

WHOLEHEALTH LIVING® CHOICES NETWORK
PARTICIPATING PRACTITIONER AGREEMENT
CERTIFICATE OF PARTICIPATION FOR CHOICES PROGRAMS

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

- 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

SIGNATURE LINE

This Agreement is a contract between WholeHealth Networks, Inc. (“WHN”), a subsidiary of Tivity Health Support LLC, and the undersigned practitioner (“Practitioner”), (each a “Party,” and together the “Parties”) and consists of page 1 and 2, and the Terms and Conditions on Pages 4 and 5 (“Terms”).

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 Specific Credentials Requirements section).

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

DISCOUNT AGREEMENT

Practitioner will offer Services to Network participants at a discount of _____% (minimum of 10%–30%) to all of Practitioner’s usual charges for Services (the “Discount”). If the Discount is left blank, Practitioner will provide a **20% discount. Practitioner acknowledges that certain Network group clients only agree to accept Practitioners who offer discounts of 20% or more.** This Agreement and the Discount are effective on the date that Practitioner signs this Agreement (“Effective Date”). This Agreement will continue until the date that is one year after the Effective Date, and on such date and on each one-year anniversary thereof will automatically renew for additional consecutive one-year renewal terms unless a Party gives written notice to the other Party that it does not seek to renew this Agreement. Such notice of non-renewal must be sent at least 90 days (30 days for Practitioners in Illinois) prior to the expiration of the then-current term.

In consideration of Practitioner providing the Services at the Discount, WHN shall: (i) certify Practitioner as a Participating Practitioner in its Network; (ii) advertise Practitioner’s Services to Network clients; and (iii) extend the term of this Agreement to one-year renewable terms. Practitioner has reviewed all provisions of this Agreement, including the Terms, understands the meaning and consequences of such provisions, has had the opportunity to consult with counsel, and voluntarily agrees that the Terms will govern the relationship of the Parties.

 Practitioner’s Printed Name

 Practitioner’s Signature
 Please print and sign.

 Date

Primary Location:

Clinic Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____ Office Fax: _____

Office Contact: _____ Title: _____

Website Address: _____ Email Address: _____

Secondary Location:

Clinic Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____ Office Fax: _____

Office Contact: _____ Title: _____

Website Address: _____ Email Address: _____

* If you have additional locations, please list them on a separate sheet.

Provider's Date of Birth: ___/___/___ Individual NPI # _____

State License # _____ State License Expiration Date _____

Malpractice Carrier (attach current face sheet) _____ Malpractice Limits: _____

Malpractice Policy # _____ Malpractice Expiration: _____

Colleges/Specialty Institutions: _____ Graduation Date(s): _____

Do you wish to have your Website listed on your profile? _____

What is your first year of practice? _____

What non-English languages do you or your office staff speak fluently? Please list _____

Practice Focus:_____
_____**Payment Methods Accepted:**

- Visa American Express Cash
 MasterCard Discover Personal Check

Average Fee Range: \$ _____ - \$ _____

Special Offers:_____
_____**Correspondence/Communication Preference:**

- Email Email Address _____ Fax Fax Number _____
 United States Postal Service

PRIMARY LOCATION OFFICE HOURS

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
A.M.	A.M.	A.M.	A.M.	A.M.	A.M.
P.M.	P.M.	P.M.	P.M.	P.M.	P.M.

SECONDARY LOCATION OFFICE HOURS

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
A.M.	A.M.	A.M.	A.M.	A.M.	A.M.
P.M.	P.M.	P.M.	P.M.	P.M.	P.M.

DEFINITIONS

1. **Choices Program** means a discount cash payment arrangement where the Practitioner agrees to provide Participants in WHN-contracted Choice programs access to practitioner's services at a specific discount % off the practice's Published Fee Schedule. Practitioner has specified a discount within the range of 10% to 30%, on services not covered by any health insurance or governmental program. Discount does not apply to co-payments or deductibles for covered services. This discount is to be offered to all Participants in all WHN contracted Group Choice programs, for which WHN provides notice to Practitioner. Participants simply show the Practitioner their Group ID card or WHN discount card to receive the discount. Payment for services, after the discount, is the complete responsibility of the Participant. (Discount must be applied to personal health services and therapies delivered by Practitioner's office, and may extend, at the Practitioner's discretion, to dispense health related supplies and durable medical goods).
2. **Published Fee Schedule** means the current retail or non-discounted fee schedule that applies to the Practitioner's services to the general public and to the fees for service charged to patients when Practitioner is a non-participating provider in the patient's insurance plan.
3. **Unrestricted License** means that the practitioner's health care license, registration, or certification is valid for full practice within the jurisdiction's regulated scope of practice for that health care professional specialty, and is not subject to stipulations, practice limitations, probationary periods, temporary supervision requirements, or other limitations. Limitations include peer review actions and malpractice claims settled or pending.

TERMS AND CONDITIONS OF PARTICIPATION

1. **Practitioner Portal; Policies and Procedures.** Practitioner shall fully comply with WHN's Network policies and procedures, including credentialing, quality management, utilization review, audit, investigation, licensure, insurance, non-discrimination, participation criteria, authorization to contract, billing and accounting requirements, experience and language requirements, premises standards, state-specific Network business requirements established by WHN, and legal compliance addenda, all of which are expressly incorporated into this Agreement and can be found on the Network electronic resource library at <https://www.wholehealthpro.com> ("**Practitioner Portal**").
2. **Non-discrimination.** No person in the United States shall, on the grounds of race, color, sexual orientation, religion, sex or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any WHN contracted Choices Program. Practitioner will comply with all requirements imposed by or pursuant to the regulations of the appropriate federal agency effectuating Title VI of the Civil Rights Act of 1964.
3. **Termination.** WHN may terminate this Agreement at any time for cause without prior written notice. Practitioner's failure to fully comply with the requirements found on the Practitioner Portal or in this Agreement shall be deemed to constitute cause.
4. **Provision of Services.** In respect of the Services, Practitioner shall do the following: (i) provide the Discount; (ii) provide Services at standards of professional practice applicable to Practitioner; (iii) comply with all Network requirements as notified on the Practitioner Portal; (iv) provide Services in an efficient, cost effective, and high quality manner, within the business requirements for participation included in Practitioners' application for membership in the Network; (v) provide Services under the conditions and limitations contained in this Agreement and in group contracts; (vi) not be obligated to provide any service to Network participants that the Practitioner does not usually provide to others; (vii), not provide Services that Practitioner is not authorized by law or by WHN to provide to Network participants; (viii) not illegally discriminate against any Network participant in providing, refusing, or declining to provide Services.
5. **Directory Listing.** WHN will identify Practitioner in its Network group-specific online and offline practitioner directories. Listings in the online directories will include name, specialty(ies) and discount percentage.
6. **Practitioner Licensure Requirements.** At any time upon 5 days' advance notice and within 5 days of renewal, loss, or lapse of licensure, Practitioner shall submit to WHN, documentary evidence acceptable to WHN that Practitioner holds a current unrestricted license and/or certification to provide the Services.
7. **Published Fee Schedule.** Practitioner is entitled to change its agreed upon Discount to Services no more than once every six (6) months. Practitioner agrees to notify WHN a minimum of thirty (30) days in advance of any change in name, address, phone number practice status or Discount to Services rate. Failure to apply the Discount to Services shall be a material breach of this Agreement. Practitioner shall seek payment for Services (after application of the Discount) only from Choices Program participants and not from WHN.
8. **Indemnification; Hold Harmless.** Practitioner shall indemnify, defend, and hold harmless WHN and its directors, officers, subsidiaries, affiliates, employees, subcontractors, and agents ("**Representatives**") from and against any and all claims for losses, costs, or damages of every kind and character arising out of or in connection with the actions of Practitioner in performing Services or caused by the negligence or misconduct of Practitioner or its agents, contractors, or employees (for example, claims made against WHN or its Representatives by Network participants, groups, members, customers and/or clients).
9. **Claim.** The term "**Claim**" means any dispute, claim or controversy arising between Practitioner and WHN and/or its Representatives, whether known or unknown, pre-existing, present, or future, or arising out of or relating to this Agreement, or the breach of this Agreement, whether based in tort, statute, or in contract, pursuant to applicable law, or otherwise, whether in connection with the actions of a Party or an agent, employee, or subcontractor of that Party (all a "**Claim**").
10. **Waiver of Class Actions.** As of the Effective Date, each Party waives any equitable, constitutional, or statutory right to have any Claim adjudicated in a court of law or to join or consolidate its Claim with any other practitioner, or enforce any claim as a class representative, in a class action, or as a private attorney general. Neither Party shall mediate, arbitrate, or seek adjudication of any Claim on a class action basis. Each Party will affirmatively opt out of any class action regarding a Claim or dispute between the Parties and a Party shall be entitled to specific performance to enforce the provisions of this section.
11. **Mandatory Arbitration Agreement.** Any Claim shall be determined by final and binding arbitration by a single arbitrator administered by the American Arbitration Association under its Commercial Arbitration Rules. No Party shall be able to join or consolidate Claims with any other Party. Judgment on any award rendered by the arbitrator may be entered in any court having jurisdiction. Neither Party may disclose the existence or results of any arbitration. THE PARTIES HAVE READ AND UNDERSTAND THIS ARBITRATION AGREEMENT AND KNOWINGLY AND VOLUNTARILY AGREE TO ITS TERMS.
12. **Compliance with Laws.** Practitioner and all persons providing the Services, including employees, representatives, or agents of Practitioner's practice shall comply with all state, federal, and local laws and regulations applicable to the Services, including laws and regulations regarding privacy, security, and confidentiality of information received from Network participants. **Insurance.** Practitioner shall maintain insurance covering: (i) general, professional, and premises liabilities in compliance with the Practitioner Portal and (ii) extended liability insurance (e.g., "nose" or "tail" policies) to insure retroactive coverage after any termination or change in Practitioner's professional liability insurance.

- 13. Insurance.** Practitioner shall maintain insurance covering: (i) general, professional, and premises liabilities in compliance with the Practitioner Portal and (ii) extended liability insurance (e.g., “nose” or “tail” policies) to insure retroactive coverage after any termination or change in Practitioner’s professional liability insurance.
- 14. Severability.** If a court or government authority with competent jurisdiction over the Parties or the subject matter of this Agreement finds any term of this Agreement illegal, invalid, or unenforceable, that term shall be excluded to the extent of such illegality, invalidity, or unenforceability and all other terms of this Agreement shall remain in full force and effect. To the extent permitted and possible, the illegal, invalid, or unenforceable term shall be deemed replaced by a term that is valid and enforceable and that comes closest to expressing the intention of such invalid or unenforceable term.
- 15. Existing Business Relationship.** The Parties have a pre-existing business relationship and are sophisticated business parties with knowledge of contractual agreements and other legal business matters.
- 16. Damages Cap.** Money damages awarded by an arbitrator or any court of law related to any Claim shall be capped at the aggregate amount of discount applied to Services to Network participants by Practitioner provided pursuant to this Agreement within the prior 3 months. No Party shall be liable to the other for special, consequential, incidental, indirect, punitive, indirect, lost profits, trebling of damages, pain and suffering (including mental), or speculative damages even if the Party has been advised of such possibility.
- 17. Attorney’s Fees.** If a Party fails to submit its Claim to arbitration, unsuccessfully challenges the arbitrator’s decision, fails to comply with the arbitrator’s decision or award, or joins or does not opt out of a class action relating to any Claim, the other Party is entitled to all costs of suit, including reasonable attorneys’ fees.
- 18. Consent to Communicate.** Practitioner expressly consents to any communication sent by or on behalf of WHN, received before the Effective Date of this Agreement or after, whether by telephone, letter, email, facsimile, or otherwise.
- 19. Notices.** The Parties agree that all notices shall be sent to a Party’s address as provided on the first page of this Agreement.
- 20. Applicable Law; Venue.** This Agreement and any Claim shall be governed by the laws of the State of Tennessee. The venue for any dispute arising out of Practitioner’s performance of Services shall be the state where such Services were performed. Venue for all other purposes and for any Claim shall be in Nashville, Tennessee.
- 21. Waiver of Breach.** A Party’s waiver of a breach of this Agreement by the other Party shall not effect a waiver of any subsequent breach of the same or any other provision of this Agreement.
- 22. Agency, Successors; Third Party Beneficiaries; Assignment.** Neither Party is an agent of the other. This Agreement shall inure to the benefit of, and be binding upon the Parties and their respective successors and assigns. This Agreement is entered into for the sole benefit of the Parties and their Representatives, and nothing contained herein or in the Parties’ course of dealings shall be construed as conferring any third party beneficiary status on any person or entity who is not a Party or its Representative. This Agreement may not be assigned by Practitioner without the prior written consent of WHN.
- 23. Survivability.** Termination of this Agreement shall not relieve the Parties of the obligations set forth in Sections 7-15, terminate any provision that by its terms is intended to survive termination, or relieve Practitioner of obligations with respect to Services provided before termination or obligations to protect Network participants.
- 24. Entire Agreement.** This Agreement constitutes the entire agreement of the Parties and supersedes all prior oral or written communications, contracts, or agreements between the Parties.

PARTICIPATION REQUIREMENTS

Liability/Insurance: All Practitioners with health care licenses and Practitioners with specified unlicensed hands-on specialties (see specialty list) agree to maintain professional liability insurance. Per the current WHN policy for CAM practitioners, a minimum of \$200,000 per occurrence and \$500,000 aggregate is required while limits of 1M/3M are required for all MD’s and DO’s, as well as ND’s and DC’s who also are credentialed for acupuncture. (Members who participate in certain regional contracts involving both covered benefits and choice programs may be required to have higher limits.) Practitioner agrees to maintain required premises and comprehensive general liability insurance in amounts of \$100,000 per claim and \$100,000 per year, or the minimum required by state law, whichever is greater. Furthermore, the Practitioner agrees to obtain extended liability insurance (sometimes called “nose” or “tail” policies), to insure retroactive coverage for professional acts performed during the term of this agreement, should the Practitioner terminate this agreement and change or terminate professional malpractice coverage.

Practice Experience: All practitioners are required to have 12 months experience in the credentialed practice specialty.

Patient Services: Practitioners must speak fluent English or have access to an interpreter.

Health Information Privacy Regulatory Compliance and Business Associate Agreement:

Practitioner agrees that practitioner’s practice will remain compliant with applicable state and federal regulations regarding privacy and confidentiality of individually identifiable health information.

WHN agrees to adhere to applicable state and federal privacy regulations with respect to Protected Health Information, as defined under the Health Insurance Portability and Accountability Act of 1996, received from Practitioner’s practice.

Premises Standards: Health care office locations must follow OSHA safety standards, and home offices must have separate treatment room or studio and professional signage as allowed by local zoning.

Practitioner Licensure Requirements:

- Practitioners must give evidence of current unrestricted license in the specialty (ies). With some practitioner types; WHN has established additional criteria, such as dual credentialing in both a licensed field as well as by meeting certification standards for the unlicensed practice specialty.
- Acceptance of practitioner types who meet WHN credentialing criteria for training and certification is also subject to state-by-state application of network business criteria established by WHN and their network clients.

NETWORK CERTIFICATION AND RELEASE OF INFORMATION

QUERIES TO THE NATIONAL PRACTITIONER DATA BANK OR STATE LICENSING BOARD

State and federal licensing and regulatory boards will be queried if you apply. If your application is rejected for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating or omitting a relevant fact in connection with your application, the rejection may be reported to the National Practitioner Data Bank.

RIGHT TO CORRECT ERRONEOUS INFORMATION

Practitioner has the right to review information submitted in support of your Network Application and contract 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.

CERTIFICATION OF APPLICATION HEALTH CARE LICENSE AND MALPRACTICE CLAIM STATUS

- I certify all statements in this application are correct and I agree with the terms of this agreement with WHN.
- I certify that I have and will maintain during the course of my contractual relationship with WHN the unrestricted healthcare license(s) required for my specialties as a WHN network practitioner. Unrestricted license means that the practitioner’s healthcare license is valid for full practice within the jurisdiction’s regulated scope of practice for that health care professional specialty, and not subject to stipulations, practice limitations, probationary periods, temporary supervision requirements, or other limitations. I will notify WHN if my license status changes.
- If there are national standards and/or state licensure standards for a practitioner type that is not licensed, registered, or certified by the applicable state jurisdiction, WHN has recognized certain national standards applicable for its network. I certify that I meet these standards for training, experience, and examination, as summarized in this application, in the absence of local licensure, or in addition to any existing lesser local requirements. I recognize that WHN standards do not substitute for my meeting such state licensure requirements for health care practice as may periodically be instituted or updated by state jurisdictions.
- I have ___ have not ___ had any malpractice claims or award involvement. **If you have past or current claims, please fill out the professional liability section.**

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize WHN to consult with past employers, administrators and members of institutions with which I have been or am currently associated, and with others who may have information bearing on my qualifications as a Practitioner, including past and present malpractice carriers to obtain and verify my credentials and professional competence. I further consent to the inspection by representatives of WHN of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications including information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges. I consent to the release and exchange of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to WHN. I authorize the medical and/or professional associations of which I am a member to turn over to the representatives of WHN a copy of my application for membership and related documents. I release from liability all representatives of WHN for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations that provide information to WHN in good faith and without malice concerning my professional competence, character and ethics.

Signature: _____ Date: _____

Practitioner Name: _____ Title or Designation (DC, LAc, GCFP, etc): _____

A photocopy of this document shall be as effective as the original when so presented (Signature stamps are not acceptable).

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. 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: _____

Please print and sign.

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

Integrative Holistic Physician	<input type="checkbox"/> A minimum of 200 hours course work in alternative medicine or osteopathic principles, or be certified by the American Board of Holistic Medicine of Holistic Medicine <input type="checkbox"/> Hold a valid unrestricted state license to practice medicine <input type="checkbox"/> Professional liability insurance of \$1,000,000 / \$3,000,000
Massage Therapy	<input type="checkbox"/> Hold a valid unrestricted state massage license OR <input type="checkbox"/> Current jurisdictional (city/county, etc.) license. PLUS either of the following: <ul style="list-style-type: none"> <input type="checkbox"/> Certificate of NCBTMB exam passage (National Certification Board of Therapeutic Massage & Bodywork OR <input type="checkbox"/> Certificate of active professional AMTA or ABMP membership (requires 500 hrs. training) OR <input type="checkbox"/> Meet WholeHealth Networks, Inc. qualifications for alternative bodywork training and certification (Rolfing, Myotherapy, Reiki, Hellerwork, Oriental Body Work, etc.) <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
Massage Therapy-Clinical	<input type="checkbox"/> Hold a valid unrestricted state massage license <input type="checkbox"/> Certification by the National Certification Board for Massage or Therapeutic Bodywork (NCBMTB) or an equivalent State licensing exam <input type="checkbox"/> Evidence of professional continuing education in massage totaling at least 60 hours of course work in the past four years <input type="checkbox"/> Copy of Certificate of Completion of at least one advanced massage modality practice training program of 25 hours or more <input type="checkbox"/> Documentation of at least two calendar years in active clinic practice <input type="checkbox"/> Two Letters of Reference from health professionals attesting to personal and clinical practice characteristics, at least one of which <u>must be</u> from a referring or supervising MD, DO, DC, PT, RN or WholeHealth Networks, Inc. credentialed clinical massage practitioner <u>who has supervised your practice</u> PLUS : <input type="checkbox"/> Documentation of supervised contact hours performing clinical massage: <ul style="list-style-type: none"> <input type="checkbox"/> 500 contact hours required for applicants with only a basic 500 hour massage education OR <input type="checkbox"/> 250 contact hours required for applicants with 1,000 hour basic massage education that Includes clinical assessment, clinical pathology, and clinical charting OR <input type="checkbox"/> Postgraduate clinical training equivalent to 250 contact hours after their basic 500 hour education <input type="checkbox"/> Professional liability insurance of \$200,000/\$600,000 or \$500,000/\$500,000
Mind-Body Skills Instructor	<input type="checkbox"/> Certification by Peggy Huddleston of satisfactory completion of training in administering the "Prepare for Surgery, Heal Faster" program OR <input type="checkbox"/> Written documentation of completion of training in the MindBodySpirit Professional Training Program, offered by the Center for MindBody Medicine in Washington, DC, OR <input type="checkbox"/> 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 <input type="checkbox"/> Written Documentation of completion of training as a meditation Instructor in a formal or apprenticeship training program PLUS <input type="checkbox"/> Attestation of a minimum of 200 hours or training and/or practice teaching
Mindfulness Based Stress Reduction Teachers	<input type="checkbox"/> MBSR Teacher Certification evidenced by a Certification by the Center for Mindfulness A at the University of MA OR <input type="checkbox"/> Copy of Attestation to 200 hours of experience teaching Mindfulness-Based Stress Reduction (MBSR) PLUS <input type="checkbox"/> Written Documentation of completion of Mindfulness-Based Stress Reduction in Mind/Body Medicine A 5- or 7-Day Residential Training Retreat offered by the Center for Mindfulness at University of Massachusetts Medical School OR <input type="checkbox"/> 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 <input type="checkbox"/> 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	<input type="checkbox"/> A listing of current certification as MT-BC by the Certification Board for Music Therapists (CBMT) OR <input type="checkbox"/> 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 <input type="checkbox"/> Current membership in the American Music Therapy Association (AMTA)
Naturopathic Physician	<input type="checkbox"/> Graduation from a naturopathic medical college with a minimum four-year graduate degree <input type="checkbox"/> 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. <input type="checkbox"/> Professional liability insurance of at least \$200,000/\$500,000
Nutritional Counselor	<input type="checkbox"/> Hold a valid unrestricted state license as a nutritionist OR (if non-licensed state) <input type="checkbox"/> Certified as a Certified Clinical Nutritionist (CCN) by the Clinical Nutrition Certification Board OR <input type="checkbox"/> Certified as a Certified Nutritionist (CN) by the National Institute of Nutritional Education <input type="checkbox"/> Professional liability insurance limits of at least \$200,000/\$500,000
Occupational Therapist	<input type="checkbox"/> Graduation from an accredited college or formal training program <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> NBCOT certification (not required but recommended) <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
Asian/Oriental Bodywork	<input type="checkbox"/> Hold a valid unrestricted state or local license PLUS <input type="checkbox"/> 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 <input type="checkbox"/> Certification in Asian Bodywork Therapy by the Nat Cert Commission for Acupuncture and Oriental Med (NCCAOM) <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000

Pain Practitioner	<input type="checkbox"/> 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 <input type="checkbox"/> Graduation from an accredited college or formal training program for the primary license recognized by the state licensing agency <input type="checkbox"/> Current professional liability insurance policy meeting primary specialty requirements, or at least \$200,000 / \$500,000 <input type="checkbox"/> Certification as a Diplomat, Fellow or Clinical Associate in Pain Management by exam of the American Academy of Pain Management OR <input type="checkbox"/> Certified by the American Board of Pain Medicine OR <input type="checkbox"/> 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	<input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> Health Fitness Director or Program Director certification by the American College of Sports Medicine <input type="checkbox"/> Certified by the Health & Fitness Program of certification by the Canadian Society for Exercise Physiology (CSEP) PLUS <input type="checkbox"/> Evidence of at least 15 CEU's of continuing education in exercise and fitness specialties every two years
Physical Therapist	<input type="checkbox"/> Graduation from an accredited college or formal training program <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
Pilates Instructor	<input type="checkbox"/> Pilates Certified Teacher from the Pilates Method Alliance (PMA) OR <input type="checkbox"/> Letter attesting current employment at Studio or Educational Organization that is registered with PMA OR <input type="checkbox"/> Evidence of Training through or by a Pilates Instructor program recognized by the Pilates Method Alliance OR <input type="checkbox"/> Certificate of completion in a comprehensive Pilates teacher training course with a 400 hour minimum requirement <input type="checkbox"/> 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: <input type="checkbox"/> International Childbirth Education Association (ICEA) OR Childbirth and Postpartum Professional Association (CAPP) OR La Leche League International accredited Leader program OR International Board of Lactation Consultant Examiners (IBLCE)
Qi Gong	<input type="checkbox"/> Certification from the National QiGong Association (NQA) or individual training program <input type="checkbox"/> A minimum of 200 hours of formal training <input type="checkbox"/> One year teaching experience
Reflexologist	<input type="checkbox"/> Credentialed with WholeHealth Networks, Inc. as a massage therapist <input type="checkbox"/> Certification from the American Reflexology Certification Board <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
Tai Chi	<input type="checkbox"/> Certification from the individual training program <input type="checkbox"/> A minimum of 200 hours of training and/or practice teaching <input type="checkbox"/> One year documented teaching experience
Yoga	<input type="checkbox"/> 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 <input type="checkbox"/> One year in practice experience following completion of training or working under supervision in a Yoga facility



**AMENDMENT TO
PARTICIPATING PRACTITIONER AGREEMENT**

This Amendment to the Participating Practitioner Agreement (the "Amendment") is entered by and between **WholeHealth Networks, Inc.** ("WHN") and the undersigned practitioner ("Practitioner"), and shall be effective upon the date this Amendment is fully signed by both parties.

WITNESSETH

WHEREAS, the parties wish to amend certain terms and conditions contained in the Participating Practitioner Agreement (the "Agreement") between WHN and Practitioner as more particularly set forth below.

NOW THEREFORE, in consideration of the mutual covenants, conditions, and agreements set forth herein, and for other good and valuable consideration, the receipt and sufficiency of which are acknowledged, the parties hereto agree as follows:

1. Practitioner agrees to participate in the Health and Fitness Product ("Health and Fitness Product") network being arranged by WHN, in accordance with the terms and conditions set forth in the group summary document attached as Attachment 1 to this Amendment. The Practitioner agrees to participate in this Health and Fitness Product throughout the duration of the Agreement.
2. Except as amended by this Amendment, the Agreement and all its provisions and exhibits shall remain in full force and effect as of the date hereof. The terms and conditions of the Agreement will continue to remain in full force and effect, except as modified herein. If there is any conflict between this Amendment and the Agreement with respect to the subject matter of this Amendment, this Amendment shall control. This Amendment may be executed in counterparts, including by electronic transmission of a PDF signature page.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their duly authorized representatives.

PRACTITIONER

Signature: _____
Please print and sign.

Date: _____

Printed Name: _____

Provider's Date of Birth: ___/___/_____

NPI Number: _____

Email Address: _____

ATTACHMENT 1 TO AMENDMENT – GROUP SUMMARY

Network Status:	Open
Product Type:	The Health and Fitness Product
Eligible Practitioners:	WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC, contracted Acupuncturists, Chiropractors, and Massage Therapists

Program Design:

Notwithstanding any provision of the Agreement, the following additional provisions shall be applicable to Practitioners providing services to Participants who elect to participate in a new health and fitness product being jointly developed by WholeHealth Networks, Inc. and a large, nationally known brand in the older adult wellness space (the “Health and Fitness Product”).

The Health and Fitness Product shall provide Participants with Twenty and No/100 Dollars (\$20.00) vouchers (each, a “Voucher”) to be utilized for complementary health services (e.g., acupuncture, massage therapy, chiropractic). Depending on the Participant’s election, this Voucher shall either only be provided to the Participant as a one-time benefit for enrolling, or may be a recurring monthly Voucher for as long as the Participant is enrolled in the Health and Fitness Product. In addition to the agreed upon discount set forth in Practitioner’s Agreement, the Practitioner agrees to accept the voucher from the Participant in accordance with the following provisions:

1. The Practitioner agrees to accept the Voucher as a cash equivalent for services provided to the Participant. For the initial presentation of a Voucher from a Participant, the Practitioner agrees to accept the voucher with no reimbursement from WHN. For any additional Vouchers (the monthly recurring Vouchers), the Practitioner shall submit the Voucher to WHN for reimbursement of the listed amount on the Voucher.
2. The Practitioner must adhere to the following requirements in order to be reimbursed by WHN:
 - a) Notify and submit the Voucher to WHN in the manner agreed upon by the Parties (e.g., web, mail or fax) within forty-five (45) days after acceptance of the Voucher from a Participant. This notification must include the date the Voucher was submitted and the name (and any other requested identifying information) of the Participant who submitted the Voucher.
 - b) Ensure that the submitted Voucher was not accepted beyond the listed expiration date on the Voucher.
 - c) Ensure the submitted Voucher is not the initial Voucher that is not eligible for reimbursement.
3. WHN shall remit payment to Practitioner for all eligible and submitted Vouchers within forty-five (45) days after WHN receives the Voucher and validation from Practitioner.
4. Participants agree to pay remaining balance of Practitioners cash charges at time of service.

Questions:

- **Provider Experience Center:** 1-800-274-7526
- **Voucher redemption:**
 - Via the web: <https://WholeHealthPro.com>
 - After logging, you will see “Redeem Voucher” on the left side of the screen
 - Via the mail: Tivity Health, 1445 S. Spectrum Blvd., Suite 100 Chandler, AZ 85286 (ATTN: Voucher Redemption)
 - Via fax: 1-469-522-5931
- **Address Changes:** provider.updates@tivityhealth.com
- For more information about WHN visit our provider website <https://www.WholeHealthPro.com>

Request for Taxpayer Identification Number and Certification

**Give form to the
 requester. Do not
 send to the IRS.**

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
	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 your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number
or
Employer identification number

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

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).

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 on page 4.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

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

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a “saving clause.” Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called “backup withholding.” Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the “Name” line. You may enter your business, trade, or “doing business as (DBA)” name on the “Business name” line.

Limited liability company (LLC). Check the “Limited liability company” box only and enter the appropriate code for the tax classification (“D” for disregarded entity, “C” for corporation, “P” for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner’s name on the “Name” line. Enter the LLC’s name on the “Business name” line.

For an LLC classified as a partnership or a corporation, enter the LLC’s name on the “Name” line and any business, trade, or DBA name on the “Business name” line.

Other entities. Enter your business name as shown on required federal tax documents on the “Name” line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the “Business name” line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the “Exempt payee” box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
2. The United States or any of its agencies or instrumentalities,
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,
7. A foreign central bank of issue,
8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
9. A futures commission merchant registered with the Commodity Futures Trading Commission,
10. A real estate investment trust,
11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
12. A common trust fund operated by a bank under section 584(a),
13. A financial institution,
14. A middleman known in the investment community as a nominee or custodian, or
15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 7

¹ See Form 1099-MISC, Miscellaneous Income, and its instructions.

² However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at www.ssa.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting www.irs.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship or disregarded entity owned by an individual	The owner ³
For this type of account:	Give name and EIN of:
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: spam@uce.gov or contact them at www.consumer.gov/idtheft or 1-877-IDTHEFT(438-4338).

Visit the IRS website at www.irs.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.