



# HEALTHWAYS

21251 Ridgetop Circle  
Suite 150, Sterling, VA 20166  
Fax: 1-888-492-1026  
Phone: 1-800-274-7526

## HEALTHWAYS WHOLEHEALTH LIVING® NETWORK

### PARTICIPATING PRACTITIONER AGREEMENT CERTIFICATE OF PARTICIPATION FOR AFFINITY PROGRAMS

#### INSTRUCTIONS

This form must be typed or printed legibly in blue or black ink. Below is a list of the items that must be submitted along with this application:

- Copy of license(s) if applicable
- Copy of insurance face sheet for professional and business liability policy
- Copy of educational or training certificates, diploma, or specialty training documentation letter(s)
- Signed release and attestation statement, with professional liability form if applicable.

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

#### SIGNATURE LINE

I, \_\_\_\_\_, ("PRACTITIONER"), hereby tender this Certificate of Participation in Healthways WholeHealth Networks, Inc ("HWHN") upon the terms and conditions set forth in this HWHN Participating Practitioner Agreement. With this Certificate, Practitioner agrees to serve as a Participating Practitioner member of HWHN for Affinity Programs, and hereby specifically authorizes and appoints HWHN to act on its behalf to contract for the provision of discounted cash services by Practitioner under HWHN Affinity Programs. I hereby attest to my meeting the network standards for my professional specialty and for my business operations as outlined in the Terms and Conditions, Participation Requirements, and Practitioner Credentials sections of this document, with respect to the following practice specialties.

#### PRACTITIONER SPECIALTIES

Please check all specialties for which you are applying for network participation. **You must include all of the credentials for a specialty in order for it to be added to your profile. You must meet credentialing criteria for each specialty** (please refer to the Practitioner Specialty Specific Credentials Requirements section).

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

#### DISCOUNT AGREEMENT

I agree to extend a \_\_\_\_\_% (minimum of 10%-30%) discount from all of my usual service charges to all HWHN Affinity Program participants referred to me. I will not charge HWHN Affinity Program participants more than the discounted rate for all of my services. If this is left blank, Practitioner agrees to a 20% discount. I understand, by agreeing to participate, HWHN will identify my practice in Group-specific online and offline directories to members seeking services under HWHN Affinity Group client contracts. I understand certain HWHN Group clients may only accept affiliates who offer 20% or more discount levels to their beneficiaries. Practitioners' listings in the online directories will be prioritized by discount level and include my name, specialty (ies) and discount level.

Practitioner's Printed Name \_\_\_\_\_ Practitioner's Signature \_\_\_\_\_ Date \_\_\_\_\_

Accepted by: \_\_\_\_\_ Martie Stabelfeldt, VP, Physical Medicine Ops \_\_\_\_\_ Date \_\_\_\_\_

**Primary Location:**  
 Clinic Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_  
 Office Contact: \_\_\_\_\_ Title: \_\_\_\_\_  
 Website Address: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Secondary Location:**  
 Clinic Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_  
 Office Contact: \_\_\_\_\_ Title: \_\_\_\_\_

Website Address: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

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

State License # \_\_\_\_\_ State License Expiration Date \_\_\_\_\_

Malpractice Carrier (attach current face sheet) \_\_\_\_\_ Malpractice Limits: \_\_\_\_\_

Malpractice Policy # \_\_\_\_\_ Malpractice Expiration: \_\_\_\_\_

Colleges/Specialty Institutions: \_\_\_\_\_ Graduation Date(s): \_\_\_\_\_

Do you wish to have your Website listed on your profile? \_\_\_\_\_

What is your first year of practice? \_\_\_\_\_

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

**Practice Focus:**

\_\_\_\_\_  
 \_\_\_\_\_

**Payment Methods Accepted:**

- Visa
- MasterCard
- American Express
- Discover
- Cash
- Personal Check

Average Fee Range: \$ \_\_\_\_\_ - \$ \_\_\_\_\_

Special Offers:

\_\_\_\_\_  
 \_\_\_\_\_

**Correspondence/Communication Preference:**

- Email Email Address \_\_\_\_\_
- Fax Fax Number \_\_\_\_\_
- United States Postal Service

PRIMARY LOCATION OFFICE HOURS						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
AM	AM	AM	AM	AM	AM	
PM	PM	PM	PM	PM	PM	
SECONDARY LOCATION OFFICE HOURS						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
AM	AM	AM	AM	AM	AM	
PM	PM	PM	PM	PM	PM	

## DEFINITIONS

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

## TERMS AND CONDITIONS OF PARTICIPATION

1. Practitioner agrees to cooperate with HWHN's Quality Management programs. The Quality/Utilization Management (Q/UM) committee is responsible for evaluating a practitioner's professional performance record while participating in the network. It may review fees, quality of care, and administrative complaints and/or audit the services of Practitioners under this Agreement. It may impose sanctions and determine if the applicant's practice meets network standards for ongoing membership and participation in HWHN programs. HWHN, in accordance with health care industry guidelines, maintains a grievance and appeal process for decisions adversely affecting Practitioners eligibility for participation in Group plans.
2. No person in the United States shall, on the grounds of race, color, sexual orientation, religion, sex or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any HWHN contracted Group Affinity Program. Practitioner will comply with all requirements imposed by or pursuant to the regulations of the appropriate federal agency effectuating Title VI of the Civil Rights Act of 1964.
3. Practitioner represents and warrants that the information provided to HWHN, including, but not limited to the information attested to in each Practitioner's application, practice profile updates, and credentials updates, is true, complete, and current.
4. Failure to honor the contracted discounts, or inconsistent application of the Published Fee Schedules, or failure to inform HWHN of changes in practice status will be considered a material breach of this agreement. HWHN will accept changes in the Published Fee Schedules every six months. Failure to comply with Quality Management investigations, and/or submission of false information, is grounds for termination.
5. HWHN agrees to indemnify, defend, and hold the Practitioner harmless from and against any and all claims, losses, costs, damages, expenses of every kind and character and liabilities, including attorney's fees and costs, (hereinafter "claims" or "claim") incurred in connection with such claims, including any action or proceeding brought thereon, arising from or as a result of any accident, injury, loss or damage whatsoever caused to any person or to the property of any person arising out of or in connection with this Agreement caused by the negligence or misconduct of HWHN or its agents, contractors, servants or employees of HWHN excepting; however, in each case, claims caused by the negligence or misconduct of Practitioner or its agents, contractors, servants or employees of Practitioner. Practitioner agrees to defend, indemnify and hold HWHN and contracting Groups harmless from and against any and all claims, losses, costs, damages, expenses of every kind and character and liabilities, including attorney's fees and cost, (hereinafter "claims" or "claim") incurred in connection with such claims, including any action or proceeding brought thereon, arising from or as a result of any accident, injury, loss or damage whatsoever caused to any person or to the property of any person arising out of or in connection with this Agreement caused by the negligence or misconduct of Practitioner or its agents, contractors, servants or employees of Practitioner excepting; however, in each case, claims caused by the negligence or misconduct of Group/HWHN or its agents, contractors, servants, or employees of Group/HWHN.

## PARTICIPATION REQUIREMENTS

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

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

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

**Health Information Privacy Regulatory Compliance and Business Associate Agreement:**

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

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

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

**Practitioner Licensure Requirements:**

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

**NETWORK CERTIFICATION AND RELEASE OF INFORMATION**

**QUERIES TO THE NATIONAL PRACTITIONER DATA BANK OR STATE LICENSING BOARD**

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

**RIGHT TO CORRECT ERRONEOUS INFORMATION**

Practitioner has the right to review information submitted in support of your Network Application and contract to the extent permitted by law and HWHN will notify you of any information obtained during the review that differs substantially from the information you provide. You will then have the right to correct any erroneous information from HWHN.

**CERTIFICATION OF APPLICATION HEALTH CARE LICENSE AND MALPRACTICE CLAIM STATUS**

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

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize HWHN to consult with past employers, administrators and members of institutions with which I have been or am currently associated, and with others who may have information bearing on my qualifications as a Practitioner, including past and present malpractice carriers to obtain and verify my credentials and professional competence. I further consent to the inspection by representatives of HWHN of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications including information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges. I consent to the release and exchange of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to HWHN. I authorize the medical and/or professional associations of which I am a member to turn over to the representatives of HWHN a copy of my application for membership and related documents.

I release from liability all representatives of HWHN for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations that provide information to HWHN in good faith and without malice concerning my professional competence, character and ethics.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

**PROFESSIONAL LIABILITY INFORMATION FORM**

Please complete this form explaining any professional liability claims or lawsuits brought against you, settled, or dismissed. The information provided should include pending and closed cases, as well as dismissed or dropped claims or suits. Please obtain information from your insurer if necessary. Copy this form if you have more than one claim to report.

**Practitioner Name:** \_\_\_\_\_ **Case Number:** \_\_\_\_\_

**Current status of legal action:**

_____ Pending	Court Date (if available): _____
_____ Dismissed or Dropped	Date: _____
_____ Closed	Date: _____

**Resolution:**

_____ No Payments	
_____ Out of Court Settlement	Amount: \$ _____
_____ Judgment or Award	Amount: \$ _____

**Date of Filing:** \_\_\_\_\_

**Date of Incident:** \_\_\_\_\_

**Professional Liability Insurer:** \_\_\_\_\_

**Allegation:**

\_\_\_\_\_

**Details of incident including your role, relating events, and patient outcome:**

\_\_\_\_\_

**Have you made any changes in your practice as a result of this incident? Attach separate sheet if required.**

\_\_\_\_\_

I certify to the best of my knowledge that all information provided above is correct and complete. I understand that any significant misstatement or omissions on this application may constitute cause for denial or revocation of my contract.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PRACTITIONER SPECIALTY SPECIFIC CREDENTIALS REQUIREMENTS**

*Please check the information that applies to your specialty (ies). You will be listed in the directories by these categories.*

<b>Acupuncture</b>	<input type="checkbox"/> Graduation from a National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) accredited program <input type="checkbox"/> Hold a valid unrestricted state license and/or NCCAOM certification <b>OR</b> <input type="checkbox"/> Physician Acupuncturists ( <b>MD/DO</b> ) must hold a valid unrestricted license to practice medicine Including acupuncture, and either be a member of the Am Academy of Medical Acupuncture (AAMA), or be certified by the Am Board of Medical Acupuncture <input type="checkbox"/> <b>NDS and DCs</b> need to have 200 hours of acupuncture training and meet ND or DC state scope of practice criteria <input type="checkbox"/> Professional liability insurance limits of 1M/3M are required for all MD's and DO's as well as ND's and DC's who practice acupuncture <b>OR</b> liability insurance limits of at least \$200,000 / \$500,000 for licensed acupuncturists only
<b>Behavioral Health</b>	<input type="checkbox"/> Hold a valid unrestricted state license in a behavior health discipline, i.e. Psychologists, Social Worker etc. <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Biofeedback</b>	<input type="checkbox"/> Certification from the Biofeedback Certification Institute of America (BCIA) <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Childbirth Educator</b>	Applicants may qualify as a Childbirth Educator, with documented training and certification under the auspices of at least <b>one</b> of the following programs: <input type="checkbox"/> International Childbirth Education Association (ICEA) <input type="checkbox"/> Childbirth and Postpartum Professional Association (CAPP) <input type="checkbox"/> American Academy of Husband Coached Childbirth (AAHCC – Bradley ® Method) <input type="checkbox"/> ASPO/Lamazé – Lamazé Certified Childbirth Educator <input type="checkbox"/> Prepared Childbirth Educators (PCE) <input type="checkbox"/> The Academy of Certified Birth Educators & Labor Support Professionals (ACBE) <input type="checkbox"/> Birth & Beginnings Education (BABE)
<b>Chinese Herbal Medicine</b>	<input type="checkbox"/> National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Herbal Practitioner certification, or state license exam for Chinese Herbal Medicine <input type="checkbox"/> Credentialed as a licensed acupuncturist or other licensed profession <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Chiropractic</b>	<input type="checkbox"/> Graduation from an accredited college <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Dietician Registered/Licensed</b>	<input type="checkbox"/> Hold a valid unrestricted state license and/or American Dietetic Association/Commission on Dietetic Registration (ADA/CDR) accreditation <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Doulas</b>	Applicants may qualify as a Doulas, with documented training and certification as a prenatal, labor/birth, or postpartum Doula under the auspices of at least <b>one</b> of the following programs: <input type="checkbox"/> International Childbirth Education Association (ICEA) <input type="checkbox"/> Doula of North America (DONA) <input type="checkbox"/> Childbirth and Postpartum Professional Association (CAPP) <input type="checkbox"/> National Association of Postpartum Care Services <b>PLUS</b> <input type="checkbox"/> Current professional liability insurance policy of \$200,000/\$500,000 minimum
<b>Energy Healing Practitioner</b>	<input type="checkbox"/> Credentialed with Healthways WholeHealth Networks, Inc. in another licensed specialty <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000 <input type="checkbox"/> Reiki Certified as a Third Degree Reiki (Reiki Master) or as a Reiki Master Teacher <b>OR</b> <input type="checkbox"/> Healing Touch Certified as a practitioner or teacher by Healing Touch International
<b>Feldenkrais</b>	<input type="checkbox"/> Guild Certified Feldenkrais Practitioner or Teacher certificate from the Feldenkrais Guild of North America <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Guided Imagery/Hypnotherapy</b>	<input type="checkbox"/> Meet Healthways WholeHealth Networks, Inc. credentialing criteria in Behavioral Health <input type="checkbox"/> Documented training in clinical Guided Imagery or Hypnotherapy <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Health and Wellness Coach</b>	<input type="checkbox"/> Certification by a professional certifying or trade organization with standards of practice, and a code of ethics acceptable to the Credentialing Committee <b>OR</b> <input type="checkbox"/> Graduation from an accredited post-secondary education program with a degree in coaching/lifestyle education field <b>OR</b> <input type="checkbox"/> Completion of a post professional continuing education program in health education and coaching acceptable to the Credentialing Committee <b>PLUS</b> <input type="checkbox"/> Current, valid, unrestricted license/registration for coaching services if required by the state in which he/she will participate
<b>Hellerwork Practitioner</b>	<input type="checkbox"/> Certified by Hellerwork International as a Certified Hellerwork Practitioner <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Herbal Consultant</b>	<input type="checkbox"/> Professional current member of the American Herbalists Guild and a minimum of 200 hours education in herbal medicine
<b>Holistic Nurse Practitioner</b>	<input type="checkbox"/> Hold a valid unrestricted state license as an advanced nurse or nurse practitioner <input type="checkbox"/> 200 or more hours course work in alternative medicine or another credentialed CAM specialty <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Homeopath</b>	<input type="checkbox"/> Certified in Classical Homeopathy by the Council for Homeopathic Certification <b>OR</b> <input type="checkbox"/> A licensed independent prescribing health practitioner (DC, ND, MD, DO, NP, etc.) otherwise credentialed by examination with a recognized state, national or international certificate of primary care or specialty care homeopathic expertise <input type="checkbox"/> One year of practice experience as a homeopathic practitioner <input type="checkbox"/> Business or professional liability insurance of at least \$200,000 / \$500,000 or \$1M/ \$3M based on license level
<b>Hypnotist (non clinical)</b>	<input type="checkbox"/> Active Certified members of the National Guild of Hypnotists, Inc. <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Integrative Holistic Physician</b>	<input type="checkbox"/> A minimum of 200 hours course documented work in alternative medicine or osteopathic principles, or be certified by the American Board of Holistic Medicine <input type="checkbox"/> Hold a valid unrestricted state license to practice medicine <input type="checkbox"/> Professional liability insurance of \$1,000,000 / \$3,000,000
<b>Massage Therapy</b>	<input type="checkbox"/> Hold a valid unrestricted state massage license <b>OR</b> <input type="checkbox"/> Current jurisdictional (city/county, etc.) license. <b>PLUS</b> either of the following: <input type="checkbox"/> Certificate of NCBTMB exam passage (National Certification Board of Therapeutic Massage & Bodywork <b>OR</b> <input type="checkbox"/> Certificate of active professional AMTA or ABMP membership (requires 500 hrs training) <b>OR</b> <input type="checkbox"/> Meet Healthways WholeHealth Networks, Inc. qualifications for alternative bodywork training and certification (Rolfing, Myotherapy, Reiki, Hellerwork, Oriental Body Work, etc.) <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Massage Therapy-Clinical</b>	<input type="checkbox"/> Hold a valid unrestricted state massage license <input type="checkbox"/> Certification at the entry level by the National Certification Board for Massage or Therapeutic Bodywork (NCBMTB) or an equivalent State licensing exam <input type="checkbox"/> Evidence of professional continuing education in massage totaling at least <b>60 hours</b> of course work in the past four years <input type="checkbox"/> Copy of Certificate of Completion of at least one advanced massage modality practice training program of 25 hours or more <input type="checkbox"/> Documentation of at least two calendar years in active clinic practice <input type="checkbox"/> <b>Two Letters</b> of Reference from health professionals attesting to personal and clinical practice characteristics, at least one of which <u>must be</u> from a referring or supervising MD, DO, DC, PT,RN or Healthways WholeHealth Networks, Inc. credentialed clinical massage practitioner <u>who has supervised your practice</u> <b>PLUS:</b> <input type="checkbox"/> Documentation of <u>supervised contact hours</u> performing clinical massage: <input type="checkbox"/> 500 contact hours required for applicants with only a basic 500 hour massage education <b>OR</b> <input type="checkbox"/> 250 contact hours required for applicants with 1000 hour basic massage education that Includes clinical assessment, clinical pathology, and clinical charting <b>OR</b> <input type="checkbox"/> Postgraduate clinical training equivalent to 250 contact hours after their basic 500 hour education <input type="checkbox"/> Professional liability insurance of \$200,000/\$600,000 or \$500,000/\$500,000

<b>Mind-Body Skills Instructor</b>	<input type="checkbox"/> Certification by Peggy Huddleston of satisfactory completion of training in administering the "Prepare for Surgery, Heal Faster" workshop program <b>OR</b> <input type="checkbox"/> Written documentation of completion of training in the MindBodySpirit Professional Training Program, offered by the Center for MindBody Medicine in Washington,DC <b>OR</b> <input type="checkbox"/> Documentation of status as a Certified Middendorf Practitioner by completion of the three year (three block) professional training offered by Middendorf Breath Institute in Berkeley,CA <b>OR</b> <input type="checkbox"/> Written Documentation of completion of training as a meditation Instructor in a formal or apprenticeship training program <b>PLUS</b> <input type="checkbox"/> Attestation of a minimum of 200 hours of training and/or practice teaching
<b>Mindfulness Based Stress Reduction Teachers</b>	<input type="checkbox"/> MBSR Teacher Certification evidenced by a Certification by the Center for Mindfulness A at the University of MA <b>OR</b> <input type="checkbox"/> Copy of Attestation to 200 hours of experience teaching Mindfulness-Based Stress Reduction (MBSR) <b>PLUS</b> <input type="checkbox"/> Written Documentation of completion of <i>Mindfulness-Based Stress Reduction in Mind/Body Medicine A 5- or 7-Day Residential Training Retreat</i> offered by the Center for Mindfulness at University of Massachusetts Medical School <b>OR</b> <input type="checkbox"/> Written Documentation of completion of <i>Practicum in MBSR</i> (formerly the <i>Internship Program</i> ) and/or <i>Teacher Development Intensive in MBSR</i> and/or <i>Supervision in MBSR</i> conducted by CFM or a CFM affiliated training program <b>PLUS</b> <input type="checkbox"/> Letter of Reference from an MBSR Instructor-trainer approved by the Center for Mindfulness (contact CFM or Healthways WholeHealth Networks, Inc. for list of approved professionals)
<b>Music Therapy</b>	<input type="checkbox"/> A listing of current certification as MT-BC by the Certification Board for Music Therapists (CBMT) <b>OR</b> <input type="checkbox"/> A listing as a Registered Music Therapist (RMT), Certified Music Therapist (CMT) or Advanced Certified Music Therapist (ACMT), as listed with the National Music Therapy Registry <b>PLUS</b> <input type="checkbox"/> Current membership in the American Music Therapy Association (AMTA)
<b>Naturopathic Physician</b>	<input type="checkbox"/> Graduation from a naturopathic medical college with a minimum four-year graduate degree <input type="checkbox"/> Hold a valid unrestricted state license. If licensure is not available by the state the practitioner must pass the Naturopathic Physicians License Exam (NPLEX) and have a valid out-of-state ND license <input type="checkbox"/> Professional liability insurance of at least \$200,000/\$500,000
<b>Nutritional Counselor</b>	<input type="checkbox"/> Hold a valid unrestricted state license as a nutritionist <b>OR (if non-licensed state)</b> <input type="checkbox"/> Certified as a Certified Clinical Nutritionist (CCN) by the Clinical Nutrition Certification Board <b>OR</b> <input type="checkbox"/> Certified as a Certified Nutritionist (CN) by the National Institute of Nutritional Education <input type="checkbox"/> Professional liability insurance limits of at least \$200,000/\$500,000
<b>Occupational Therapist</b>	<input type="checkbox"/> Graduation from an accredited college or formal training program <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> NBCOT certification (not required but recommended) <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Asian/Oriental Bodywork</b>	<input type="checkbox"/> Hold a valid unrestricted state or local license <b>PLUS</b> <input type="checkbox"/> Written documentation of Massage training program, including Oriental body work, of 500 class hours and a National Certification Board for Therapeutic Massage and Bodywork (NCBTMB) certification <b>OR</b> <input type="checkbox"/> Certification in Asian Bodywork Therapy by the Nat Cert Commission for Acupuncture and Oriental Med (NCCAOM) <input type="checkbox"/> Professional liability insurance of at least \$200,000 / \$500,000
<b>Pain Practitioner</b>	<input type="checkbox"/> Hold a current, valid, unrestricted license/registration as a health care practitioner (MD, DO, DC, PT, ND, LAc, Nurse practitioner or behavioral health) in the state in which he/she will participate <input type="checkbox"/> Graduation from an accredited college or formal training program for the primary license recognized by the state licensing agency <input type="checkbox"/> Current professional liability insurance policy meeting primary specialty requirements, or at least \$200,000 / \$500,000 <input type="checkbox"/> Certification as a Diplomat, Fellow or Clinical Associate in Pain Management by credentialing exam of the American Academy of Pain Management <b>OR</b> <input type="checkbox"/> Certified by the American Board of Pain Medicine <b>OR</b> <input type="checkbox"/> Certified by the subspecialty examination in Pain Medicine by the boards for Anesthesiology, Physical Medicine and Rehabilitation, or Psychiatry and Neurology
<b>Personal Trainer/ Exercise Specialist</b>	<input type="checkbox"/> Certification from the American College of Sports Medicine(ACSM), the American Council on Exercise (ACE), the National Strength and Conditioning Association (NSCA), National Academy of Sports Medicine (NASM), International Sports Sciences Association (ISSA) or the International Weightlifting Association (IWA), the Aerobics and Fitness Association of America (AFAA) or an equivalent program sponsored by an accredited institution of post secondary education <input type="checkbox"/> Hold a Master's Degree in Exercise Physiology from a recognized US or Canadian institution <b>OR</b> <input type="checkbox"/> Hold an Undergraduate Degree in physical education, exercise science, health science or nutrition, with additional training in physical therapy and Kinesiology, and a certification from one of the following: <input type="checkbox"/> The Center for Exercise Physiology (CEP) <b>OR</b> <input type="checkbox"/> Registered Clinical Exercise Physiologist by the American College of Sports Medicine <input type="checkbox"/> Health Fitness Director or Program Director certification by the American College of Sports Medicine <input type="checkbox"/> Certified by the Health & Fitness Program of certification by the Canadian Society for Exercise Physiology (CSEP) <b>PLUS</b> <input type="checkbox"/> Evidence of at least 15 CEU's of continuing education in exercise and fitness specialties every two years
<b>Physical Therapist</b>	<input type="checkbox"/> Graduation from an accredited college or formal training program <input type="checkbox"/> Hold a valid unrestricted state license <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Pilates Instructor</b>	<input type="checkbox"/> Pilates Certified Teacher from the Pilates Method Alliance (PMA) <b>OR</b> <input type="checkbox"/> Letter attesting current employment at Studio or Educational Organization that is registered with PMA <b>OR</b> <input type="checkbox"/> Evidence of Training through or by a Pilates Instructor program recognized by the Pilates Method Alliance <b>OR</b> <input type="checkbox"/> Certificate of completion in a comprehensive Pilates teacher training course with a 400 hour minimum requirement <input type="checkbox"/> Professional liability insurance limits of at least \$200,000/\$500,000
<b>Post Birthing/ Lactation Counselor</b>	<p>Applicants may qualify as a Postnatal Educator, Lactation Educator or Perinatal Fitness Educator, with documented training and certification under the auspices of:</p> <input type="checkbox"/> International Childbirth Education Association (ICEA) <b>OR</b> <input type="checkbox"/> Childbirth and Postpartum Professional Association (CAPP) <b>OR</b> <input type="checkbox"/> La Leche League International accredited Leader program <b>OR</b> <input type="checkbox"/> International Board of Lactation Consultant Examiners (IBLCE) <b>OR</b>
<b>Qi Gong</b>	<input type="checkbox"/> Certification from the National QiGong Association (NQA) or individual training program <input type="checkbox"/> A minimum of 200 hours of formal training <input type="checkbox"/> One year teaching experience
<b>Reflexologist</b>	<input type="checkbox"/> Credentialed with Healthways WholeHealth Networks, Inc. as a massage therapist <input type="checkbox"/> Certification from the American Reflexology Certification Board <input type="checkbox"/> Professional liability insurance limits of at least \$200,000 / \$500,000
<b>Tai Chi</b>	<input type="checkbox"/> Certification from the individual training program <input type="checkbox"/> A minimum of 200 hours of training and/or practice teaching <input type="checkbox"/> One year documented teaching experience
<b>WholeHealth Advocate</b>	<input type="checkbox"/> Certification by a National Institute of WholeHealth as a WholeHealth Educator <b>OR</b> <input type="checkbox"/> Completion of the WholeHealth Advocate Training Program of 186 CEU's offered by the Nat'l Institute of WholeHealth <b>OR</b> <input type="checkbox"/> Evidence of completion of other comparable post professional or post degree continuing education programs acceptable to the Healthways Quality Management Committee <b>PLUS</b> <input type="checkbox"/> Two years of experience as a professional health care practitioner or a health and wellness coach <input type="checkbox"/> Current, valid, unrestricted license/registration in the related health care profession, if applicable, and any coaching or lifestyle counseling registrations or certifications required by the state in which he/she will participate
<b>Yoga</b>	<input type="checkbox"/> A Registered Yoga Teacher (RYT), registered with Yoga Alliance (200/500 hour certifications) or more Yoga nationally certified course or training program <b>OR</b> <input type="checkbox"/> Certificate of completion of a comprehensive Yoga Teacher Training course <b>PLUS</b> <input type="checkbox"/> One year in practice experience following completion of training or working under supervision in a Yoga facility