OhioHealth

CREDENTIALING APPLICATION: CURRENT OHIOHEALTH PHYSICIAN

Application Process

This application is for any physician currently on an OhioHealth Hospital medical staff who wishes to add additional OhioHealth hospital(s). OhioHealth Credentialing Services (OHCS) will be your main contact for information regarding the non-hospital specific portion of your application. In addition to the requirements of this application, you may be asked to provide additional information in order to complete the credentialing process.

There are three (3) parts of the credentialing process which you must complete in their entirety.

1. **CAQH Application:** Located at https://proview/caqh.org
2. **OhioHealth Supplemental Documents:** Return completed documents:
   Email: OhioHealthCredentialing@ohiohealth.com
   Fax: 614-566-0401
3. **Hospital-Specific Documents/Information:** Provided by hospital(s) upon receipt of application

OHCS will review your CAQH Application and OhioHealth Supplemental Documents. When these items are determined to be complete, your application will be released to each hospital to which you are applying. Each hospital will process your application concurrently with OHCS and will provide the Hospital-Specific Documents/Information required to complete your credentialing at that campus.

Application Fee

Application fee must be received in order for your application to be processed for any of the OhioHealth hospitals. Please note, this is a one-time non-refundable fee. Fees listed below effective 7/1/2024.

Fee for 1 entity – $625	Fee for 6 entities – $1200	Fee for 11 entities - $1775
Fee for 2 entities – $740	Fee for 7 entities – $1315	Fee for 12 entities - $1890
Fee for 3 entities – $855	Fee for 8 entities - $1430	Fee for 13 entities - $2005
Fee for 4 entities – $970	Fee for 9 entities - $1545	
Fee for 5 entities – $1085	Fee for 10 entities - $1660	

Credit card payments can be processed at https://ohiohealthcrede.securepayments.cardpointe.com/pay
If you have questions or require other payment options, please call 614-566-0010 or 1-800-455-4460.

OhioHealth Credentialing Contact List

OHCS: (800) 455-4460
(614) 566- 0010
Berger Hospital: (740) 420-8361
Doctors Hospital: (614) 544-2236
Dublin Methodist Hospital: (614) 544-8040
Grady Memorial Hospital: (740) 615-1045
Grant Medical Center: (614) 566-9346
**Grant Medical Center includes Pickerington Methodist Hospital & Grove City Methodist Hospital*
Hardin Memorial Hospital: (740) 383-8659
Mansfield Hospital: (419) 526-8581
Marion General Hospital: (740) 383-8665
O'Bleness Hospital: (740) 592-9492
Riverside Methodist Hospital: (614) 566-5052
Shelby Hospital: (419) 526-8581
Southeastern Medical Center: (740) 439-8103
Van Wert Hospital: (419) 238-8627

PLEASE NOTE: It is ultimately your responsibility to provide all required documentation so that it can be verified. Your application will remain pending until all required information is received.

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Applicant Checklist

This checklist should be utilized as a tool for completing the application. The documents listed below are considered to be, in their entirety, your credentialing application. Please note that your application will not be considered or processed until all of these documents are completed, as instructed, and received.

☐ **CAQH on-line application is complete:**
- The CAQH must be updated and re-attested within 4 weeks of your application to an additional OhioHealth facility being returned to OhioHealth. If you need assistance completing your CAQH application, contact CAQH at https://proview.caqh.org or call 888-599-1771

☐ **Application Fee**

☐ **Current copy of the Curriculum Vitae/Resume**
- Start and end dates for Education and Work History must be in **month/year** format

☐ **Gap in Timeline**
- For practitioners who have been on staff at an OhioHealth hospital(s) less than 5 years, any gaps in the practitioner's professional timeline that span greater than 3 months within the past 5 years require an explanation

☐ **Intended Practice Plan/Alternate Coverage**

☐ **Criminal Background Disclosure**
** Any physician who joined an OhioHealth medical staff after January 2009 and has not been fingerprinted will be required to obtain fingerprints in order to join another OhioHealth hospital.

☐ **Completed Provider Information Specific to Credentialing**

☐ **Conflict of Interest/Verification of Employment History/Malpractice Claims History**

☐ **Radiation Safety Questions**

☐ **Documentation of Peer References**

☐ **Medicare/Tricare/Livanta Patient Penalty Statement**

☐ **Signed/Dated Physician & Allied Health Professional Ethics and Compliance Program Information**

☐ **Standard Authorization, Attestation and Release**

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Intended Practice Plan

OhioHealth Hospitals Membership and/or Clinical Privileges: Check all that apply and complete the table below for each hospital to which you are applying. You must indicate why you want to practice at each facility.

NOTE: Designated alternate physician(s) must be a current member of the Medical Staff with similar privileges at the hospital(s) to which you are seeking privileges. It is your responsibility to update the Medical Staff Services Office if your designee for coverage changes.

HOSPITAL	ALTERNATE PHYSICIAN(S)/GROUP	INTENDED PRACTICE PLAN (e.g. Consultations, Surgery)
☐ Berger Hospital		
☐ Doctors Hospital		
☐ Dublin Methodist Hospital		
☐ Grant Medical Center (Includes Pickerington Methodist Hospital & Grove City Methodist Hospital)		
☐ Grady Memorial Hospital		
☐ Hardin Memorial Hospital		
☐ Mansfield Hospital		
☐ Marion General Hospital		
☐ O'Bleness Hospital		
☐ Riverside Methodist Hospital		
☐ Shelby Hospital		
☐ Southeastern Medical Center		
☐ Van Wert Hospital		

Name of Your Current Primary OhioHealth Hospital: _____

Practice Name: Midwest Physician Anesthesia Services Inc Tax ID: 31-1039177
(Associated with this application)

Provider Information for the OhioHealth Clinical Directory

At the time of your initial appointment, you were asked to provide the following: email address, specialty, office phone number, office fax, pager type, pager vendor and your preferred method of contact from hospital staff for patient care purposes. If there have been any changes to this information, please go to https://clinicianportal.OhioHealth.com to update information as needed.

Applicant Printed Name	Applicant Signature	Date
_____	_____	_____

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Criminal Background Disclosure

Have you ever been convicted of, plead guilty, no contest or nolo contendere to a misdemeanor or felony, other than a minor traffic violation? (Note: a DUI or DUI reduced to reckless operation is not considered a minor traffic violation.) Do not report any conviction that has been sealed, expunged, statutorily eradicated, annulled, impounded, erased, dismissed, dismissed under a first offender's law, pardoned by the Governor or which state law allows you to lawfully deny. This background check will identify information greater than 10 years. **Failure to disclose will add processing time to your application.**

☐ No ☐ *Yes

*If yes, please explain below and include a separate sheet if necessary.

_____

_____

_____

NOTICE TO APPLICANTS

OhioHealth or affiliate including OHCS (collectively, "OhioHealth") may obtain information about you from a consumer reporting agency made in connection with your application for membership and/or privileges at an OhioHealth facility. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews. These reports may contain information including, but not limited to: verification of identification, and/or Social Security number; checks of criminal history; verification of employment; verification of education; credentials and/or licensures; sanctions/exclusions from Medicare/Medicaid and/or other information on your background or history in connection with your application for membership and privileges at an OhioHealth facility. Upon a written request made to OHCS, and within 5 days of the request, the name, address and phone number of the reporting agency and the nature and scope of the report will be disclosed to you. Before any adverse action is taken, based in whole or in part on the information contained in the report, you will be provided a copy of the report, the name, address and telephone number of the reporting agency, a summary of your rights under the Fair Credit Reporting Act, as well as additional information on your rights under the law.

** If you completed fingerprinting at the time of your initial credentialing at any OhioHealth Hospital or joined the Medical Staff prior to January 2009, your criminal background will be verified through the Employment Screening Associates (ESA) service. If you joined an OhioHealth medical staff after January 2009 and have not been fingerprinted, you will be required to obtain fingerprints in order to join another OhioHealth hospital.

_____	_____	_____
Applicant Printed Name	Applicant Signature	Date

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PROVIDER INFORMATION SPECIFIC TO CREDENTIALING

Please provide the following information so that we can ensure our records are up to date:

Provider Home Address: _____

Provider Cell Phone Number: (____) _____

Provider Email Address: _____

Provider CAQH Number: _____

Conflict of Interest

The following two questions must be answered by all applicants:

1) Do you hold a direct or indirect ownership interest in an inpatient hospital located within the state of Ohio? (For purposes of this question, "indirect ownership" means that another person or entity may own the interest, but you will receive a benefit from it, e.g., ownership by a spouse, employer, pension program or beneficial trust).

☐ No ☐ *Yes

*If yes please explain: _____

_____

2) If the answer to question 1 is "no": are you in a profit-sharing arrangement with a person or entity that holds a direct or indirect ownership interest in an inpatient hospital located within the state of Ohio?

☐ No ☐ *Yes

*If yes please explain: _____

_____

Verification of Employment History

Have you ever been subject to any disciplinary action by an employer including but not limited to termination or nonrenewal of a contract for cause?

☐ No ☐ *Yes

*If yes, please provide specific details:

_____

_____

Please make sure that your CAQH application documents all employment for the past five (5) years or since your graduation from professional school, whichever is less. Please note that you only need to provide employment information for jobs in which you functioned in a clinical capacity.

Malpractice Claims History

NOTICE TO APPLICANTS

You must provide documentation of all pending and/or settled malpractice claims against you within the last 10 years. This information, including any malpractice claims since your last appointment/reappointment, MUST be listed on your CAQH Application.

_____ _____ _____

Applicant Printed Name Applicant Signature Date

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Radiation Safety

1. **Will you be present in an area where fluoroscopy is used?** ☐ Yes ☐ No
   (e.g. surgery, cath lab, endoscopy, electrophysiology lab, radiology)

   If "yes", Ohio Department of Health regulations require that you fulfill education requirements regarding radiation safety. You will be assigned two courses on OhioHealth University that must be completed before you are present in an area where fluoroscopy is used. This is a one-time requirement for those who are new to OhioHealth or have taken on a new role working in a restricted area where ionizing radiation is used.

2. **Do you plan to personally operate* fluoroscopic equipment**? ☐ Yes ☐ No
   If yes, check all that apply:
   ☐ Mini C-Arm ☐ C-Arm ☐ O-Arm ☐ Angiographic fluoro ☐ Other fluoro

   If "yes", Ohio Department of Health regulations require that you complete site specific equipment competency documentation. You will be required to meet with the manager of the department who owns the fluoroscopic equipment to have this completed before you begin operating fluoroscopic equipment. You will receive an email notifying you of the manager to contact based on the equipment you wish to operate. This is a one-time requirement for those who are new to OhioHealth or have taken on a new role working in a restricted area where ionizing radiation is used.

   ** "Operate" means using the x-ray controls directly, including stepping on the pedal to generate x-rays, operating the controls to change views or otherwise manipulating the x-ray unit. It does not mean ordering fluoroscopic procedures, directing a rad tech to operate a fluoroscope or reviewing fluoroscopic images.*

_____	_____	_____
Applicant Printed Name	Applicant Signature	Date

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Instructions for Submitting Five (5) Peer References

At the time of your initial appointment, you were asked to supply the names of 5 peer references. While we recognize this was done during the initial application process, The Joint Commission requires us to prove current clinical competence and professionalism. We believe that peer references are a valuable assessment of professional performance and therefore we require new, up-to-date references when applying to an additional OhioHealth Hospital.

Please adhere to the following criteria when submitting the names of your five (5) peer references.

Please note that an acceptable peer must have observed your clinical practice for at least 3 months and within the past 3 years and be of the same professional discipline (Physician for Physician, Podiatrist for Podiatrist, Psychologist for Psychologist etc.) NOTE: Friends and/or relatives cannot be used as references.

You may include the same 3 references listed on the CAQH application (by CAQH policy these references cannot be a relative or a partner). You must also document 2 additional names **(one of whom may be a partner or business associate)** below as long as the references meet the above requirements.

REQUIRED REFERENCES
• Program Director & Attending Physician – These are required references if you completed training within the past twelve (12) months. • Medical Staff leader at your primary OhioHealth hospital at which you currently have membership and/or clinical privileges. The Medical Staff leader (e.g., credentials chair, peer review chair, department chair, section chair, program director, or medical director) must be able to evaluate your quality and clinical competence during the past 3 years. • If you have changed practices or employers within the past three years, one (1) reference must be from a peer member of each of the previous practices or employers. The peer member must be in your professional discipline as described above. • As a current member of a medical staff at another OhioHealth Hospital references from existing partners shall be acceptable. • If applying for telemedicine privileges a required peer reference can be: o A Medical Staff leader from the most recent hospital affiliation where the Applicant has/had membership and/or clinical privileges as long as that affiliation is within the last three (3) years. **OR** o A medical director or physician leader of the company providing telemedicine services or the medical director or physician leader of the applicant's current or most recent practice who has knowledge regarding the quality and clinical competence of the applicant.

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Documentation of Five (5) Peer References

All information must be completed on this form; a separate page **will not** be accepted. Peer references are sent electronically so a current email address for each reference will be required. **Please be aware that if this information is not legible, your application will be deemed incomplete.**

Reference 1: (Program Director if graduated in the past 12 months (OR) a Medical Staff Leader at your primary OhioHealth hospital where you hold privileges.)

First Name:	**Last Name:**	**Degree:**
Phone:		
Email Address:		
This reference is my (Choose 1): ☐ ***Medical Staff Leader*** Title: _____ *e.g. Department Chair, Medical Director, etc.* ☐ ***Program Director***	**Name of Institution:** ***(where you practiced with this reference)***	

Reference 2: (Attending Physician if graduated in the past 12 months)

First Name:	**Last Name:**	**Degree:**
Phone:		
Email Address:		
Relationship	**Name of Institution:** ***(where you practiced with this reference)***	

Reference 3:

First Name:	**Last Name:**	**Degree:**
Phone:		
Email Address:		
Relationship	**Name of Institution:** ***(where you practiced with this reference)***	

Reference 4:

First Name:	**Last Name:**	**Degree:**
Phone:		
Email Address:		
Relationship	**Name of Institution:** ***(where you practiced with this reference)***	

Reference 5:

First Name:	**Last Name:**	**Degree:**
Phone:		
Email Address:		
Relationship	**Name of Institution:** ***(where you practiced with this reference)***	

_____ _____ _____

Applicant Printed Name Applicant Signature Date

MEDICARE/TRICARE/LIVANTA PATIENT PENALTY STATEMENT

The Medicare/TRICARE/Livanta health insurance program reimburses the hospital on a DRG basis. According to Medicare/TRICARE/Livanta regulations, the hospital is required to have on file a signature of each physician that confirms receipt of the Medicare/TRICARE/Livanta penalty statement. This form needs to be signed as part of the application process.

NOTICE TO PHYSICIANS

"Medicare/TRICARE/Livanta payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his/her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal law."

This notice also applies to Ohio Medicaid payment to hospitals.

My signature below acknowledges that I have received and read the above "Notice to Physicians".

_____	_____	_____
Applicant Printed Name	Applicant Signature	Date

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Physician and Allied Health Professional Ethics and Compliance Program Information

OhioHealth Hospitals (Berger Hospital, Doctors Hospital, Dublin Methodist Hospital, Grady Memorial Hospital, Grant Medical Center, Hardin Memorial Hospital, Mansfield Hospital, Marion General Hospital, O'Bleness Hospital, Riverside Methodist Hospital, Shelby Hospital, Southeastern Medical Center and Van Wert Hospital) are committed to conducting business and providing patient care in accordance with high ethical standards and compliance with applicable laws. To that end OhioHealth has created a corporate Ethics and Compliance Office and a Compliance Program.

Physicians and Allied Health Professionals associated with any OhioHealth Hospital are expected to support this Program by being knowledgeable about the Program and the regulatory requirements affecting hospital operations. Requirements vary depending upon the employment relationship of the Physician or the Allied Health Professional with the Hospital.

Ethics and compliance violations may be grounds for corrective action under the Medical Staff Bylaws or termination of employment in accordance with the terms of the employment contract.

To learn more about OhioHealth's Ethics and Compliance Program please visit the OhioHealth eSource at: https://ohesource.ohiohealth.com/departments/EthicsCompliance/GeneralCompliance/Pages/default.aspx

Reporting

Any Physician or Allied Health Professional who believes an ethics or compliance violation has occurred or is occurring within the Hospital shall report his or her concern. The report may be made to the Vice President of Medical Affairs, President of the Medical Staff or the Corporate Ethics and Compliance Office using any of the methods listed below.

- Ethics and Compliance Office: (614) 544.4200.
- OhioHealth Ethics and Compliance Hotline: (866) 411.6181.
- Emailing details to: CompliancePrivacy@OhioHealth.com.
- Submitting a report through OhioHealth's online reporting tool at www.MyComplianceReport.com using access code: OHH.

Ethics and Compliance Attestation Form

During the initial application process all Physicians and Allied Health Professionals must sign and return the Ethics and Compliance Attestation. This attestation must also be signed and returned at each reappointment. This Attestation has been approved by the Quality of Care Committee of the OhioHealth Board, and the purpose of the Attestation is to establish linkage to the Hospital's Ethics and Compliance Program and to set educational standards.

My signature below indicates that:

I have received the Physician and Allied Health Professional Ethics and Compliance Information describing the OhioHealth Ethics and Compliance Program, and at initial appointment, I received a copy of the OhioHealth Code of Conduct. I understand that these documents represent the manner in which the OhioHealth Board of Directors expects business to be conducted within the organization. I have received the OhioHealth Ethics and Compliance office phone number and the Ethics and Compliance Hotline number where issues can be reported. I also agree to report any ethics or compliance violation I believe has occurred or is occurring within the organization.

_____	_____	_____
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Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*

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INFORMATIONAL ONLY

Notification of Practitioner Rights

- Practitioners have the right to be informed of the status of their credentialing or reappointment application upon request.
- Practitioners have the right to review information obtained and used for purposes of credentials evaluation with the exception of professional references and/or any other type of information that is deemed to be privileged and confidential and/or is protected under Ohio peer review statute.
- Practitioners have the right to correct information collected from outside sources that is erroneous. Corrections to erroneous information must be made in writing and sent to OHCS within fifteen days of notification that erroneous information has been received.
- Practitioners have the right to copy only documents in their file which they have submitted with regard to their application.
- Practitioners have the right to be credentialed in a non-discriminatory manner based upon race, gender, nationality, origin, or religion.

Sharing Privileged Provider Information

By submitting an application for appointment/reappointment and/or clinical privileges or by maintaining an appointment and/or clinical privileges at an OhioHealth hospital, the Provider agrees and recognizes, consistent with such OhioHealth hospital's medical staff bylaws or other OhioHealth system- or hospital-related documents, that Privileged Provider Information (as defined below) related to the Provider will (i) be available to each OhioHealth hospital at which the Provider currently has an appointment and/or privileges; (ii) be available to each OhioHealth hospital to which the Provider is applying for appointment/reappointment and/or privileges; and (iii) be otherwise shared between such OhioHealth hospitals, on an as-needed basis, regardless of whether the Provider has signed a separate consent or authorization related to the information. For purposes of this statement, 'Privileged Provider Information' means all information from professional review activities within the purview of applicable federal and state statutes governing the confidentiality and privilege that flow to professional review documents including, but not limited to, all information related to the credentialing of providers and information related to the quality of care provided by a provider and/or hospital.