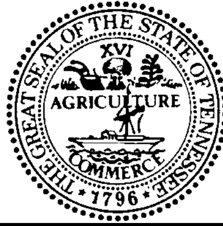

TENNESSEE DEPARTMENT OF HEALTH

MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE FOR LICENSED HEALTH CARE PROVIDERS

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. §§ 63-51-101, et seq., requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health, and is requested in this questionnaire. From the information submitted, the Department compiles practitioner profiles which the law requires to be made available to the public via the World Wide Web and our toll-free telephone line. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information may result in a delay or denial of your licensure application and/or may result in disciplinary action against your license. The professions required to submit a profile questionnaire are:

Advanced Practice Nurses
Alcohol and Drug Counselors
Audiologists
Chiropractic Physicians
Clinical Pastoral Therapists
Dentists
Dietitian/Nutritionists
Dispensing Opticians
Electrologists
Licensed Registered Respiratory Therapists
Licensed Certified Respiratory Therapists
Licensed Laboratory Personnel
Marital & Family Therapists
Massage Therapists
Medical Doctors
Nursing Home Administrators
Occupational Therapists
Optometrists
Orthopedic Physician Assistants
Osteopathic Physicians
Pharmacists
Physician Assistants
Physical Therapists
Podiatrists
Professional Counselors
Psychologists
Respiratory Care Assistants
Social Workers
Speech Language Pathologists
Veterinarians

QUESTIONNAIRE DEADLINE The provider must complete and submit the questionnaire before a license will be granted. Providers who have completed a similar questionnaire for another state's licensing board are, nevertheless, required to complete and submit this form.

Each provider who has submitted information pursuant to this chapter must update that information in by notifying the department within thirty (30) days after the occurrence of an event or the attainment of a status that is required to be reported.

COMPLETING THE QUESTIONNAIRE Complete the questionnaire by typing the information or by printing neatly in block letters in ball point pen. **Illegible questionnaires will be returned.** If you need further instruction, contact your profession's licensing board by calling (615) 532-3202 or by calling toll free at (800) 778-4123.

SUBMITTING THE QUESTIONNAIRE Mail the completed profile questionnaire to:

Tennessee Board of *(board for your profession)*
Healthcare Provider Information
665 Mainstream Drive
Nashville, TN 37243

- **Do not return pages 1 through 4 with the questionnaire to the department.**
- **Keep a copy of the questionnaire for your records.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete Part I, noting the following:

- **License number**: Fill in your Tennessee license number and indicate your profession in the space provided. **If you have not been issued a license number, please leave this blank.**
- **Social security number: Your social security number will not be published or in any way given out to the public. It is required for in-office tracking purposes only.**
- **Primary Practice Address:** Complete the practice address (if applicable). If your practice address is also your home address, you should know the Department is prohibited from placing your home address on the Internet without your request to do so. There are two questions in Part I that apply to this. Retirees: Write in "N/A" for practice address. If you do not have a practice address at the time of completing this questionnaire, you must report your practice address within 30 days of obtaining a practice address.
- **Supervising Physician**: Physician assistants and advanced practice registered nurses with a certificate of fitness must list all supervising physicians. In addition, advanced practice registered nurses must complete the **Notice and Formulary** if you are prescribing and physician assistants must complete the **PA Supervising Physician form**. Completion these forms are in addition to completing and/or updating the practitioner profile questionnaire.
  - The Notice and Formulary is online at http://tn.gov/assets/entities/health/attachments/PH-3625.pdf.
  - The PA Supervising Physician form is online at http://tn.gov/assets/entities/health/attachments/PA_Supervising_Physician_Application.pdf.

II. MEDICAL, PROFESSIONAL OR TRAINING SCHOOLS AND GRADUATE MEDICAL EDUCATION OR OTHER GRADUATE-LEVEL TRAINING

List chronologically medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association, APN certifications or any other specialty certifying body as determined by your Tennessee licensing board.

IV. STAFF PRIVILEGES

A. List all hospitals at which you hold staff privileges. The definition for “hospital” can be found at T.C.A. § 68-11-201.

V. MANAGED CARE PLANS

A. In the spaces provided, answer information about the Managed Care plans in which you participate and accept as a provider, if any. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

VI. TENNCARE PLANS

A. In the spaces provided, answer information about the TennCare plans in which you participate and accept as a provider, if any. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

VII. FINAL DISCIPLINARY ACTION BY A LICENSING BOARD

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sexual boundary violation, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license such as censure, reprimand, probation, etc.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions please list name(s) and address(es) of the agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. If the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of disposition immediately after the appeal is disposed of by the adjudicating authority.

VIII. FINAL DISCIPLINARY ACTION BY A HOSPITAL

These questions refer to final disciplinary or adverse actions taken within the previous ten (10) years, by a hospital. The term final means the matter was fully adjudicated at a hearing and the appeal's period expired, or that the applicable governing body or the hospital issued an agreed order or consent decree.

In the "Description of Violation" spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sexual boundary violation, impairment, fraud, etc.

In the "Description of Action" spaces, indicate the type of disciplinary action imposed against your privileges.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer "yes" to any of the questions please list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. If the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of disposition immediately after the appeal is disposed of by the adjudicating authority.

IX. FINAL DISCIPLINARY ACTION BY A HOSPITAL (RESIGNATION OR NON-RENEWAL OF PRIVILEGES)

These questions refer to final disciplinary or adverse actions taken within the previous ten (10) years, by a hospital. The term final means the matter was fully adjudicated at a hearing and the appeal's period expired, or that the applicable governing body or the hospital issued an agreed order or consent decree.

In the "Description of Action" spaces, indicate the type of disciplinary action imposed against your privileges.

The term **disciplinary action** includes, but is not limited to:

- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer "yes" to any of the questions please list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. If the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of disposition immediately after the appeal is disposed of by the adjudicating authority.

X. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice within the most recent ten (10) years. **If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition.** If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

XI. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19, 1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE FOLLOWING AMOUNTS ARE NOT REQUIRED TO BE SUBMITTED.

A) For Medical Doctors and Osteopathic Physicians, judgments or settlements below $75,000 are not required to be submitted.
B) For Chiropractors, judgments or settlements below $50,000 are not required to be submitted.
C) For Dentists, judgments or settlements below $25,000 are not required to be submitted.
D) For all other professions, judgments or settlements below $10,000 are not required to be submitted.

Pending malpractice claims are not required to be reported unless/until final adjudication against you.

XII. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name ________________________________ **TN License #** ______________
(if applicable)

Profession ____

TENNESSEE BOARD OF *(board for your profession)*
HEALTHCARE PROVIDER INFORMATION
TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA (Please read instructions before completing this form)

A. PROFESSION:___________________________ TN LICENSE NUMBER: _________________

B. SOCIAL SECURITY NUMBER: _______________________ **(This will not be published)**.

C. NAME:

____

(LAST) (FIRST) (MIDDLE NAME)

D. PRIMARY PRACTICE ADDRESS (attach additional sheets if necessary):

____
(PRACTICE NAME)

____
(STREET NUMBER AND NAME)

____
(CITY) (STATE) (ZIP CODE)

Is your practice address your home address? ___Y ___ N

If yes, do you want it contained in your profile as your official mailing or practice address? ___Y ___N

E. E-MAIL ADDRESS: ____

F. PRACTICE TELEPHONE: (_______)_____________________________

G. LANGUAGES, OTHER THAN ENGLISH: Indicate any translations services or languages (other than English) that may be available at your primary practice location.

1. ____________________________________ 2. ____________________________________

3. ____________________________________ 4. ____________________________________

H. SUPERVISING PHYSICIAN (applies to physician assistants and advanced practice registered nurses with a certificate of fitness): If you are required by law to be supervised by a physician indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets: (see page 2 of instructions)

1. ____

2. ____

3. ____

4. ____

Practitioner's Name ______________________________________ **TN License #** _______________
(if applicable)

Profession ____

II. MEDICAL, PROFESSIONAL OR TRAINING SCHOOLS AND GRADUATE MEDICAL EDUCATION OR OTHER GRADUATE-LEVEL TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal.

PROGRAM/INSTITUTION	CITY/STATE/COUNTRY (IF NOT COMPLETED IN THE U.S.)	DATE OF GRADUATION MM/DD/YYYY	TYPE OF DEGREE
1.			
2.			
3.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal.

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY, STATE OR COUNTRY IF NOT COMPLETED IN THE U.S.)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			

III. SPECIALTY BOARD CERTIFICATIONS (if applicable):

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) YES ___ NO ___

If "Yes", complete section below

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

Practitioner's Name ______________________________ **TN License #** ______________
(if applicable)

Profession ____

IV. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? YES ___ NO ___

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

NAME OF HOSPITAL	CITY/STATE
1.	
2.	
3.	
4.	
5.	

V. MANAGED CARE PLANS

A. Do you participate in any managed care plans? YES ___ NO ___

If "YES", list each: (Attach additional sheets, clearly labeled with this question number, if necessary)

NAME OF MANAGED CARE PLAN
1.
2.
3.
4.
5.

VI. TENNCARE PLANS

A. Do you currently participate in and accept any TennCare plan(s) as a provider? YES ___ NO ___

If "YES", list each plan in which you currently participate or accept as a provider:

NAME OF TENNCARE PLAN
1.
2.
3.
4.
5.

Practitioner's Name ______________________________ **TN License #** ______________
(if applicable)

Profession ____

VII. FINAL DISCIPLINARY ACTION BY A LICENSING BOARD (See Instructions):

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction?

YES ___ NO ___

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.	____________	________	____________	____________
	____________		____________	____________
	____________		____________	____________

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ___ NO ___

	AGENCY NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
2.	____________	________	____________	____________
	____________		____________	____________
	____________		____________	____________

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ___ NO ___

VIII. FINAL DISCIPLINARY ACTION BY A HOSPITAL (See Instructions):

A. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted or reasons related to competence or character by the hospital's governing body?

YES ___ NO ___

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.	____________	________	____________	____________
	____________		____________	____________
	____________		____________	____________

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ___ NO ___

	HOSPITAL NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
2.	____________	________	____________	____________
	____________		____________	____________
	____________		____________	____________

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ___ NO ___

Practitioner's Name ______________________________ **TN License #** ____________
(if applicable)

Profession ____

IX. FINAL DISCIPLINARY ACTION BY A HOSPITAL (RESIGNATION OR NON-RENEWAL OF PRIVILEGES):

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by any hospital in lieu of or in settlement of a pending disciplinary action related to competence or character?

YES ___ NO ___

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME/ADDRESS	DATE	DESCRIPTION OF ACTION
1.	____________________	________	____________________
	____________________		____________________
	____________________		____________________

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ___ NO ___

	HOSPITAL NAME/ADDRESS	DATE	DESCRIPTION OF ACTION
2.	____________________	________	____________________
	____________________		____________________
	____________________		____________________

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ___ NO ___

X. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction?

YES ___ NO ___

If "YES" briefly describe the offense(s):

	DESCRIPTION OF OFFENSE(S)	DATE	JURISDICTION
1.	____________________	________	____________________
	____________________		____________________

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ___ NO ___

	DESCRIPTION OF OFFENSE(S)	DATE	JURISDICTION
2.	____________________	________	____________________
	____________________		____________________

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ___ NO ___

	DESCRIPTION OF OFFENSE(S)	DATE	JURISDICTION
3.	____________________	________	____________________
	____________________		____________________

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ___ NO ___

Practitioner's Name ______________________________ **TN License #** ____________
(if applicable)

Profession ____

XI. LIABILITY CLAIMS (see instructions)

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? YES ___ NO ___

If "YES", indicate a brief description of the nature(s) of the claim, the date(s) of the claim report(s), and the amount of the judgment(s), award or settlement(s):

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.		
2.		
3.		
4.		

XII. OPTIONAL INFORMATION: (Please limit to four)

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature:

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			
4.			

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (Authority: T.C.A. § 63-51-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1.		
2.		
3.		
4.		

Practitioner's Name ______________________________ **TN License #** ____________
(if applicable)

Profession ____

Answer ALL yes/no questions with a "yes" or "no" response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

C. RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION: Have you had the responsibility for graduate medical education within the last ten(10) years?

YES ___ NO ___

D. FACULTY APPOINTMENTS: Do you currently hold a faculty appointment at a medical/health related institution of higher learning? YES ___ NO ___

If "YES", list the title of the appointment, name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. §§ 63-51-113 and/or 63-51-118.

______________________________________ Date:____________________
(Signature of Provider)

REMINDERS:

- Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law.

- If you are a DEA registrant who prescribes controlled substances, independent of the obligation to make certain information available to your licensing board, you must also register in the **Controlled Substance Monitoring Database (CSMD)**. More information regarding this obligation is available online at http://tn.gov/health/article/CSMD-about.