Peer Review Credentialing Application

*Please note, if you have an active and current CAQH application, attested to within the past six (6) months, you may download and submit this application **in lieu** of completing Kepro's Credentialing application.*

If you choose to send your CAQH Application, you must also complete the Supplemental Questionnaire and submit your CV.

Dear Peer Reviewer Applicant:

Thank you for your interest in the Kepro Peer Review Program as it signals your commitment to a significant objective – continuing improvement of the quality and utilization of health care services. We fully appreciate the value of your time and earnestly suggest that your participation in the peer review process in today's healthcare climate is close to an ethical imperative.

Kepro is a nationally recognized provider of healthcare management solutions in both state and federal government, as well as commercial clients, providing prior authorization, utilization and specialty review, and case and disease management services.

To accomplish our objectives, Kepro must have sufficient numbers of qualified peer reviewers who must meet the following criteria. The peer reviewer:

- Shall have a minimum of five (5) years active practice experience, providing direct clinical care to patients as recent as within the past three (3) years
- Are Doctors of Medicine, Osteopathic Medicine, Dentistry, Podiatry, or other Allied Health Care Practitioners
- Holds an active, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States
- Must be Board Certified in a specialty recognized by the American Board of Medical Specialties, the Advisory Board of Osteopathic Specialists, the American Dental Association (ADA), the American Board of General Dentistry (ABGD), the American Board of Podiatric Surgery (ABPS), or the American Board of Podiatric Medicine (ABPM)
- Must be located within the United States or one of its territories when conducting an internal appeal or external review

Kepro can then ensure that all quality and utilization determinations completed and follow-up actions taken are the result of true peer review. Kepro provides liability coverage for peer reviewer activities. The reviewer's name will remain confidential, except in instances where identification is required by law or by specific contract. Kepro provides compensation for our reviewers based on the type of review or service being requested and/or amount allowed by the individual customer for whom the work is being performed. Compensation of services will be made within 30 days of receipt of the completed report and invoice.

While Kepro cannot guarantee any pre-established volume commitments, your approval as a credentialed peer reviewer will present you with opportunities to work with our organization in both the private and public sector. Please contact our Credentialing Department at KeproCredentialing@kepro.com with questions. We look forward to your participation in the peer review process.

~Kepro Credentialing

INSTRUCTIONS FOR COMPLETING THE PEER REVIEWER APPLICATION AND CREDENTIALING PROCESS

Keystone Peer Review Organization (Kepro) and its subsidiary companies contract with various state and federal government agencies, as well as commercial insurance entities, to perform review. Individual contracts have unique requirements for documentation of reviewer credentials. The questions asked and information sought on the forms that follow are either requirements of those contracts and/or will facilitate our staff in contacting you regarding performance of review services. The Kepro application packet includes:

1. **Peer Reviewer Application:**
   This form collects information about your office, licensure, potential conflicts of interest, and experience. It includes questions applicable to Peer Reviewer Small Business Administration (SBA) information, which helps Kepro comply with federal government contracting requirements. Please complete this portion to allow Kepro to comply with contract requirements.
   Note: The SBA section of the application requires your signature.
   ****All applicants must complete this application.****

2. **Review Agreement:**
   This agreement explains the obligations of a peer reviewer and requests each applicant to specify those review types which he/she agrees to perform.
   ****All applicants must complete this Agreement.****

3. **HIPAA/Confidentiality Agreement:**
   This form is to acknowledge the applicant’s understanding of confidentiality and disclosure policies.
   ****All applicants must read this policy, complete this Agreement, and complete the on-line HIPAA/Code of Conduct/Conflict of Interest (COI)/Ethics training. Instructions will follow.****

4. **Authority to Release Information:**
   To meet the requirements of certain contracts, a copy of this form may need to be submitted to the Medical Staff President (or designee) of the facility in which you primarily practice and maintain staff privileges for confirmation of such privileges. ****This release must be completed by all applicants in order to ensure authorized release of confidential information.****

5. **Click the Submit button at the bottom of the last page of this document and attach a copy of your CV with the application.**

KEPRO CREDENTIALING / RE-CREDENTIALING APPLICATION

IDENTIFICATION INFORMATION		
(Click on the ***TAB*** key to move to next field)		
Date		
Last Name		
First Name		
Middle Initial		
Prefix		
Suffix (Jr., Sr., etc.)		
Title (e.g., MD, RN, MSW)		
SSN #		
NPI #		
Tax ID #		
Is Tax ID business or personal?	Business	Personal
HOME INFORMATION		
Do you prefer to be contacted at home?	Yes	No
Preferred Method of Contact (email, cell phone, other phone)		
Address 1		
Address 2		
City	State	Zip Code
County		
Phone		
Fax	Pager	Cell Phone
Email		
OFFICE INFORMATION		
Do you prefer to be contacted at your office?	Yes	No
Preferred Method of Contact (email, cell phone, other phone)		
Business Name		
Contact Person		
Contact Title		
Email Address		
Address 1		
Address 2		
City	State	Zip Code
Phone	Cell Phone	

<table>
<tr><th colspan="2">LICENSURE INFORMATION</th></tr>
<tr><td colspan="2">☐ Physician ☐ Allied Health</td></tr>
<tr><td>License Number
Type
State
Expiration Date</td><td>☐ Expired, not renewing
☐ This is a restricted License</td></tr>
<tr><td>License Number
Type
State
Expiration Date</td><td>☐ Expired, not renewing
☐ This is a restricted License</td></tr>
<tr><td colspan="2">For additional Licenses, please list information below</td></tr>
<tr><th colspan="2">BOARD CERTIFIED SPECIALTIES (MDs and DOs only)</th></tr>
<tr><td>Specialty
Effective Date</td><td>☐ This is a time-limited certification that expires:
☐ This is a lifetime certification
☐ I am willing to review this specialty</td></tr>
<tr><td>Subspecialty</td><td>☐ This is a time-limited certification that expires:
☐ This is a lifetime certification</td></tr>
<tr><td>Specialty
Effective Date</td><td>☐ This is a time-limited certification that expires:
☐ This is a lifetime certification
☐ I am willing to review this specialty</td></tr>
<tr><td>Subspecialty</td><td>☐ This is a time-limited certification that expires:
☐ This is a life-time certification</td></tr>
<tr><th colspan="2">SPECIAL QUALIFICATIONS:
Please provide a list of your special qualifications</th></tr>
<tr><td>For Allied Health professionals, please identify your certifications.</td><td></td></tr>
<tr><td>For all applicants, please identify expertise you offer Kepro (Examples: languages other than English, expertise with particular settings, experience in specific contracts, such as HRSA or BFCC areas). Type as many as you have, separated by commas.</td><td></td></tr>
</table>

Kepro

GENERAL QUESTIONS	
Are you currently involved in active practice?	☐ **Yes** ☐ **No** If yes, please estimate your average hours per week:
Are you currently involved in clinical teaching?	☐ **Yes** ☐ **No** If yes, please estimate your average hours per week:
Have you ever provided direct patient care?	☐ **Yes** ☐ **No** If yes, enter the date you started providing direct patient care: *Note: If your direct patient care has had periods of interruption, please enter the date that you most recently started providing direct patient care.*
Do you currently provide direct patient care?	☐ **Yes** ☐ **No** If yes, please estimate your average hours per week: If no, please indicate month and year you stopped providing direct patient care:
Do you have any gaps in work history?	☐ **Yes** ☐ **No** If yes, please explain. Please specify the amount of time that lapsed in work history, if greater than three months:
Have your privileges to practice been abridged or suspended in any way, or is any action now pending?	☐ **Yes** ☐ **No** If yes, please explain:
Do you currently have any charges or sanctions filed against you in a criminal, civil, or administrative proceeding, or do you have reason to believe that such charges or sanctions will be filed?	☐ **Yes** ☐ **No** If yes, please explain:
Have you ever entered a plea of guilty or nolo contendere where the offense involved the use or delivery of a controlled substance? If your conviction has been expunged, please answer No.	☐ **Yes** ☐ **No**
Have you ever been enrolled in any Professional Health Monitoring Program (PHMP)?	☐ **Yes** ☐ **No** If *Yes*, please provide the reason for your participation and the dates in which you were in PHMP. If yes, *h*ave you successfully completed the program? ☐ **Yes** ☐ **No**
Do you have utilization/quality assurance or peer review experience?	☐ **Yes** ☐ **No** If yes, give area of expertise and number of years' experience:
Are you willing to testify?	☐ **Yes** ☐ **No**
Do you have ABQAURP certification?	☐ **Yes** ☐ **No** Date of certification:
Are you willing to complete Expedited Reviews?	☐ **Yes** ☐ **No**

COMPLIANCE TRAINING

The following courses are a requirement of Kepro. If you have completed any of these courses in the last 15 months, you may submit documentation of completion. Courses that you have completed must cover the topics outlined. Preferred sources of external content include CMS/HHS/Medicaid and Medicare provider-required training, commercial trainings published by SAI Global, Navex, LawRoom, and similar training providers, which focus on healthcare related topics.

Ethics and Code of Conduct:	Ethics & Code of Conduct (ECOC) includes important content about using a Code of Conduct, including its purpose, employees' and managers' responsibilities, consequences for Code violations, resources for questions and reporting and information about non-retaliation. It also addresses Anti-Bribery; Confidential Information; Conflicts of Interest; Data Privacy; Gifts and Entertainment; Political Activities; Speaking on Behalf of our Organization; and Workplace Violence and Abusive Conduct.
Conflicts of Interest:	Conflicts of Interest provides critical guidance on recognizing and handling conflicts – or potential conflicts – that can threaten organizational integrity. Learners will explore how conflicts in key areas, including outside activities, financial and business interests, and personal relationships can harm their employer and put jobs at risk.
HIPAA Fundamentals:	This course helps those organizations meet the training requirements found in HIPAA's Privacy and Security Rules. It does this by offering an engaging, informative look at learners' obligations under the law to properly safeguard and control the use and disclosure of protected health information (PHI). It includes tips and best practices for fulfilling those responsibilities as well as important insights on the notification and reporting processes and procedures to follow if a HIPAA violation is suspected.
Healthcare Fraud Prevention:	This training helps to recognize and prevent the most common types of healthcare fraud: physician self-referrals (Stark law), kickbacks, and false claims. Users learn about risks related to certain activities and the role of exceptions and safe harbors. They also learn the importance of documenting financial relationships with physicians, the need for accuracy in filing claims with government health programs, the penalties for violations, and what to do if a violation is discovered.

I have taken compliance courses at another entity that may meet the requirements of Kepro. The following courses have been completed within the last 15 months. Please send certificates of completion OR list the courses below:

Topic	**External Course Name**	**External Course Content Provider**	**Date Completed**
HIPAA Privacy and Security			
Fraud, Waste, and Abuse			
Ethics			
Conflict of Interest			

Peer Reviewer Acknowledgement	
I acknowledge that all information provided in this application and disclosure is true, correct, and complete to the best of my knowledge and belief. I will notify Kepro within three (3) business days of any material changes to the application. I understand and agree that any material misstatement or omission in this application may constitute grounds for denial or revocation of participation. I acknowledge that I have read this application in its entirety. I further agree that a photocopy of this document may serve as a duplicate original. Facsimile signatures or signatures imprinted in an electronic medium, such as .pdf format, shall be deemed to be original signatures.	
I have reviewed and agree to the Peer Reviewer Acknowledgement as outlined above.	☐ **Yes** ☐ **No**
By typing my name, I acknowledge that I have read and understood this application/document in its entirety and agree to the content of this document.	
Date signed	

Note: *Any firm that has misrepresented its status in the above listed categories in order to obtain a subcontract from Keystone Peer Review Organization, Inc., will be subject to the punishments as defined in 115 U.S.C.645(d) and FAR 52-219-9 (e).*

Signature of this form constitutes certification of compliance with all provisions within this form.

REVIEW AGREEMENT

My signature at the conclusion of this agreement indicates my willingness to participate as a peer reviewer when requested by Kepro or its subsidiaries and to conduct reviews in accordance with the applicable contract, URAC, or state-mandated time frames.

I understand that Kepro is relying upon the current accuracy of the information contained in my Peer Reviewer Application and will continue to rely upon its accuracy in deciding whether to request my services as a reviewer.

I further understand that I will be compensated for my peer review services based on the type of review or service and/or amount allowed by the individual contract and that compensation to me as a peer reviewer for any provision of the services required hereunder does not contain direct or indirect incentives to make inappropriate review decisions.
I agree to maintain and safeguard the confidentiality of all medical records and data received by me relevant to the performance review activities. I further agree to promptly advise Kepro of any issue with respect to a conflict of interest or perceived conflict of interest in connection with review activities.

I also agree to fully cooperate with Kepro and client personnel in connection with preparation of all time logs, administrative forms, review reports, depositions, and other oral or written testimony, which may be required in connection with my review activities.

I agree to notify Kepro within three (3) business days of any changes regarding my credentials or contact information noted within this application as well as any changes or restrictions to licensure, Drug Enforcement Administration (DEA) registration, and professional board certifications. Except to the extent specifically modified by this Agreement, I hereby ratify and affirm all authorizations, applications, consents, and agreements executed by me in connection with my acceptance by Kepro as a reviewer under the Social Security Act and other applicable regulations.

HIPAA/CONFIDENTIALITY AGREEMENT - PEER REVIEWERS

Kepro has entered into a Business Associate Agreement with a Covered Entity subject to the Health Insurance Portability and Accountability Act of 1996 and its implementing simplification regulations (45 CFR §§ 160-164) (HIPAA), which among other restrictions and conditions establish permitted uses and disclosures of Protected Health Information (PHI).

Pursuant to the terms of the Business Associate Agreement, Kepro is required to ensure that its agents (e.g., peer reviewers) and subcontractors agree to the same restrictions and conditions that apply to Kepro with respect to PHI.

In the course of providing peer review services for Kepro, you may create or receive PHI from or on behalf of Kepro, or a Covered Entity, or have access to PHI. Therefore, the following restrictions and conditions with respect to PHI apply to you as a peer reviewer:

I. DEFINITIONS

Terms used but not otherwise defined in this HIPAA Agreement shall have the same meaning as those terms in 45 C.F.R. §§ 160.103 and 164.501.

II. PERMITTED USES AND DISCLOSURES

Except as otherwise limited in this HIPAA Agreement, a peer reviewer may use or disclose PHI (1) to perform functions, activities, or services for, or on behalf of, Kepro and/or Covered Entity as directed by Kepro or in this HIPAA Amendment, provided that such use or disclosure would not violate HIPAA if made by Kepro or Covered Entity or (2) as required or permitted by applicable law, rule, regulation, or regulatory agency or by any accrediting or credentialing organization to whom the Covered Entity, Kepro, or the peer reviewer is required to disclose such PHI. In addition,

i. Peer reviewer may disclose PHI, if necessary, if the following requirements are met:
   a. The disclosure is required by law; or
   b. Peer reviewer obtains reasonable assurances from the person to whom the information
      is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies peer reviewer of any instances of which it is aware in which the confidentiality of the PHI has been breached.

ii. *Peer reviewer may use PHI to provide Data Aggregation services to Kepro or Covered Entity* as permitted by HIPAA.

a. Restrictions: Peer reviewer shall not use or disclose PHI for any other purpose not described above.

b. Appropriate Safeguards: Peer reviewer shall implement appropriate and reasonable safeguards to prevent use or disclosure of PHI other than as permitted in this HIPAA Amendment. When reviews are performed at a location other than the Kepro office (i.e., at a reviewer's home or office), confidential information will be transported under reasonable security as follows:

1. When confidential information is transported offsite, the vehicle will be locked. Confidential information must be placed in a locked trunk whenever possible. If the vehicle does not have a trunk, the information must be kept in a covered container (i.e., a box with a lid). Unattended confidential information will be stored under lock and key.
2. When using public transportation, confidential information must be carried in a locked briefcase or suitcase or in a covered container.
3. Any confidential information mailed to or from offsite locations must be properly packaged and deposited in an official United States Post Office receptacle, delivered directly to a post office, or mailed using a mailing service, which has been approved by Kepro. The information must not be placed in private mailbox for pick-up.

c. Reporting of Improper Use or Disclosure: Peer reviewer shall report to Kepro in writing any use or disclosure of PHI of which he/she becomes aware that is not in compliance with the terms of this HIPAA agreement.

d. Mitigation: Peer reviewer shall mitigate, to the extent practicable, any harmful effect that is known to the peer reviewer of a use or disclosure of PHI in violation of the requirements of this HIPAA agreement.

III. TERMINATION

Term: The Term of this HIPAA agreement shall be effective as of the date set forth below and shall terminate when peer reviewer ceases to perform peer review services for Kepro, however, certain obligations shall survive termination of this HIPAA agreement as set forth in Section III C.

A. **Termination for Cause**: In the event that a peer reviewer materially breaches any provision of this HIPAA agreement and fails to cure or take substantial steps to cure Page 14 of 16 such material breach to Kepro's satisfaction within thirty (30) days after receipt of written notice from Kepro, Kepro will terminate the services of the peer reviewer.

B. **Return or Destruction of PHI**: Upon termination, if feasible, peer reviewer shall return or destroy all PHI received from, or created or received on behalf of, Kepro and/or Covered Entity that the peer reviewer still maintains in any form and shall retain no copies of such information. Prior to doing so, peer reviewer further agrees to recover any PHI in the possession of its subcontractors or agents. If it is not feasible to return or destroy PHI, peer reviewer shall provide to Kepro notification of the conditions that make return or destruction of PHI infeasible. Peer reviewer shall continue to extend the protections of this HIPAA agreement to such PHI and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible.

IV. MISCELLANEOUS

A. No Third-Party Beneficiaries: Nothing expressed or implied in this HIPAA Agreement is intended to confer, nor shall anything herein confer, upon any person other than Kepro, the peer reviewer, and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

B. Governing Law: This HIPAA Agreement shall be governed by and construed in accordance with the substantive law of the Commonwealth of Pennsylvania without regard to conflicts of laws, unless parties mutually agree to change governing law.

III. INDEMNIFICATION

The Parties agree to indemnify, defend, and hold harmless each other and each other's respective employees, directors, officers, subcontractors, agents, or other members of each other's workforce (collectively referred to as the "Indemnified Party") against all costs suffered by the Indemnified Party, including but not limited to any and all actual and direct losses, liabilities, fines, penalties, costs, or expenses (including reasonable attorneys' fees) arising from or in connection with a material breach of this HIPAA agreement by the Indemnifying Party. This provision shall survive the expiration or termination of this HIPAA agreement.

1. I have received, read, and understand Kepro's restrictions and conditions with respect to PHI, as detailed in this agreement.
2. I will conduct myself in accordance with these restrictions and conditions.
3. I understand that to violate these restrictions and condition will lead to immediate termination of my services by Kepro.
4. I also understand that unauthorized disclosures of medical information or PHI may lead to:
    a. a fine of not more than $1,000 and/or imprisonment for not more than six months, under the Social Security Act;
    b. criminal penalties with a maximum fine of $250,000 and up to ten years in prison for misuse of such information and civil penalties up to $100 per person per violation.

AUTHORITY TO RELEASE INFORMATION

In applying for appointment as a peer reviewer or consultant to Kepro and/or its subsidiaries, I, hereby authorize Kepro, or its representatives, to consult with Name of Applicant healthcare facilities with which I have been associated and with others who may have information bearing on my professional qualifications, clinical competence, credentials, behavior, or any other matters which may be relevant to my appointment as a peer reviewer. I release from any liability all representatives of Kepro for their acts performed in good faith and without malice in connection with evaluating me and my credentials and release from liability all individuals and organizations who provide information to Kepro, or its designees, in good faith and without malice concerning my professional qualifications, clinical competence, credentials, behavior, and other qualifications, which may be relevant to my appointment as peer reviewer including otherwise privileged or confidential information.

PEER REVIEWER APPLICATION POTENTIAL EXCLUSION

A peer reviewer applicant, at the time of initial credentialing or recredentialing, may be declined participation for the following:

1. Evidence of incompetence, meaning the gross or repeated deviation from the standard of care by failing to conform to minimal standards of acceptable and prevailing medical practice or failure to maintain appropriate professional boundaries.
2. Evidence that the applicant has engaged in any unethical conduct, including actions likely to deceive, defraud, or harm patients or the public.
3. Evidence that the applicant has been sanctioned or has sanctions pending by federal, state, or local government programs.
4. Evidence that the applicant has personally engaged in or otherwise contributed to the submission of claims for payment that were false, negligently incorrect, intentionally duplicated, or indicated other abusive billing practices.
5. Evidence that the applicant has engaged in any conduct resulting in a felony or gross misdemeanor conviction. For purposes of this provision, a plea of guilty or a plea of no contest to a felony or gross misdemeanor charge constitutes a conviction.
6. Evidence that the applicant has engaged in any sexual misconduct or in any behavior toward a patient that could be reasonably interpreted by the patient as physical, emotional, or sexual abuse or harassment.
7. Evidence of using or prescribing for self or self-administration of any controlled substance, dangerous drug (as specified in law), or alcoholic beverages, which are dangerous or injurious to the applicant, any other person public, or that the practitioner's ability to practice safely is impaired by that use.
8. Evidence of repeated acts of clearly excessive prescribing, furnishing, administering of controlled substances, repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and the medical reason for prescribing (note that in no event shall a physician or surgeon who is lawfully treating intractable pain be reported for excessive prescribing).
9. Evidence that the applicant has had hospital privileges suspended or revoked for other than the failure to sign medical records.
10. Evidence that the applicant does not hold an active, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States. Thank you for your interest in participating as a peer reviewer.

FEDERAL CONTRACTING DESIGNATION DEFINITIONS

1. **Small Business Concern –** A business concern eligible for assistance from SBA as a small business is one that is organized for profit with a place of business located in the United States. It must operate primarily within the United States or make a significant contribution to the U.S. economy through payment of taxes or use of American products, materials, or labor. Together with its affiliates, it must meet the numerical size standards as defined in the Small Business Size Regulations, 13 CFR 121. For more information, please go to Size standards (sba.gov)
2. **Woman-Owned Small Business -** A business that meets the following criteria: (a) Is at least 51 percent owned by one or more women; or, in the case of any publicly owned business, at least 51 percent of the stock of which is owned by one or more women; and (b) Whose management and daily business operations are controlled by one or more women." For more information, please go to Women-Owned Small Business Federal Contracting Program (sba.gov)
3. **HUBZone** – Historically Underutilized Business Zone. To qualify as a HUBZone small business concern, the firm must be: (a) Small; (b) Located in a "historically underutilized business zone" (HUBZone); (c) Owned and controlled by one or more U.S. Citizens; and (d) One that at least 35 percent of its employees reside in a HUBZone. For more information, please go to HUBZone program (sba.gov)
4. **Self-Certified Business -** A small business must be at least 51 percent owned and controlled by a socially and economically disadvantaged individual or individuals. African Americans, Hispanic Americans, Asian Pacific Americans, Subcontinent Asian Americans, and Native Americans are presumed to qualify. Other individuals can qualify if they show by a preponderance of evidence that they are disadvantaged. All individuals must have a net worth of less than $750,000, excluding the equity of the business and primary residence. Successful applicants must also meet applicable size standards for small businesses in their industry. For more information, please go to Size standards (sba.gov).
5. **Veteran-Owned Small Business -** A small business concern where: (A) Not less than 51 percent of which is owned by one or more veterans (as defined at 38 U.S.C. 101(2)) or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more veterans; and (B) The management and daily business operations of which are controlled by one or more veterans. According to 38 U.S.C. 101 (2), veteran is defined as "a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable." For more information, please go to Veteran-owned businesses (sba.gov).
6. **Service-Disabled Veteran-Owned Small Business -** A small business concern where:(A) Not less than 51 percent of which is owned by one or more service-disabled veterans or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more service-disabled veterans; and (B) The management and daily business operations of which are controlled by one or more service-disabled veterans or in the case of a veteran with permanent and severe disability, the spouse or permanent caregiver of such veteran. A service-disabled veteran means a veteran, as defined in 38 U.S.C. 101(2), with a disability that is service-connected, as defined in 38 U.S.C. 101(16). From U.S.C. 101 (16), the phrase service connected (in terms of service disabled) means: "with respect to disability or death, that such disability was incurred or aggravated, or that the death resulted from a disability incurred or aggravated, in line of duty in the active military, naval, or air service." For more information, please go to Veteran-owned businesses (sba.gov).

Save a copy for your personal record.

Email this application along with your CV to keprocredentialing@kepro.com.