



**JACKSON
& COKER**

**ADVANCED PRACTITIONER
INITIAL CREDENTIALING
APPLICATION**

Revised 06/06

GENERAL INSTRUCTIONS

Jackson & Coker must credential all providers prior to placement into any practice location. All information requested in this application is necessary to complete the credentialing process. This information is based on the standards for credentialing established by the National Committee for Quality Assurance (NCQA). Failure to provide the specific requested information will result in delay in verification and approval of your credentialing file.

Prior to completing this application, please read and observe the following:

- ▶ Type or print legibly your responses.
- ▶ Note that modification to the wording or format of this application or agreement will invalidate it.
- ▶ All questions must be answered fully and truthfully. If an answer requires an explanation, please provide it on the appropriate form provided. Make additional copies of any of the attached forms if more than one is needed and provide your name on all attachments.
- ▶ Note that "See CV" is only acceptable for the education section of this application and only then if month/years are provided and complete address of each school or training facility is provided.
- ▶ Month/year must be provided in the work history section. Any gap of time greater than sixty (60) days during the five year period must be explained.
- ▶ If a particular section does not apply to you, write "n/a" in that section.
- ▶ Any changes to your responses must be lined through and initialed. Use of any form of correctional fluid or tape is not acceptable.
- ▶ Please sign and provide a current date on the attestation and release pages of the application, the provider agreement and any other forms completed.
- ▶ After the application has been completed in its entirety, make a copy of the application to retain in your files or computer for future use. Attach all documentation shown on the next page to your application prior to mailing.

ADVANCED PRACTITIONER INITIAL CREDENTIALING CHECKLIST

- _____ Completed Credentialing Application
- _____ Signed and Currently Dated Attestation and Release forms
- _____ Completed W-9 Federal Tax Form
- _____ Current Curriculum Vitae with Complete Professional History in chronological order (month and year must be included)
- _____ Copy of Diploma and Training Certificate(s),
- _____ Current CME (list of CME activity for the past two years)
- _____ Copy of Current Board Certificate AANA/CRNA
- _____ Copy of All Current Active State License Wallet Card(s)
- _____ Copy of Federal DEA and State Controlled Substance Registrations or certificate(s)
- _____ Copy of Any: BLS, ACLS, ATLS, PALS, APLS Certificate(s)
- _____ Certificate of Professional Liability Insurance Coverage or Declaration Page (Face Sheet) of Policy
- _____ Third party documentation for all Malpractice/Disciplinary Actions OR completion of Appropriate Explanation Form Attached (if applicable)
- _____ Permanent Resident Card, Green Card or Visa Status (if applicable)
Note: All non United States citizens must provide a copy of their green card
- _____ Military Discharge Record -Form DD-214 (if applicable)
- _____ 3 Written Letters of Recommendation From Providers Who Have Directly Observed You In Practice Within the Past Year. (Please ask them to specify the date they last observed you in practice - month/year)
- _____ Signed Provider Agreement
- _____ Recent Photograph
- _____ Copies of Current Immunization records and current TB test results (if available)

Please return all of the above requested documents in the enclosed postage-paid envelope or mail to:

**JACKSON & COKER
3000 OLD ALABAMA ROAD
SUITE 119-608
ALPHARETTA, GA 30022**

If you have any questions or need further information, please call the Credentialing Department at (800) 272-2707.

ADVANCED PRACTITIONER INITIAL CREDENTIALING APPLICATION FOR JACKSON & COKER

Personal Information	Last Name Suffix(Jr, Sr, III) First Name Middle			Degree	Social Security Number	
	Home Address				Home Phone Number	
	City		State		Zip code	Home Fax Number
	Office Address				Office Phone Number	
	City		State		Zip code	Office Fax Number
	Citizenship	Birthplace	Date of Birth		Email address:	
Education And Training	Undergraduate School				Degree	
	Dates (From mm/yy To mm/yy)		City		State	
	Graduate School				Degree	
	Dates (From mm/yy To mm/yy)		City		State	
	Additional Training -- Facility Name				Specialty	
	Dates (From mm/yy To mm/yy)		City		State	
	Additional Training -- Facility Name				Specialty	
	Dates (From mm/yy To mm/yy)		City		State	
	Additional Training -- Facility Name				Specialty	
	Dates (From mm/yy To mm/yy)		City		State	
Professional Certification	Certification Board		Date Certified	Date Certified	Recertification Date	
	Certification Board		Date Certified	Date Certified	Recertification Date	
Clinical Certification	BLS Certification: Yes <input type="checkbox"/> No <input type="checkbox"/> Expiration Date: _____		ACLS Certification: Yes <input type="checkbox"/> No <input type="checkbox"/> Expiration Date: _____		ATLS Certification: Yes <input type="checkbox"/> No <input type="checkbox"/> Expiration Date: _____	
					PALS Certification: Yes <input type="checkbox"/> No <input type="checkbox"/> Expiration Date: _____	
Federal Provider Information	Federal DEA Number:	DEA Expiration Date:	UPIN Number:	Medicare #/State:	Medicaid #/State:	
				BC/BS #/State:	Champus/Railroad #:	

Provider Name: _____

LICENSURE

Please enter the information in the table below for all states in which you have held a medical license.

STATE	LICENSE NUMBER	LICENSE STATUS	DATE LICENSE GRANTED (MM/YY)	LICENSE EXPIRATION DATE (MM/DD/YY)	MEDICARE PROVIDER NUMBER	MEDICAID PROVIDER NUMBER	CONTROLLED SUBSTANCE PERMIT NUMBER
		Initial License <input type="checkbox"/> <input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					
		<input type="checkbox"/> Active <input type="checkbox"/> Inactive					

Additional licenses listed on attached sheet

REFERENCES

Please list two **physician** references and two professional references that are able to comment upon your **current (within the past year)** clinical and professional capabilities.

Name	Position	Phone #
Address	City State Zip code	Fax #
Name	Position	Phone #
Address	City State Zip code	Fax #
Name	Position	Phone #
Address	City State Zip code	Fax #
Name	Position	Phone #
Address	City State Zip code	Fax #

Provider Name: _____

WORK HISTORY

Please list all your practice locations and employment affiliations to cover at least the past five years of clinical practice. Please list month and year for all effective dates. Please provide a separate explanation of work gaps over 60 days in duration. If you desire Jackson & Coker not to contact these facilities, please check the appropriate box and attach a letter of explanation.

From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact <input type="checkbox"/>		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact <input type="checkbox"/>		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact <input type="checkbox"/>		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact <input type="checkbox"/>		Address	City	State	Zip Code
From (mm/yy)	To (mm/yy)	Hospital / Facility Name	Phone		
Do Not Contact <input type="checkbox"/>		Address	City	State	Zip Code

PREVIOUS LOCUM TENENS EXPERIENCE:

Please list all previous locum tenens experience in the spaces below. Use additional pages as necessary.

Name of Facility _____
Address _____
Phone # _____ FAX # _____
Dates of Coverage: _____

Name of Facility _____
Address _____
Phone # _____ FAX # _____
Dates of Coverage: _____

Name of Facility _____
Address _____
Phone # _____ FAX # _____
Dates of Coverage: _____

Name of Facility _____
Address _____
Phone # _____ FAX # _____
Dates of Coverage: _____

Name of Facility _____
Address _____
Phone # _____ FAX # _____
Dates of Coverage: _____

Provider Name: _____

DISCIPLINARY ACTIONS

If your answer to any of the following questions is "Yes", please provide a full explanation on the attached Credentialing Application Explanation Form and include any additional documentation if necessary.

Have any of the following ever been, or are currently in the process of being: denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished? If the answer is "Yes" to any item please provide an explanation as outlined above.

1. Medical License in any state? <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Institutional affiliation / status? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. DEA Registration (federal or state programs)? <input type="checkbox"/> Yes <input type="checkbox"/> No	7. Professional society membership or fellowship / Board certification? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Other Professional Registration / License? <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Any professional sanction (e.g. government, administrative agency or other)? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Clinical Privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No	9. Participation in any private, federal, or state health insurance program (e.g. Medicare, Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Membership / Rights on any medical staff? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Do you currently have any physical or mental condition including current alcohol or drug dependency that may affect your ability to practice or exercise the privileges typically associated with the specialty and position for which you are applying?
 Yes No

Are you currently using illegal drugs or legal drugs in an illegal manner?
 Yes No

Is there any reason that you are unable to perform the essential functions of the position for which you are applying safely and according to accepted standards of performance with or without reasonable accommodation? If yes, explain on the attached form
 Yes No

Have you ever been convicted of a felony or misdemeanor?
 Yes No

Is there any other issue which should be disclosed that may have an adverse impact on your ability to deliver effective clinical health care services?
 Yes No

MALPRACTICE CLAIMS HISTORY

Have you ever been denied professional liability insurance or denied renewal of an existing policy?
If the answer to the above question is "YES" please attach a brief explanation.
 Yes No

Have any malpractice claims, suits, settlements, or arbitration proceedings been made against you?
 Yes No

Are you aware of any claims, suits, or settlements currently pending or of any intent to file a claim or suit?
 Yes No

If your answer to either of the above questions is "Yes" please provide the following information on each claim and provide a brief clinical summary of each case on the attached Professional Liability Claims Information Form..

	Plaintiff Name and Insurance Carrier	Location (County, State)	Status (Dismissed / Settled / Judgment / Pending)	Date of Incident (mm/yy)	Amount of Award or Settlement (if appropriate)
# 1					Summary Included <input type="checkbox"/>
# 2					Summary Included <input type="checkbox"/>
# 3					Summary Included <input type="checkbox"/>
# 4					Summary Included <input type="checkbox"/>

Additional Malpractice Claims or incidents are listed on attached sheet

Please list your current malpractice insurance carrier and the associated information. If you currently do not carry any malpractice insurance, please list the last malpractice insurance carrier which provided coverage for you. In addition, please list any malpractice insurance carrier who has been associated with any malpractice claim, suit or settlement listed below.

Malpractice Insurance Carrier	Policy Number	Policy Dates From (mm/yy)	Policy Dates To (mm/yy)	Amount of Coverage

PROFESSIONAL LIABILITY CLAIMS INFORMATION FORM

The following information is necessary to complete the credentialing verification process and will be kept confidential.

Please print or type answers to the following for any malpractice claims reported to your malpractice insurance carrier, opened, closed, settled or paid. For initial credentialing, please complete a separate form for each claim; For recredentialing, just complete separate forms for the past two (2) years. One case per sheet only (please photocopy first if additional sheets are needed)

PROVIDER'S NAME (required): _____

1. Claim filed by Name:

Name of Patient Involved:

Age:

Month and Year of Occurrence: ____/____

(event precipitating claim)

Month and Year of Lawsuit: ____/____

Insurance Carrier at Time:

2. What is/was your status: Primary Defendant Co-defendant Other

Please Explain and list other Defendants:

What was the patient's outcome?

How were you alleged to have caused harm or injury to this patient?

Please provide specifics in reference to the adverse event:

What is/was your role in this event?

Current Status: **(please check one)**

Still pending: as of (date) ____/____/____

Who is handling the defense of the case? _____

Trial date set, awaiting trial? Yes No Trial Date: ____/____/____

Settled out of court? Yes No Date: ____/____/____ Amount of Settlement: \$ _____

Dismissed: Date: ____/____/____

Defense Verdict: Date: ____/____/____

Plaintiff Verdict: Date: ____/____/____

Judgment Amount: \$ _____ Date: ____/____/____

Amount Paid on your behalf (by you or carrier: \$ _____

This professional Liability Claims Information Form is required on all claims/lawsuits that are reported by your malpractice insurance carrier and/or the National Practitioner Data Bank. Clinical details are required for all suits, regardless of status or settlement amount.

I certify that the information contained in this form is correct and complete to the best of my knowledge.

Applicant's Signature: _____ **Date:** _____

Print Name: _____

ATTESTATION AND SIGNATURE

I hereby affirm that the information provided by me on this application and attachments is true, complete and correct and that Jackson & Coker will rely on the truthfulness of my statements in evaluating my potential as an independent contractor physician for locum tenens assignments or potential for referral for a permanent position. I further acknowledge that (a) the decision to offer me as a candidate is solely at the discretion of Jackson & Coker, (b) any information received from references or other agencies by Jackson & Coker may not be released to me without the consent of the reference or agency, and (c) I agree that I will not enter into an arrangement to provide temporary or permanent physician services with any individual, group or institution to whom I am referred by Jackson & Coker except through Jackson & Coker with the written consent of Jackson & Coker.

Applicant's Signature: _____ **Date:** _____

Print Name: _____

RELEASE AND WAIVER

Attach recent photo here

I, _____, hereby authorize the following individuals and entities to release all information (documented, oral or other) about me in their possession to Jackson & Coker or its agents:

1. All hospitals at which I have held staff privileges, whether full or limited, temporary or permanent; and all hospitals at which I have received training.
2. All medical/osteopathic societies, educational institutions, specialty boards, and other medical/osteopathic organizations with which I have been associated.
3. All state or Canadian health care licensure boards, federal health agencies to include the National Practitioner Data Bank, and federal and state drug control agencies.
4. All licensed physicians, nurses or other health care professionals of any state, commonwealth, district, or Canadian province.
5. All agencies from which I currently have or previously have obtained malpractice insurance coverage.
6. All attorneys who have participated in civil or criminal actions in which I was named party that pertain to or directly affect my ability to obtain or retain a state medical license, obtain or retain clinical privileges and/or practice medicine.

I hereby release the above-named individuals and entities from all liability for the release of information to Jackson & Coker or its agents.

I further authorize Jackson & Coker or any of its duly authorized agents to make any investigations that they deem necessary to secure information concerning me which is relevant to the requirement for the granting of clinical privileges as an independent contractor or for licensure, and I further authorize them to release such information they now or may have in the future concerning me to any federal, state, county or local governmental entity or any hospital or other health care facility upon showing that the release of the information is vital to the health, safety, and welfare of the general public.

I hereby make this release and waiver of rights for the purpose of allowing Jackson & Coker or its agents to carry out its duties pursuant to my request for evaluation of my credentials for clinical privileges and/or a license to practice my profession.

Applicant's Signature: _____ **Date:** _____

Print Name: _____

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"/> Other ▶	
	<input type="checkbox"/> Exempt from backup withholding	
	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. person (including a U.S. resident alien).

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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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.

U.S. person. 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.

In 3 above, 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.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

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 recipient 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 (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include 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 4 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 regarding 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). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

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 From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" 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.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

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 recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 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 recipients 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt recipients 1 through 7 ²

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-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., 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.socialsecurity.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 ID Numbers under Related Topics. 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. Writing "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 recipients, see *Exempt From Backup Withholding* 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 single-owner LLC	The owner ³
For this type of account:	Give name and EIN of:
6. Sole proprietorship or single-owner LLC	The owner ³
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). If you are a sole proprietor, IRS encourages you to use your SSN.

⁴ List first and circle the name of the legal 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 regarding 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.

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.