WOMACK ARMY MEDICAL CENTER
NON PRIVILEGED PERSONNEL LICENSE/REGISTRATION FORM

The proponent is MCXC-QSD-CRE
Data Required by Privacy Act of 1974

Authority: 10 USC 3012, 8012, and 5031

Principal Purpose: Is to provide a standardized electronic method of credentialing healthcare providers. The information provided in this form will be used to process the healthcare provider into the DOD Centralized Credentials Quality Assurance System (CCQAS) as required by the Office of the Assistant Secretary of Defense for Health Affairs Policy Letter dated 22 April 2003.

Routine Uses: Is for tracking and storing information about healthcare providers' demographics, education, licenses, certifications, affiliations, insurance and other credentials.

Disclosure: Disclosure of this information is voluntary. However, failure to provide the required information will result in the individual not being entered into the CCQAS data base as required by the Office of the Assistant Secretary of Defense for Health Affairs Policy Letter dated 22 April 2003.

Specialty/Title: (RN, LPN, Tech, 68W, Pharmacist, etc.)			
Last Name	First	Middle	Suffix
Other Names Used Last	First	Middle	Suffix
Rank:	SSN:	DOB:	
Home Address:	City:	State:	Zip Code:
Cell Phone:	Work Phone:	Home Phone:	
AKO E-mail Address:	Personal E-Mail Address:		
Check One: ☐ Active Duty ☐ GS ☐ Reserve ☐ Contract ☐ Volunteer			
Department:	Work Center:	Supervisor:	
Unit: (Active Duty/ Reserve Only)			
LICENSE INFORMATION: (Please list all licenses)			
State:	License#:	Exp. Date:	
State:	License#:	Exp. Date:	
University/College/Technical School Attended Name and Address:	Degree Received: (AS, BS, etc.)	Date Received:	
University/College/Technical School Attended Name and Address:	Degree Received: (AS, BS, etc.)	Date Received:	

Has your license in ANY state ever been limited, suspended, revoked or voluntarily suspended? Have you ever been disciplined by any state licensing board?

☐ Yes ☐ No

If yes, explain:

By signing this document I understand that it is my responsibility to keep my license(s) up to date. I will ensure that I will bring any documents that are required during in processing that were not available or provided.

SIGNATURE:	DATE:
WITNESS:	DATE:

STATEMENT OF RELEASE

I hereby give Credentials Office release from liability and any and all individuals and organizations who provide information to the hospital of its medical staff in good faith and without malice concerning prime source verification if all my professional credential documents (i.e., state license, national certifications, etc.), and I hereby consent to the release of such information.

_____ _____

Signature of Applicant Date

_____

Typed/Printed Name and Grade/Rank

STATEMENT OF UNDERSTANDING

LIST OF EXCLUDED INDIVIDUALS/ENTITIES (LEIE) AS A CONDITION OF EMPLOYMENT

References:

a. Social Security Act, Sections 1128, 1128B(f) and 1156. http://www.ssa.gov/OP_Home/ssact/title11/1128.htm.

b. Title 5, Code of Federal Regulations (CFR), Part 752, Adverse Actions. http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title05/5tab_02.tpl.

c. Title 42, CFR, Notice and Appeals, Subpart E, Sections 1001.2001 through 1001.2007. http://www.gpo.gov/fdsys/granule/CFR-2010-title42-vol5/CFR-2010-title42-vol5-sec1001-2001.

d. DoDI 5505.12, Anti-Fraud Program at Military Treatment Facilities (MTFs), Change 1, October 13, 2013, and Attachment E-1

In accordance with listed references, individuals who have defrauded the US Government, or who have committed certain other acts delineated in the statute, are excluded from reimbursement from Federal healthcare programs for varying periods of time.

Accordingly, any individual who supplies health care items or provides services, and is listed on the Office of the Inspector General, US Department of Health and Human Services (HHS), List of Excluded Individuals/Entities (LEIE), is prohibited from participating in any capacity in the Military Health System, either directly or through the purchased care system.

This prohibition applies to any Federal employee who is paid by the Federal Government for delivering a healthcare item or service, including, without limitation, both privileged and non-privileged providers.

As a condition of employment, I, _____, understand that my employer will query my name against the HHS LEIE database on a monthly basis to verify that I have not defrauded the US Government or committed certain other acts delineated in the statute. I further understand that I am subject to removal from Federal service through adverse action procedures if my name is listed on the LEIE.

Current Employee printed name:_____

Current Employee Signature:_____ **Date:**_____