy of Pain Management **OR**
	❑	Certified by the American Board of Pain Medicine **OR**
	❑	Certified by the subspecialty examination in Pain Medicine by the boards for Anesthesiology, Physical Medicine and Rehabilitation, or Psychiatry and Neurology
Personal Trainer/ Exercise Specialist	❑	Certification from the American College of Sports Medicine(ACSM), the American Council on Exercise (ACE), the National Strength and Conditioning Association (NSCA), National Academy of Sports Medicine (NASM), International Sports Sciences Association (ISSA)or the International Weightlifting Association (IWA), the Aerobics and Fitness Association of America (AFAA) or an equivalent program sponsored by an accredited institution of post secondary education
	❑	Hold a Master's Degree in Exercise Physiology from a recognized US or Canadian institution **OR** an Undergraduate Degree in physical education, exercise science, health science or nutrition, with additional training in physical therapy and Kinesiology, and a certification from one of the following: The Center for Exercise Physiology (CEP) **OR** Registered Clinical Exercise Physiologist by the American College of Sports Medicine
	❑	Health Fitness Director or Program Director certification by the American College of Sports Medicine
	❑	Certified by the Health & Fitness Program of certification by the Canadian Society for Exercise Physiology (CSEP) **PLUS**
	❑	Evidence of at least 15 CEU's of continuing education in exercise and fitness specialties every two years
Physical Therapist	❑	Graduation from an accredited college or formal training program
	❑	Hold a valid unrestricted state license
	❑	Professional liability insurance limits of at least $200,000 / $500,000
Pilates Instructor	❑	Pilates Certified Teacher from the Pilates Method Alliance (PMA) **OR**
	❑	Letter attesting current employment at Studio or Educational Organization that is registered with PMA **OR**
	❑	Evidence of Training through or by a Pilates Instructor program recognized by the Pilates Method Alliance **OR**
	❑	Certificate of completion in a comprehensive Pilates teacher training course with a 400 hour minimum requirement
	❑	Professional liability insurance limits of at least $200,000/$500,000
Post Birthing/ Lactation Counselor		A Postnatal Educator, Lactation Educator or Perinatal Fitness Educator, with documented training and certification under the auspices of:
	❑	International Childbirth Education Association (ICEA) **OR** Childbirth and Postpartum Professional Association (CAPPA) **OR** La Leche League International accredited Leader program **OR** International Board of Lactation Consultant Examiners (IBLCE)
Qi Gong	❑	Certification from the National QiGong Association (NQA) or individual training program
	❑	A minimum of 200 hours of formal training
	❑	One year teaching experience
Reflexologist	❑	Credentialed with WholeHealth Networks, Inc. as a massage therapist
	❑	Certification from the American Reflexology Certification Board
	❑	Professional liability insurance limits of at least $200,000 / $500,000
Tai Chi	❑	Certification from the individual training program
	❑	A minimum of 200 hours of training and/or practice teaching
	❑	One year documented teaching experience
Yoga	❑	A Registered Yoga Teacher (RYT) **OR** a registered with Yoga Alliance (200/500 hour certifications) **OR** a nationally certified course or training program **OR** Certificate of completion of a comprehensive Yoga Teacher Training course **PLUS**
	❑	One year in practice experience following completion of training or working under supervision in a Yoga facility

Attestation

1. I certify to the best of my knowledge that all information provided above is correct and complete. I understand that any significant misstatement or omission on this application may constitute cause for denial or revocation of my contract.
2. I authorize WHN to consult with past employers, malpractice carriers regarding claims history and limitations, educational institutions regarding graduation, and any other persons to obtain and verify my credentials and qualifications as a Practitioner. I release WHN and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.
3. I consent to the release by any person to WHN all information that may reasonably be relevant to an evaluation of my professional competency, character, moral and ethical qualifications, including any information relating to any disciplinary action; suspension, refusal, restriction or revocation of state license; and hereby release any such person providing such information from any and all liability from doing so.
4. I agree to inform WHN promptly if any information on this material changes. **Signature stamps are not acceptable.**
5. Practitioner has the right to review information submitted in support of the credentialing application to the extent permitted by law and WHN will notify you of any information obtained during the review that differs substantially from the information you provide. You will then have the right to correct any erroneous information from WHN.

Signature: _____ Date: _____

Practitioner Name: _____

A photocopy of this consent shall be as effective as the original when so presented.

IMPORTANT: Please submit the following documents with this Application. Include documentation for all specialty types you are applying for. Missing documentation will result in a processing delay.

1. A copy of your current license with expiration date.
2. A copy of your current certifications and educational diplomas, or documentation of specialty training.
3. A copy of your current IRS W-9 form (Taxpayer Identification Number and Certification, attached) for all separate physical addresses.
4. A copy of your current DEA certificate, for physicians.
5. Copy of insurance face sheet for professional and business liability policy.

PROFESSIONAL LIABILITY INFORMATION FORM

Please complete this form explaining any professional liability claims or lawsuits brought against you, settled, or dismissed. The information provided should include pending and closed cases, as well as dismissed or dropped claims or suits. Please obtain information from your insurer if necessary. This information will be reviewed by the Credentialing Committee; it may be used to determine your membership status. Copy this form if you have more than one claim to report.

Practitioner Name:_____ **Case Number:** _____

Current status of legal action:

_____Pending Court Date (if available): _____

_____Dismissed or Dropped Date: _____

_____Closed Date: _____

Resolution:

_____No Payments

_____Out of Court Settlement Amount: $ _____

_____Judgment or Award Amount: $ _____

Date of Filing: _____

Date of Incident: _____

Professional Liability Insurer: _____

Allegation: _____

Details of incident including your role, relating events, and patient outcome:

Have you made any changes in your practice as a result of this incident?

Attach separate sheet if required.

I certify to the best of my knowledge that all information provided above is correct and complete. I understand that any significant misstatement or omissions on this application may constitute cause for denial or revocation of my contract.

Signature: _____ Date: _____