APPLICATION FOR ALLIED HEALTH PROFESSIONAL AFFILIATION AND CLINICAL PRIVILEGES

(Physician Assistants, Advanced Registered Nurse Practitioners, Certified Registered Nurse Anesthetists, Certified Nurse Midwives and Anesthesiology Assistants)

Dear Allied Health Professional:

Thank you for your interest in applying for clinical privileges at Broward Health's affiliated facilities, including Broward Health Medical Center/Chris Evert Children's Hospital, Broward Health Coral Springs, Broward Health Imperial Point, Broward Health North and our affiliated community health services.

The Corporate Credentials and Qualifications Department is the centralized office that handles application requests and the processing for all of the Broward Health facilities. We look forward to working with you and answering any questions you may have in order to facilitate a smooth process.

1. Complete the attached pre-application in full. Type or print neatly all responses. Submit the completed, signed form along with the requested documents/ forms to the Credentials and Qualifications Department (CQD).

It is your responsibility to supply the Credentials and Qualifications Department (CQD) with the following information:

- Non-refundable pre-application fee of **$150**. Check made payable to:
  - "**North Broward Hospital District- Account #: 118320**"
    - Pre-Application
    - Release of Information Form
    - Background Release of Information Disclosure
    - Sponsorship Form (Allied Health Only)
      - For ARNP's/ CRNA's / CNM's State Protocols With Supervising Physician(s)
    - Copy of Curriculum Vitae (CV)

2. The Credentials Specialist (CS) prescreens applicants to determine eligibility as per the Medical Staff Bylaws. The applicant then receives an email with information about how to apply online.

3. The applicant must login to the application site and complete the full online application in its entirety (*20 days to be completed*). Mandatory fields must be completed in order to proceed. All other fields must also be completed or marked N/A, as applicable.
   - **Please note**: In order to cover all verification expenses your initial application fee must be received within 5 business days of your completed on-line application. Initial application fee of **$150**. Check made payable to:
     - "**North Broward Hospital District- Account #: 118320"**
   - Failure to do so will result in the delay of the processing of your application. Additionally, your application will be considered incomplete until such time we receive this payment.

4. Applicants must select one of the BH facilities to be his/her primary facility. For AHPs, this should be where your main physician sponsor has designated as his/her primary facility, or where you anticipate having the most patient activity. Changes of a primary facility may only be requested at the time of reappointment. You may also apply at one or more secondary BH facilities by paying the applicable additional application fee for each.

5. Be sure to include three (3) professional references, which should ideally be in the same discipline or specialty. They should not be close relatives, and/or associates you intend to join in practice are **NOT** acceptable. Please select colleagues that are currently familiar with your professional practice and have known you for at least a year.

6. Hospital affiliations and employment history should cover at least the past ten (10) years.

7. All references, hospital affiliations, and employers listed in the application should include complete mailing addresses, phone numbers, and either fax numbers and/or email addresses.

8. In the application website, you will find required reading, including:
   - Medical Staff Bylaws
   - Medical Staff Rules and Regulations

- Link to “Credentialed Staff Orientation” (online orientation education)
  - This link directs you to page with presentations that you must view. After viewing the presentations, you must complete the quiz and save the certificate of completion. The certification of completion must be returned to the CQD to indicate compliance with required online education. Additionally, the application contains a statement in which you must attest to receiving and reading this required information, of which you are bound to comply.
  - Other materials may be placed on the website for you to review to ensure adequate knowledge of Broward Health requirements and regulatory standards.

9. Be sure to review the “Documents List Required for Initial Applications” that explains all items that must be provided with the application.

The credentialing process typically takes 60-90 days from receipt of application to complete, and we will communicate with you and/or your representative to work as efficiently as possible. You are expected to provide thorough and accurate information. Missing, incomplete or vague information delays the process and can affect the timing of your ability to exercise hospital privileges. Applicants can expedite the process by ensuring correct contact information for current and former affiliations, employers and references listed in the application and advising them to promptly reply when contacted by the CQD.

Completed applications are reviewed by a specialty reviewer (an individual in the same or a similar specialty), which makes a recommendation to the section chair, department chair, and/or designee. A positive recommendation will be forwarded to the Credentials and Qualifications Committee of the facility(s) for which you have applied. Applications not receiving a positive recommendation for medical staff appointment and/or clinical privileges will be reported to the Credentials and Qualifications Committee of the facility(s) for which you have applied. Each hospital’s medical staff (through its Credentials and Qualifications Committee and its Medical Executive Committee) retains the right to review and make recommendations based upon the completed application, the recommendations of the reviewers, and their interviews with you (as applicable).

A **Medical Staff Administration** representative will contact you regarding the following:

- Whether or not a personal interview is required with a Department Chair and/or the C&Q Committee
- Confirmation that you have scheduled or completed CPOE training and when your ID badge will be issued
- Arrangements of a hospital tour and/or hospital orientation
- Expectations of when approval may occur
- Any other information relative to the hospitals for which you have applied

You may not provide patient care or otherwise exercise any clinical privileges until you have been notified of approval.

After approval, you are obligated to inform the CQD of any change of physician sponsorship, demographic changes, protocol changes, requests for privilege changes (additions, deletions or modifications), requests for status changes, and updates concerning licensure, board status, criminal activity malpractice actions, etc.

Again, we thank you for your interest in Broward Health. If we can be of any assistance during the application process, Please contact the Credentials and Qualifications Department (CQD) at (954) 473-7575. Or by email to credentials@browardhealth.org,
Or alternatively by fax: 954-473-7255.

(NOTE) Please MAIL all Pre-Applications and Fees to the Credentials & Qualifications Department Directly - Pre-applications will **NOT** be accepted via fax or email.

Sincerely,

Kathy Ellis, CPMSM
Director, Medical Staff - Credentials & Qualifications Department

BROWARD HEALTH

The mission of Broward Health is to provide quality healthcare to the people we serve and support the needs of all physicians and employees.

BrowardHealth.org

Medical Staff Application Fees

Application and membership fees are due upon receipt of the application or no more than 15 days of receipt. Failure to submit ***all required fees*** within 20 days will result in the application being considered incomplete and/or a voluntary withdraw or resignation as appropriate. Please note applications will not be processed without full payment of ***all required fees.***

Application Fee for Credentials and Qualifications Department (CQD)

- ***All fees as described herein are non-refundable***.
- Checks must be made payable to:
  - "**North Broward Hospital District**- Account Number: 118320"

Corporate Credentials & Qualifications Department
Attn: *Credentials Specialist*
1800 NW 49th Street
Suite 110
Fort Lauderdale, FL 33309

Fee Assessment Schedule for Credentials and Qualifications Department (CQD)

	Department	Medical Staff	AHPs
Pre-Application Fees	**CQD**	**$250.00**	**$150.00**
Initial Application Fees/ Facility Change Requests	**CQD**	**$250.00**	**$150.00**
Late Fees	**CQD**	**$250.00**	**$250.00**

Initial *Membership* Fees for Medical Staff Administration

Primary Region | Non-Primary Region(s)

- Checks must be made payable to "**Medical Staff Fund**" for each facility to which you are applying, to the attention of the Reg. Mgr., Medical Staff Administration.

Medical Staff Administration			
Broward Health Medical Center Attn: TBA 1600 S Andrews Avenue Fort Lauderdale, FL 33316 954-355-4864	**Broward Health Coral Springs** Attn: Lametrius "Meme" Baker - Greene 3000 Coral Hills Drive Coral Springs, FL 33065 954-344-3143	**Broward Health Imperial Point** Attn: Teresa Colaluca 6401 N Federal Highway Fort Lauderdale, FL 33308 954-776-8628	**Broward Health North** Attn: Debbie Brown 201 E Sample Road Deerfield Beach, FL 33064 954-786-6973

Fee Assessment Schedule for Medical Staff Administration

	Department	Medical Staff	AHPs
Initial ***Membership*** Fees Primary Region	**MSO**	**$350.00**	**$175.00**
Initial ***Membership*** Fees Non-Primary Region(s)	**MSO**	**$150.00** per additional Region	**$100.00** per additional Region

CQD Team Contact Information

Corporate Headquarters' Office	Credentials Specialists' Office
Kathy D. Ellis, CPMSM Director of Medical Staff (Credentials & Qualifications) Department of Quality 1800 NW 49th Street, Suite 110 Fort Lauderdale, FL 33309	1800 NW 49th Street Suite 110 Fort Lauderdale, FL 33309
Phone: 954-473-7041 Fax: 954-473-7009 Email: Kdellis@browardhealth.org	Phone: 954-473-7575 Fax: 954-473-7255 Email: credentials@browardhealth.org

Last Updated 04/11/2017

Name	Last Name Assignments	Other Assignments	Phone	Email
TBD	Reappointments A-G			
Joel Scinto, Credentials Specialist **Phone Option 2**	Reappointments H-R (covering E-G) *Except for Anesco*	•EmCare Group's Reappointments and Miscellaneous Requests •Back-up for Jill	954-473-7230 954-320-3384 fax	jscinto@browardhealth.org
Kelly Wagner, Credentials Specialist **Phone Option 5**	Reappointments S-Z (covering A-D) *Except for EmCare*	•Anesco's Reappointments and Miscellaneous Requests •Back-up for Cynthia	954-473-7415 954-320-3397 fax	kwagner@browardhealth.org
Bridget Howard, Credentialing Coordinator/Supervisor **Phone Option 4 or 0 for General Info**	Initial Appointments A-G *Except for EmCare & Schumacher*	•Anesco's Initial Applications •Quality Reviews •Expirables Monitoring • Demographics Updates •Staff Training •Technical Assistance •Hospital Outreach	954-473-7416 954-888-3696 fax	bhoward@browardhealth.org
Jill Fluke, Credentials Specialist **Phone Option 3**	Initial Appointments H-Q *Except for EmCare and Anesco*	• Schumacher Hospitalists' Initial Applications •Back-up for Joel	954-473-7547 954-473-7255 fax	jfluke@browardhealth.org
Cynthia Martinez, Credentials Specialist **Phone Option 6**	Initial Appointments R-Z *Except for Schumacher & Anesco*	•EmCare Group's Initial Appointments •Back-up for Kelly	954-473-7424 954-888-3598 fax	cemartinez@browardhealth.org

Pre-Appointment Application – Allied Health Professional

Physician Sponsors *List All Sponsors*	Which Facility Do You Anticipate Working at Most (Primary Facility)? **(Select one)**	Do you wish to apply at any additional Facilities? **(Select all that apply)**	Previous Affiliations and Privileges? **(Select all)**	Dates of Previous Privileges
_____	☐ Broward Health Coral Springs	☐ Broward Health Coral Springs	☐ Broward Health Coral Springs	_____
_____	☐ Broward Health Imperial Point	☐ Broward Health Imperial Point	☐ Broward Health Imperial Point	_____
_____	☐ Broward Health Medical Ctr	☐ Broward Health Medical Center	☐ Broward Health Medical Ctr	_____
_____	☐ Broward Health North	☐ Broward Health North	☐ Broward Health North	_____
_____	☐ Community Health Services,	☐ Community Health Services,	☐ Community Health Services,	_____
_____	Site(s): _____	Site(s): _____	Site(s): _____	_____

Last	First	Middle
Previous last names/ maiden *if applicable*		
Social Security #	Date of Birth	Place of Birth

Degree(s) **Specialty(ies) For Which You Wish to Have Hospital Privileges** *should match board certification(s)*

Degree	☐ Nurse Practitioner ☐ Physician Assistant Sub-Specialty: ☐ Nurse Anesthetist ☐ Nurse Midwife ☐ Emerg Dept ☐ Other _____

Primary Email Address

Name of Practice Group or Affiliation _____
_____ Group or Affiliation Tax ID_____
_____or, Solo Practice Tax ID _____
Office Manager's Name_____Office Manager's Email _____

Primary Office Information

Address	Suite #	City/State	Zip
Telephone #	Fax #	Backline #	
Pager #	Answering Service #		

Home Information

Address	Apt #	City/State	Zip
Landline Home #	Fax #	Cell #	

Board Certifications

Specialty Board	Original Certification Date / /	Last Recertification Date / /	Expiration Date / /
Board Eligible? (if not certified) ☐ Yes ☐ No	If not certified, date you completed training program: / /		

Licenses

State: Florida	Date Issued:	#	Expiration Date:
State:	Date Issued:	#	Expiration Date:
State:	Date Issued:	#	Expiration Date:
State:	Date Issued:	#	Expiration Date:
State:	Date Issued:	#	Expiration Date:
State:	Date Issued:	#	Expiration Date:

Other Certifications *Include legible copies – Broward Health requires ACLS/PALS **ONLY** from the American Heart Assn.*

ACLS – Date Issued & Expiration	PALS – Date Issued & Expiration	NRP – Date Issued & Expiration	ATLS – Date Issued & Expiration

Identification Numbers

NPI #	Medicare #	Medicaid #	Other

Answer the following questions: *Provide full details of all questions answered "yes."*	**Yes**	**No**
1. Have you ever failed to complete any professional medical-related training program?		
2. Has your license or registration to practice ever been limited, suspended, surrendered or revoked, either voluntarily or involuntarily?		
3. Are there any previously successful or currently pending challenges or investigations to your licensure or registration?		
4. Have you ever voluntarily or involuntarily relinquished your license or registration?		
5. Is your license or registration currently under investigation by any state, governmental agency or medical organization?		
6. Have you ever been refused clinical privileges on a hospital staff?		
7. Has your request for any specific clinical privileges ever been denied or granted with stated limitations?		
8. Have you ever voluntarily or involuntarily relinquished your privileges, or have you agreed to withdraw your privileges?		
9. Have your privileges at any hospital ever been voluntarily or involuntarily suspended, diminished, revoked or not renewed?		
10. Have you ever been subject to disciplinary action in any hospital, medical organization, or healthcare facility?		
11. Do you have any current sanctions or pending investigations affecting your ability or authorization to participate in any federal healthcare program or which might cause you to become an ineligible person?		
12. Have judgments or settlements been made against you in professional liability cases, or are there any current or former investigations pending? *If yes, please complete the liability claim form.*		
13. Have you been convicted of or pled guilty or no contest (nolo contendre) to any criminal activity as defined in Section 2.1.15 of the Broward Health Medical Staff Bylaws, or is any charge of said criminal activity pending? *If yes, please include incident date and location, description of the charges and case status.*		
14. Do you have any physical or mental health conditions including chemical dependence/addiction, that may affect your ability to safely perform the essential functions of your practice and the clinical privileges for which you have applied? *All applicants must complete the Health Attestation and have it confirmed by a physician who can attest to the validity of the statement. All applicants must comply with Broward Health's illegal drug screening requirements.*		
15. Do you have any barriers that would prevent your ability to communicate both verbally and in writing in English in an understandable manner sufficient for the safe delivery of patient care?		
16. Are there any other issues or concerns that the medical staff should be aware of in consideration of your application for medical staff membership and/or clinical privileges? If yes, please provide details.		

Signature:_____ Date: _____

Please make sure you complete the pre-application in its entirety. Any undisclosed information may disqualify your application request for membership.

Return completed form by email to credentials@browardhealth.org, or alternatively by fax: 954-473-7255. Call 954-473-7575 if you have questions or need assistance. You will be contacted by email concerning next steps.

Updated 12/8/2014; 4/9/2015; 5/04/2016; 3/30/2017

STATEMENT OF SPONSORING PHYSICIAN

This form must be completed and signed by <u>each</u> sponsoring physician.

However, if sponsorship is by a contracted group for services (i.e., emergency, imaging, anesthesia services), the physician medical director of the group may sign as the single sponsor for the group.

The herein listed sponsoring physician(s) for applicant acknowledge that the AHP will function under his/her supervision and sponsorship in the hospital setting under his/her supervision at all times, and said sponsor(s) agree to assume full responsibility while practicing within Broward Health. Sponsor(s) is obligated and agrees to notify the CDQ immediately upon termination of sponsorship and supervision, for any reason.

AHP Name: _____

Scope of practice under sponsor(s) supervision: *Must attach a copy of protocol on file with the state licensing agency, if required to file such protocol. A copy of any updated protocols must be provided to the CQD within 5 business days of filing with the state licensing agency.*

- ❑ The applicant provides his/her own liability coverage, as attested to by copy of the malpractice verification of coverage. c*opy attached*
- ❑ The applicant is covered under my liability coverage, as attested to by copy of the malpractice verification of coverage. *copy attached*
- ❑ The applicant is not covered by liability coverage, will function under my direct supervision, and I assume complete liability of said applicant while functioning in Broward Health under my supervision and sponsorship.

Sponsor Name	Sponsor Signature	Date Signed

RELEASE OF INFORMATION

I hereby authorize the Board of Commissioners, Officers of the Medical Staff, and the Credentials and Qualification Department and Committees of the North Broward Hospital District, d/b/a Broward Health, and its various facilities and administrators of the various facilities of the Broward Health to write to any references listed by me in my application for medical staff membership and/or clinical privileges at Broward Health and any of its facilities or to any other physician, person, agency or organization. I hereby request and authorize any and all agencies, organizations, educational institutions, governmental bodies, corporations, and/or persons including, without limitations, any and all attorneys and/or insurance companies contacted in connection with my application to truthfully answer any questions posed by the above-named hospitals, committees, board, staff and person, to disclose all information, experience, character, citizenship, and professional background to the fullest extent of their knowledge; and/or to verify or refute any representations or claims which I have made in my application for affiliation and/or clinical privileges.

I hereby release and covenant to hold harmless from any and all claims, demands, and causes of action arising from any statements made concerning me, or my medical qualifications, and all agencies, organizations, educational institutions, governmental bodies, corporations, and/or persons conducting investigations, evaluations, or making inquiries or responding to same in connection with my application for affiliation and clinical privileges at one of the facilities of Broward Health.

I agree that a copy of this release shall be sent to those references listed in this application, together with a request for information concerning me and my background, in order that the people writing references may feel free to express their honest opinions about my abilities as an allied health professional and my reputation as a citizen to the officers and officials of Broward Health and various facilities that are considering my application for affiliation and clinical privileges at Broward Health or one of its various facilities.

PRINT NAME: _____ SIGNATURE: _____

DATE: _____

Affix a current, passport-sized photo in the block to the right for identification verification by references.	Affix Photo Here

DISCLOSURE AND AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR THE PROCUREMENT OF A BACKGROUND REPORT

DISCLOSURE

In reference to the Fair Credit Reporting Act, Section 604 (b) and 606 (a), a consumer report may be obtained on you for credentialing purposes at any time during the credentialing application process, or, if you are approved, during your tenure while affiliated with Broward Health. It may be an investigative consumer report that includes information as to your consumer or employment character, reputation, and characteristics. You have a right to request disclosure of the nature and scope of the investigative consumer report, which may involve interviews with any sources having information of the above.

AUTHORIZATION

I consent to have an investigative consumer report made as to my credit history, motor vehicle driving record, social security information, criminal record, civil record, education and employment history and other pertinent information for credentialing purposes, including initial or reappointment approval decisions. I hereby authorize North Broward Hospital District d/b/a Broward Health to obtain a background report containing the foregoing information from Accurate Background, Inc. (and/or any of their licensed agents) located at 6 Orchard, Suite 200, Lake Forest, CA 92630, (800) 784-3911. I am aware that the background report I consent to have prepared, may include information obtained from a variety of sources, including but not limited to Federal, State, County government agencies, national credit reporting agencies, and others. I am aware that if I choose, I may obtain a complete disclosure of the nature and scope of any report prepared about me if I make a written request to Broward Health within a reasonable time after I execute this authorization.

I also authorize and request every person, firm, company, corporation, governmental agency, court, law enforcement office, credit agency, educational institution, workers compensation agency, and any other entity having control or possession of any information pertaining to me or my background to furnish same to any requesting party and release them from liability and responsibility in doing so. By this Authorization for Release of Information and for the Procurement of a Background Report, I hereby forever release, discharge, exonerate, hold harmless and indemnify Accurate Background, Inc., its client (North Broward Hospital District d/b/a Broward Health), affiliates, employees, representatives, agents, subcontractors, clients and any other person, entity, organization or institution furnishing information to them from any and all liabilities of every nature and kind, including but not limited to claims for libel, slander, invasion of privacy, related tort claims, misuse of information obtained from Accurate Background, Inc., and any other claim or cause of action arising out of the furnishing, inspection or copying of any documents, files, records, and other information, or the investigation made by or on behalf of Accurate Background, Inc., unless such release is determined to violate the public policy of the state or federal district in which this contract is executed, and in that event this release will be permitted to the maximum extent allowed by the governing law. I understand that this Disclosure and Authorization form, in original, faxed, photocopied or electronic form, will be valid for any reports that may be requested by Broward Health or Accurate Background, Inc and its affiliates.

I also understand that if appointed to the medical staff or approved as an allied health professional affiliated with Broward Health, my consent will apply throughout my appointment term, unless I revoke or cancel my consent by sending a signed letter or statement to Broward Health at any time, stating that I revoke my consent and no longer allow Broward Health to obtain consumer or investigative consumer reports about me.

I acknowledge that I am being given a copy of the "Summary of Your Rights Under the Fair Credit Reporting Act" prepared pursuant to 15 U.S.C. Section 1681-1681u. If I am a resident of California at the time of applying, a summary of the provisions of California Civil Code section 1786.22 is also being provided to me with this form.

** Federal law prohibits discrimination in employment on the basis of age, race, creed, religion, sex, or national origin. Many states also prohibit some or all of the above types of discrimination and discrimination based on marital status. This information will be used for purposes of identification only. Without this information, we may be unable to distinguish you from another person in the event we discover adverse information during our background investigation.*

_____ _____

APPLICANT'S SIGNATURE DATE

Para informacion en espanol, visite www.ftc.gov/credit o escribe a la FTC Consumer Response Center, Room 130-A 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.ftc.gov/credit or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
    - o a person has taken adverse action against you because of information in your credit report;
    - o you are the victim of identify theft and place a fraud alert in your file;
    - o your file contains inaccurate information as a result of fraud;
    - o you are on public assistance;
    - o you are unemployed but expect to apply for employment within 60 days.

  In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.ftc.gov/credit for additional information.
- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.ftc.gov/credit for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.ftc.gov/credit.
- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.ftc.gov/credit.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:

TYPE OF BUSINESS:	CONTACT:
Consumer reporting agencies, creditors and others not listed below	Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 1-877-382-4357
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 800-613-6743
Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)	Federal Reserve Consumer Help (FRCH) P O Box 1200 Minneapolis, MN 55480 Telephone: 888-851-1920 Website Address: www.federalreserveconsumerhelp.gov Email Address: ConsumerHelp@FederalReserve.gov
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)	Office of Thrift Supervision Consumer Complaints Washington, DC 20552 800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institution's name)	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 703-519-4600
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Consumer Response Center, 2345 Grand Avenue, Suite 100 Kansas City, Missouri 64108-2638 1-877-275-3342
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	Department of Transportation , Office of Financial Management Washington, DC 20590 202-366-1306
Activities subject to the Packers and Stockyards Act, 1921	Department of Agriculture Office of Deputy Administrator - GIPSA Washington, DC 20250 202-720-7051