Elizabeth Glaser Pediatric AIDS Foundation | *Until no child has AIDS.*

REQUEST FOR BIDS (RFB) - EGPAF LESOTHO
Ref. 2016/12/001

EGPAF Lesotho
30 Princess Margaret Road, LCA Complex, Ground Floor, Maseru

PROCUREMENT OF PRACTITIONER SERVICES

FIRM DEADLINE: FRIDAY, 20 JANUARY 2017 at 12:00 noon

TERMS OF REFERENCE

BACKGROUND

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) is a nonprofit organization dedicated to preventing pediatric HIV infection and eliminating pediatric AIDS through research, advocacy, and prevention, care, and treatment programs. Founded in 1988, EGPAF works in 14 countries around the world. The EGPAF Lesotho country office is one of the major HIV service partners of the Lesotho Ministry of Health (MOH) since 2004. The EGPAF office first opened doors in Lesotho in 2006. To support Lesotho's HIV Program, EGPAF has received funding from several donors to implement different projects in collaboration with the MOH. EGPAF program support has been in the areas of HIV testing and counselling services, pediatric & adult HIV care & treatment, Prevention of Mother-to-Child Transmission of HIV (PMTCT) services, tuberculosis (TB) services, TB/HIV integration, strategic information and evaluation, quality improvement, operational research, and health systems strengthening.

With an adult HIV prevalence rate of 25%, Lesotho has the second highest HIV prevalence globally. Basotho women are significantly more affected by HIV than men. Despite huge investments into fighting the epidemic by both government and developmental partners, there has not been any significant reduction in HIV incidence and antiretroviral treatment (ART) coverage has remained sub-optimal, with only about 42% of adults and 57% of children living with HIV in Lesotho currently on ART. The Ministry of Health recognizes that the tipping point of the HIV epidemic and elimination of HIV and AIDS cannot be achieved without concerted efforts targeted at priority populations in the country. Factory workers are one of the priority populations in Lesotho with an estimated HIV prevalence of 42% among the more than 40,000 factory workers, who are predominantly young women. Innovative approaches are needed to scale up access to comprehensive HIV services amongst this population.

RATIONALE

In spite of the fact that TB/HIV are highly prevalent among factory workers, they often are not able to access services because of the nature of their work. With the withdrawal of ALAFA's support to factories for TB/HIV prevention, care and treatment services, a significant gap was created. EGPAF, in collaboration with the MoH and with support from the United States Government's President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID), seeks the services of ***Registered***

Private Medical Practitioners to provide comprehensive and integrated TB and HIV services to factory workers in Maseru.

PROJECT GOAL, OBJECTIVES, AND STRATEGIES OF THE ASSIGNMENT

- ✓ **Project Goal:**
  - To reduce morbidity and mortality among HIV infected factory workers in Maseru through early identification and initiation on antiretroviral therapy and sustained adherence and retention.

- ✓ **Project objectives:**
  - To increase access to HIV diagnosis among factory workers.
  - To increase ART initiation for HIV infected factory workers
  - To improve adherence and retention in care and on treatment for HIV infected factory workers.

- ✓ **Project strategies**. The strategies to be used in this project are:
  - Mobilization for HIV testing amongst factory workers.
  - Provision of comprehensive TB/HIV services through private practitioners.
  - Deployment of trained staff to augment the provision of comprehensive quality HIV services for factory workers.
  - Implementation of test and treat approach amongst factory workers.
  - Monitoring implementation progress and project outcomes.

- ✓ **Expected project outcomes:**
  - Increase in uptake of HIV testing among factory workers.
  - Increase in access to comprehensive TB and HIV services for factory workers.
  - Improved adherence, retention and viral suppression amongst HIV infected factory workers.

IMPLEMENTION APPROACH

The MoH currently has an existing MOU with the Independent Private Medical Practitioners of Lesotho Association which is the governing body for most private general practitioners (GPs) in the country. Using this MOU, the Government of Lesotho (GoL) has been able, in the past, to draw up service contracts with individual practitioners who are members of the association to facilitate payment of services provided to factory workers. Building on this arrangement, the Foundation will establish a package of services to be provided to selected factories in Maseru through selected private practitioners who are currently based in catchment areas where these factories exist. Each private practice will be permitted to provide services to a maximum of approximately 500 HIV-positive factory workers *per physician* working in the practice in order to promote a high standard of care. The placement of additional human resources by EGPAF will be considered upon consultation between EGPAF and successful private practitioners. The package of services to be provided will include:

- HIV Testing services
- ART initiation and maintenance
- General and enhanced adherence counseling
- Blood draws for lab tests, including viral load
- TB screening, diagnosis and treatment
- STI screening and treatment
- Cervical cancer screening
- Opportunistic infection diagnosis and treatment
- Family planning services

- HIV prevention counseling
- Condom distribution
- PMTCT Services

LOGISTICS

The duration of the assignment shall be 1 year with a possibility of renewal based on performance and funding availability. It is anticipated that there will be a requirement for additional years of service from the winning vendor, but funds are currently not available except for the initial base year. In recognition of this, the resulting contract will include options that EGPAF will choose to exercise should the additional funding become available. Contractor rates in future years will be adjusted accordingly by a percentage not exceeding the official national rate of inflation.

The assignment will be conducted in Maseru Factories staring 1 March 2017. The medical practitioners will be responsible for all necessary equipment to fulfill the assignment, and to provide necessary training material required to perform the tasks. They will also be responsible for own transportation & lodging.

Payment will be made via wire transfer. The structure for payment will be negotiated between the Foundation and the selected Medical practitioners prior to contract execution. This solicitation is a Cost-Reimbursable contract.

KEY CONTRACT TERMS/FINANCIAL MODEL

Unless stated otherwise in the statement of the work, the Contractor is responsible for providing equipment and/or supplies required to perform the services.

The anticipated contract type is **Cost-Reimbursable** with a ceiling. The compensation provided to each of the selected contractors will likely be fixed based on the below assumptions (though may be adjusted once the final contracts are executed). The rates will be set by the Foundation and are not open to negotiation.

Details	Fees
Doctor's Fees	M150 per patient per visit (capped to 4 patient visits per year)
Lab and Medicines for Opportunistic Infections	M3,000 per quarter per Doctor
Counsellors and Records Assistants	In Kind - provided by EGPAF as needed

MEDICAL PRACTIONERS' RESPONSIBILITIES

The medical practitioners, under the supervision of the EGPAF Technical Director, will be required to submit formal quarterly written reports and provide monthly updates as requested by EGPAF. Unless mutually agreed upon by both parties, rates/prices submitted in this financial model will be captured in the final contract and remain fixed for the duration of the contract.

FOUNDATION RESPONSIBILITIES

The Foundation in collaboration with Maseru District Health Management Team (DHMT), who will be MoH representative, will provide the medical practitioners with the following:

- HIV Management refresher training
- Mentorship and site support for both factory-based and private clinics.

- Supervision to ensure that Medical Practitioners abide by new ART and HTS National Guidelines for 2016

NB: The MOH will continue to provide HIV test kits, free ARVs, OI medications and laboratory services to private practitioners for HIV-positive factory patients.

EVALUATION CRITERIA AND SUBMISSION REQUIREMENTS

The Foundation will select the profile/proposal that presents the ***BEST VALUE*** to the Foundation. All bids will be weighed and evaluated against the following Evaluation Criteria based on the corresponding submission requirements detailed below. Each bid must contain and/or address the items listed for each Evaluation Criteria. Please submit your Submission Requirements in the order they appear below (using attached forms, where applicable).

I. Medical Practice Profile – 20%

- ✓ Completion of *Medical Practitioner's Profile*, Section I (see Attachment 1)

II. Past Performance of Similar Work – 30%

- ✓ Completion of *Medical Practitioner's Profile*, Section II (see Attachment 1)
- ✓ A minimum of two (2) professional reference letters from similar assignment, including contact information.

III. Experience and Qualifications – 20%

- ✓ Copy of Curriculum Vitae (CV)
- ✓ Copy of Educational Certificates
- ✓ Proof of status as Registered Private Medical Practitioner in Lesotho
- ✓ Completion of *Medical Practitioner's Profile*, Sections III – IX (see Attachment 1)

IV. Technical methodology and approach – 30%

- ✓ A maximum two (2) page technical summary that provides a high level overview of the approach and methodology. This may include the applicant's proposed approach and a work plan outlining the stages needed to complete the assignment.

In addition, all applicants are required to be registered and authorized to perform the scope of work detailed above. Copies of a valid business license, company registration certificate, and other related documents may be submitted with each bid. Please note that if it is not submitted with the bid, these will be required prior to execution of the final contract and initiation of the proposed assignment.

Failure to provide any of the above Submission Requirements may be considered non-responsive and disqualify the applicant from selection.

Completed proposals *must* be submitted by the tender either electronically to procurement-ls@pedaids.org or in a sealed envelope in-person to: Elizabeth Glaser Pediatric Aids Foundation, Attention: Senior Procurement & Logistics Manager, 30 Princess Margaret Road, LCA Complex, Ground Floor, Maseru. All submissions, should clearly indicate on the proposal (or in the subject line of the email if submitted electronically) the unique RFB Reference Number located at the top of this document.

FINAL FIRM DEADLINE: **Friday, 20th January 2017 at 12:00 noon, Lesotho Time.**
Late applications may be rejected without consideration.

After the evaluation and prior to making a final decision, the Foundation reserves the right to potentially:

1) Visit the bidders' facilities in-person to verify the company's capabilities, operational framework, and capacity.
2) Interview all finalists further to either discuss any aspects related to the bidders' technical approach or provide the bidder the opportunity to present its proposed methodology and approach to the Foundation's evaluation committee prior to making a final decision.

PROPOSED TIMELINE

Date	Activity
15 Dec, 2016	Pre Bidders conference will be held at Ministry of Health (MoH) Auditorium to give a brief on thee envisaged work place program and share the expression of interest requirements, expectations, and obligations to all prospective bidders.
22 Dec, 2016	Release of RFP. It can be picked up in person at the EGPAF main offices located at 30 Princess Margaret Road, LCA Complex, Ground Floor, Maseru, or accessed on the Foundation's public website at: http://www.pedaids.org/pages/contracting-opportunities.
06 Jan, 2016	Submission of all contractual and technical inquiries related to this RFP directed to Procurement & Logistics Manager, EGPAF Lesotho, procurement-ls@pedaids.org. All subject lines of emails must reference the unique RFP Reference Number located at the top of this document. No phone calls will be accepted.
10 Jan, 2017	Response to all inquiries released and posted on the EGPAF website at: http://www.pedaids.org/pages/contracting-opportunities.
20 Jan, 2017	Deadline for Proposal submission.
23-Jan to 3-Feb, 2017	Review of Proposals and finalist meetings.
14 Feb, 2017	Final decision announced and Offerors notified
1 Mar, 2017	Contract executed and Services begin.

Please note it is our best intent to comply with the above timeline but unavoidable delays may occur.

ADDITIONAL INFORMATION

All bids and communications should be identified by the unique RFB number reflected on the first page of this document.

Any bid not addressing each of the foregoing items could be considered non-responsive. Any exceptions to the requirements or terms of the RFB must be noted in the bid. The Foundation reserves the right to consider any exceptions to the RFB to be non-responsive.

Late bids may be rejected without being considered.

This RFB is not an offer to enter into agreement with any party, but rather a request to receive bids from persons interested in providing the services outlined above. Such bids shall be considered and treated by the Foundation as offers to enter into an agreement. The Foundation reserves the right to reject all bids, in whole or in part, enter into negotiations with any party, and/or award multiple contracts.

If the medical services provided to the Factories are deemed unacceptable or fail to meet any of the conditions or specifications described in the submitted quote (unless otherwise agreed upon by the Foundation), the Foundation will have the opportunity to cancel the contract with penalty and receive full re-payment for any potential costs already incurred and paid to the assigned doctors.

The Foundation shall not be obligated for the payment of any sums whatsoever to any recipient of this RFB until and unless a written contract between the parties is executed.

EGPAF shall use its best endeavours to ensure that funds provided under this tender does not provide direct or indirect support or resources to organizations and individuals associated with terrorism, promote or advocate the legalization or practice of prostitution or sex trafficking and assistance to drug traffickers. If, during the course of this tender, EGPAF discovers any link whatsoever with any organization or individual associated with any or all of these, they shall be excluded or disqualified from the tendering process.

EGPAF reserves the right to terminate the procurement should the selected bidder be unable to fulfill its expected obligations. The full terms and conditions of the procurement will be incorporated within the signed contract between EGPAF and the selected bidder.

Equal Opportunity Notice. The Elizabeth Glaser Pediatric AIDS Foundation is an Equal Employment Opportunity employer and represents that all qualified bidders will receive consideration without regard to race, color, religion, sex, or national origin.

Ethical Behavior. As a core value to help achieve our mission, the Foundation embraces a culture of honesty, integrity, and ethical business practices and expects its business partners to do the same. Specifically, our procurement processes are fair and open and allow all vendors/consultants equal opportunity to win our business. We will not tolerate fraud or corruption, including kickbacks, bribes, undisclosed familial or close personal relationships between vendors and Foundation employees, or other unethical practices. If you experience of suspect unethical behavior by a Foundation employee, please contact our Fraud Investigations team at fraud@pedaids.org or the Foundation's Ethics Hotline at www.reportlineweb.com/PedAids. Any vendor/consultant who attempts to engage, or engages, in corrupt practices with the Foundation will have their proposal disqualified and will not be solicited for future work.

ATTACHMENT 1:

MEDICAL PRACTITIONER'S PROFILE

Elizabeth Glaser Pediatric AIDS Foundation | *Until no child has AIDS.*

MEDICAL PRACTITIONER'S PROFILE

The purpose of this form is to capture as much information as possible from the Medical Practitioners who will participate in the bid process for the workplace program. By completing this form, all applicants certify the information in this application is complete, accurate, and current. He/she also acknowledges that any misstatements in or omissions from this application constitute cause for denial or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original.

This form is divided into the following nine (9) sections:

I. Basic Information: Primary Practice
II. Basic Information: Individual Practitioner
III. General and Scope-Specific Experience of Individual Practitioner
IV. Prior Work Experience
V. Education and Training
VI. Certifications, Licenses, Registrations, Memberships, etc.
VII. Hospital Affiliations and Professional Liability
VIII. Practitioner Attestation Questions
IX. Professional Liability Action Detail

To complete this profile, please observe the instructions/guidelines captured below. All information provided by the applicant and contained in this form will remain confidential.

1) All responses should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, please attach additional sheets and reference the question being answered.
2) Please do not use abbreviations.
3) All sections must be completed in their entirety. ***Sections II-IX should be completed for every medical doctor in the practice who will be providing services to factory workers within this agreement.*** If a particular sub-section is not applicable to the applicant, please indicate by checking the box provided.
4) A complete *Curriculum Vitae (CV)* must be submitted with the form. ***Submitting a CV is not an acceptable substitute for completing this form in its entirety.***
5) Please sign and date this form in the designated areas.
6) Please document any YES responses on the *Practitioner Attestation Questions* page.

Ethical Behavior. As a core value to help achieve our mission, the Foundation embraces a culture of honesty, integrity, and ethical business practices and expects its business partners to do the same. Specifically, our procurement processes are fair and open and allow all vendors/consultants equal opportunity to win our business. We will not tolerate fraud or corruption, including kickbacks, bribes, undisclosed familial or close personal relationships between vendors and Foundation employees, or other unethical practices. If you experience of suspect unethical behavior by a Foundation employee, please contact our Fraud Investigations team at fraud@pedaids.org or the Foundation's Ethics Hotline at www.reportlineweb.com/PedAids. Any vendor/consultant who attempts to engage, or engages, in corrupt practices with the Foundation will have their proposal disqualified and will not be solicited for future work.

<table>
<tr><th colspan="2">I. BASIC INFORMATION: PRIMARY PRACTICE</th></tr>
<tr><td>NAME OF PRIMARY PRACTICE:</td><td></td></tr>
<tr><td>PHYSICAL ADDRESS:</td><td></td></tr>
<tr><td>MAILING ADDRESS:</td><td></td></tr>
<tr><td>WEBSITE (if applicable):</td><td></td></tr>
<tr><td>TYPE OF LEGAL ENTITY:</td><td>☐ Sole Trader
☐ Partnership
☐ Limited Liability Company
☐ Other (explain):</td></tr>
<tr><td>PRACTICE NUMBER:</td><td></td></tr>
<tr><td>L.R.A. REGISTRATION NUMBER:</td><td></td></tr>
<tr><td>TAX CLEARANCE CERTIFCATE ID NUMBER:</td><td></td></tr>
<tr><td>PRACTICE SETTING:</td><td>☐ Clinic/Group
☐ Solo Practice
☐ Home-Based
☐ Primary Care Site
☐ Urgent Care
☐ Other (explain):</td></tr>
<tr><td>EMPLOYEE SIZE (TOTAL):</td><td>☐ 0 – 10 employees
☐ 11 – 20 employees
☐ 21 – 50 employees
☐ 50 – 100 employees
☐ Over 10 employees</td></tr>
<tr><td>BREAKDOWN OF STAFF:</td><td><table><tr><th>Cadre</th><th># of Employees</th></tr><tr><td>Doctors</td><td></td></tr><tr><td>Nurses</td><td></td></tr><tr><td>Counselors</td><td></td></tr><tr><td>Pharmacy</td><td></td></tr><tr><td>Lab</td><td></td></tr><tr><td>Other</td><td></td></tr></table></td></tr>
<tr><td>HOURS OF OPERATION. During what hours will you be able to provide service delivery</td><td>Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____
Saturday: _____
Sunday: _____</td></tr>
<tr><td>Does your practice provide 24-hour coverage?</td><td>☐ Yes ☐ No*

*If no, please explain how your patients obtain advice and care after hours:</td></tr>
</table>

I. BASIC INFORMATION: PRIMARY PRACTICE	
OTHER PRACTICE PERSONNEL:	***Office Manager/Administrator*** Name: _____ Telephone #: _____ Email Address: _____ ***Credentialing Contact*** *(if different from Office Manager/Administrator)* Name: _____ Telephone #: _____ Email Address: _____
In the space provided below, please briefly provide information about your operational and financial systems to track and manage delivery, include your ability to refer back to each consultation and bill for services:	
MEDICAL PRACTICE'S EXPERIENCE WORKING IN FACTORIES:	☐ No previous experience ☐ Less than 1 year ☐ 1 – 2 years ☐ 3 – 5 years ☐ Over 5 years of experience
In the space provided below, briefly describe in the below area your experience in a factory setting. Include, where applicable, specific details of factories worked at and a broad overview of services performed.	

II. BASIC INFORMATION: INDIVIDUAL PRACTITIONER	
FULL NAME:	
PHYSICAL ADDRESS:	
MAILING ADDRESS:	
OFFICE NUMBER:	
PAGER NUMBER:	
MOBILE NUMBER:	
EMAIL ADDRESS:	
CITIZENSHIP:	
LANGUAGES PRACTITIONER IS FLUENT IN:	☐ English ☐ Sotho ☐ Other *(specify):*
DEGREES EARNED:	
PRACTITIONER PROFILE	☐ Primary Care Physician ☐ Specialist ☐ Other *(explain)*:
PRIMARY SPECIALTY:	
PRACTICING SUB-SPECIALTIES:	
INDIVIDUAL PRACTITIONER'S EXPERIENCE WORKING IN FACTORIES:	☐ No previous experience ☐ Less than 1 year ☐ 1 – 2 years ☐ 3 – 5 years ☐ Over 5 years of experience
YEARS OF TOTAL PROFESSIONAL EXPERIENCE IN MEDICINE OR MEDICAL-RELATED FIELDS:	☐ 0 – 2 years ☐ 3 – 5 years ☐ 5 – 10 years ☐ Over 10 years of experience
START DATE AT CURRENT PRIMARY PRACTICE:	
PERSONAL PROFESSIONAL WEBSITE *(if applicable)*:	
Are you registered with the Independent Private Practitioners of Lesotho Association?	☐ *Yes* ☐ *No*
TWO (2) PROFESSIONAL REFERENCES: *[List at least two (2) professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation are directly familiar with your work and can attest to your competence in your specialty area. If you have been out of residency or fellowship for a period of*	Reference #1: Title and Specialty: _____ Address: _____ Contact Phone #: _____ Email Address: _____ Relationship: _____ Reference #2: Title and Specialty: _____

II. BASIC INFORMATION: INDIVIDUAL PRACTITIONER	
less than three years, one reference must be from the Program Director. Please include signed reference letters for each reference listed with your bid submission]	Address: _____ Contact Phone #: _____ Email Address: _____ Relationship: _____ *Add additional references, if applicable.*

III. GENERAL AND SCOPE-SPECIFIC EXPERIENCE OF INDIVIDUAL PRACTITIONER	
Are you experienced with any of the following services? *(select all that apply)*	☐ HIV Testing ☐ TB/HIV consultation and services, including ART and TB treatment initiation and maintenance ☐ Adherence, retention, and VL suppression amongst HIV-infected people ☐ Blood draws for lab tests ☐ TB screening and referral for treatment ☐ STI screening and treatment ☐ Cervical cancer screening ☐ OI treatment ☐ Family planning services ☐ HIV prevention counseling ☐ Condom distribution ☐ Other *(please specify)*
Have you previously worked with workers in factories or similar environments in Lesotho?	☐ *Yes* ☐ *No** **If YES, please proceed with the rest of this section. Otherwise, please skip to the next section of this application.*
What was the nature of those services? *(select all that apply)*	☐ HIV Testing ☐ TB/HIV consultation and services, including ART and TB treatment initiation and maintenance ☐ Adherence, retention, and VL suppression amongst HIV-infected people ☐ Blood draws for lab tests ☐ TB screening and referral for treatment ☐ STI screening and treatment ☐ Cervical cancer screening ☐ OI treatment ☐ Family planning services ☐ HIV prevention counseling ☐ Condom distribution ☐ Other *(please specify)*
What is the estimated total number of factory workers (including family members) you have successfully tested and treated in the past?	☐ 0 – 20 ☐ 20 – 50 ☐ 50 - 100 ☐ 100 – 200 ☐ 200+
Please list all factories have you provided practitioner services to?	
Are you authorized to prescribe medication?	☐ *Yes* ☐ *No*
Briefly describe your availability over the next year to provide service delivery to factory workers. If applicable, please indicate specific dates	

where you will be unavailable.	
HOURS OF OPERATION. During what hours will you be able to provide service delivery?	Monday: _____ Tuesday: _____ Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____ Sunday: _____

IV. PRIOR WORK EXPERIENCES

PRIOR WORK EXPERIENCE(S):

For each reference listed, please attach a signed reference letter as part of your submission.

☐ *Does not apply.*

Institution Name (1): _____
Position: _____
Contact Name: _____
Address: _____
Phone #: _____
Email Address: _____
Start Date: _____
End Date: _____
Reason for Leaving: _____

Institution Name (2): _____
Position: _____
Contact Name: _____
Address: _____
Phone #: _____
Email Address: _____
Start Date: _____
End Date: _____
Reason for Leaving: _____

Institution Name (3): _____
Position: _____
Contact Name: _____
Address: _____
Phone #: _____
Email Address: _____
Start Date: _____
End Date: _____
Reason for Leaving: _____

Add additional experiences, if applicable.

V. EDUCATION AND TRAINING

UNDERGRADUATE EDUCATION: ☐ *Does not apply.*	School Name (1): _____ Address: _____ Degree(s) earned: _____ Primary Area of Study: _____ Graduation Date: _____ School Name (2): _____ Address: _____ Degree(s) earned: _____ Primary Area of Study: _____ Graduation Date: _____ *Add additional schools, if applicable.*
MEDICAL/PROFESSIONAL EDUCATION: ☐ *Does not apply.*	School Name (1): _____ Address: _____ Degree earned: _____ Primary Area of Study: _____ Start Date: _____ Graduation Date: _____ School Name (2): _____ Address: _____ Degree(s) earned: _____ Primary Area of Study: _____ Start Date: _____ Graduation Date: _____ *Add additional schools, if applicable.*
MASTER DEGREE PROGRAM / POST-GRADUATE EDUCATION ☐ *Does not apply.*	School Name (1): _____ Address: _____ Degree earned: _____ Primary Area of Study: _____ Start Date: _____ Graduation Date: _____ School Name (2): _____ Address: _____ Degree(s) earned: _____ Primary Area of Study: _____ Start Date: _____ Graduation Date: _____ School Name (3): _____ Address: _____ Degree(s) earned: _____ Primary Area of Study: _____ Start Date: _____

V. EDUCATION AND TRAINING

	Graduation Date: _____ *Add additional schools, if applicable.*
INTERNSHIPS: ☐ *Does not apply.*	Institution Name (1): _____ Address: _____ Type of Internship: _____ Specialty: _____ Start Date: _____ End Date: _____ Program Director: _____ Institution Name (2): _____ Address: _____ Type of Internship: _____ Specialty: _____ Start Date: _____ End Date: _____ Program Director: _____ *Add additional internships, if applicable.*
FACULTY/TEACHING APPOINTMENTS: ☐ *Does not apply.*	Institution Name (1): _____ Address: _____ Position: _____ Start Date: _____ Completion Date: _____ Faculty Director: _____ Institution Name (2): _____ Address: _____ Position: _____ Start Date: _____ Completion Date: _____ Faculty Director: _____ *Add additional appointments, if applicable.*

VI. CERTIFICATIONS, LICENSES, REGISTRATIONS, MEMBERSHIPS, ETC.

BOARD CERTIFICATIONS: ☐ *Does not apply.*	Issuing Board (1): _____ Specialty: _____ Date Certified: _____ Date Re-certified: _____ Expiration (if any): _____ Issuing Board (2): _____ Specialty: _____ Date Certified: _____ Date Re-certified: _____ Expiration (if any): _____ Issuing Board (3): _____ Specialty: _____ Date Certified: _____ Date Re-certified: _____ Expiration (if any): _____ *Add additional board certifications, if applicable.*
ALL OTHER PROFESSIONAL LICENSES, REGISTRATIONS, AND CERTIFICATIONS INCLUDING CURRENT MEDICAL LICENSE FROM LESOTHO MEDICAL, DENTAL & PHARMACY BOARD: ☐ *Does not apply.*	Description (1): _____ License/Reg./Cert. #: _____ Date Issued: _____ Expiration Date: _____ Year Relinquished: _____ Reason: _____ Description (2): _____ License/Reg./Cert. #: _____ Date Issued: _____ Expiration Date: _____ Year Relinquished: _____ Reason: _____ *Add additional items, if applicable.*
PROFESSIONAL MEMBERSHIPS/ AFFILIATIONS: ☐ *Does not apply.*	Name (1): _____ Date joined: _____ Current Member? ☐ *Yes* ☐ *No* Name (2): _____ Date joined: _____ Current Member? ☐ *Yes* ☐ *No* Name (3): _____ Date joined: _____ Current Member? ☐ *Yes* ☐ *No* *Add additional affiliations, if applicable.*

VII. HOSPITAL AFFILIATIONS AND PROFESSIONAL LIABILITY

PRIMARY HOSPITAL AFFILIATION: ☐ *Does not apply.*	Name: _____ Department: _____ Address: _____ Phone #: _____ Status: _____ Appointment Date: _____
SECONDARY HOSPITAL AFFILIATION(S): ☐ *Does not apply.*	Name (1): _____ Department: _____ Address: _____ Phone #: _____ Status: _____ Appointment Date: _____ Name (2): _____ Department: _____ Address: _____ Phone #: _____ Status: _____ Appointment Date: _____ Name (3): _____ Department: _____ Address: _____ Phone #: _____ Status: _____ Appointment Date: _____ *Add additional hospital affiliations, if applicable.*
PROFESSIONAL LIABILITY / CURRENT INSURANCE CARRIER: ☐ *Does not apply.*	Carrier Name: _____ Policy #: _____ Address: _____ Phone #: _____ Per claim amount: _____ Aggregate amount: _____ Start Date: _____ Expiration Date: _____

VIII. PRACTITIONER ATTESTATION QUESTIONS

Please answer all of the following questions. If your answer to any of the following questions is 'Yes", provide details as specified on a separate sheet. If you attach additional sheets sign and date each sheet.

		Professional Sanctions
Are you now in the process of being or have you ever been denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?		
☐ *Yes*	☐ *No*	License to practice any profession in any jurisdiction
☐ *Yes*	☐ *No*	Other professional registration or certification in any jurisdiction
☐ *Yes*	☐ *No*	Specialty or subspecialty board certification
☐ *Yes*	☐ *No*	Membership on any hospital medical staff
☐ *Yes*	☐ *No*	Clinical privileges at any facility, including hospitals, clinics, etc.
☐ *Yes*	☐ *No*	Governmental, national, or international regulatory agency or any public program
☐ *Yes*	☐ *No*	Professional society membership or fellowship
☐ *Yes*	☐ *No*	Participation/membership in a medical aid or other entity
☐ *Yes*	☐ *No*	Academic Appointment
☐ *Yes*	☐ *No*	Authority to prescribe controlled substances
Have you ever been:		
☐ *Yes*	☐ *No*	Subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?
☐ *Yes*	☐ *No*	Found by a professional disciplinary board to have committed unprofessional conduct as defined in applicable national provisions?
☐ *Yes*	☐ *No*	The subject of any reports to a local, national, national data bank, or other licensing or disciplinary entity?
		Criminal History
☐ *Yes*	☐ *No*	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?
☐ *Yes*	☐ *No*	Do you have notice of any such anticipated charges?
☐ *Yes*	☐ *No*	Are you currently under government investigation?
		Affirmation of Abilities
☐ *Yes*	☐ *No*	Do you presently use any drugs illegally?
☐ *Yes*	☐ *No*	Do you have, or have you had in the last 5 years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other) that affects or will affect your ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.
☐ *Yes*	☐ *No*	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?
		Litigation and Malpractice History *(If you answer "Yes" to any of the following questions, please document in* Professional Liability Action Detail *of this application.)*
☐ *Yes*	☐ *No*	Have allegations or claims of professional negligence been made against you at any

VIII. PRACTITIONER ATTESTATION QUESTIONS

	time, whether or not you were individually named in the claim or lawsuit?
☐ *Yes* ☐ *No*	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgement (court-ordered damage award) in a professional lawsuit?
☐ *Yes* ☐ *No*	Are there and such claims being asserted against you now?
☐ *Yes* ☐ *No*	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?
☐ *Yes* ☐ *No*	Are any of the privileges that you are requesting not covered by your current malpractice coverage?

ATTESTATION

I hereby certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Practitioner Name _____ Signature _____ Date _____

IX. PROFESSIONAL LIBAILITY ACTION DETAIL

☐ *Does not apply.*

Please list any past or current professional liability claim(s) or lawsuit(s) in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other regulated information. Copy this section as needed and submit a separate page for EACH claim/ event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.

Date and Clinical Details of the Incident, with Preceding Events

Are you now in the process of being or have you ever been denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?

Date:	

Details:

Your role and specific responsibility in the incident:

Subsequent events, including patient's clinical outcome:

Date suit or claim was filed:	
Name and Address of Insurance Carrier than handled the claim:	
Your status in the legal action (primary defendant, co-defendant, other):	☐ Primary Defendant ☐ Co-Defendant ☐ Other *(explain)*:
Current status of suit or other action:	
Date of settlement, judgment, or dismissal:	
If case was settled out-of-court, or with a judgment, settlement amount attributed to you?	

ATTESTATION

I hereby certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below

Practitioner Name Signature Date