APPLICATION FOR INITIAL CREDENTIALING
Allied Health Professionals

The credentialing process for the OhioHealth hospitals is managed by OhioHealth Credentialing Services (OHCS), which is OhioHealth's central verification office. OHCS will be your main contact for information regarding the non-hospital specific portion of your application. Once a completed application is received, it can take OHCS up to 60 days to complete the background and verification process**. Please note that this timeframe does NOT include applicable Hospital committee approval, which can be an additional 30-60 days.**

There are three (3) main parts to the credentialing process. Each part must be completed in its entirety. Your application will initially be processed by OHCS and will then be passed on to each hospital to which you are applying for further processing.

1) **CAQH Application:**
   (a) Located at **https://proview/caqh.org.** See attached instructions for completion.
   (b) CAQH ID must be submitted with this paperwork. Refer to page 6 for details.
   (c) Be sure to authorize access to OhioHealth.

2) **OhioHealth Supplemental Documents**:
   (a) Completion of the attached documents is required even if you already have privileges at another OhioHealth hospital.
   (b) Submit these documents even if your Ohio license and/or DEA are pending.
   (c) **Return completed documents via email at OhioHealthCredentialing@ohiohealth.com** or fax to 614-566-0401.

3) **Hospital-Specific Documents/Information**:
   (a) Hospital-specific documents, e.g., delineation of privileges and governing documents will be sent to you directly from the respective Medical Staff Offices of the hospitals to which you are applying.
   (b) OhioHealth uses Epic, referred to as CareConnect, for our electronic medical record (EMR). If you plan to treat patients in any of the OhioHealth Hospital(s), where CareConnect has been implemented, you will be required to complete the necessary CareConnect training. You will be contacted by a CareConnect representative to schedule your training.
   (c) Questions related to this information should be directed to:

Berger Hospital: (740) 420-8361
Doctors Hospital: (614) 544-2236
Dublin Methodist Hospital: (614) 544-8040
Grady Memorial Hospital: (740) 615-1045
Hardin Memorial Hospital: (740) 383-8659
Grant Medical Center: (614) 566-9346
*Grant Medical Center includes Pickerington Methodist Hospital & Grove City Methodist Hospital
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 ensure that all required documents are obtained and verified. Your application will remain pending until all required information is received.

OhioHealth

AHP APPLICANT CHECKLIST

Please utilize this checklist as a tool for completing the application. The detailed notes are meant to assist you with the pertinent information that must accompany 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;** except those noted as voluntary forms.

- ☐ **CAQH on-line application is complete**
  - The CAQH has been updated and re-attested within the past 4 weeks from the date the applicant applied for credentialing at OhioHealth and/or OhioHealthy.
    - In addition to completing the entire application, please ensure that the CAQH application documents what group (Tax ID) the applicant is joining/getting credentialed for.
  - CAQH includes all state license(s) numbers, DEA Registration numbers and current and past insurance policies. *The CAQH application must indicate if any of these documents are pending.*
    - The applicant's DEA must have an Ohio address and considered to be "fee paid" before the applicant is scheduled to start working. (This rule does not apply to locum tenens and telemedicine physicians)
- ☐ **Gap in Timeline** – all gaps in the applicant's professional timeline that span greater than 3 months require an explanation
- ☐ **Participation Selection Page** is completed
- ☐ **Application Fee** (refer to page 5 for details).
- ☐ **Unique Provider Email address –** The email address provided will be used by OhioHealth to communicate pertinent information. This email address is NOT shared with outside organizations or with patients but may be shared within the organization. **Your unique email address must belong to you specifically and cannot be your office manager's email.**
- ☐ **Current Malpractice Insurance Face Sheet (if available at the time of submitting the application) –** the policy must document the provider's name on either the actual face sheet or an attached roster. Documentation of current malpractice insurance is necessary in order to complete the file but not required at the time of submission.
- ☐ **Current copy of the Curriculum Vitae/Resume**
  - Start and end dates for Education and Work History must be in **month/year** format
- ☐ **Intended Practice Plan/Supervising/Collaborating Coverage for the OhioHealth Hospitals**
  - Both the primary supervising/collaborating physician and intended practice plan needs to be signed and dated and populated for **all hospital entities** to which the applicant is applying.
- ☐ **Portrait Quality Color Professional Photograph** (PASSPORT photo/selfie is not acceptable)
- ☐ **Completed Conflict of Interest Questions**
  - Both questions are answered and an explanation is provided if applicable
- ☐ **Completed Provider Information Specific to Credentialing**
- ☐ **Completed OhioHealth Clinical Directory**
- ☐ **Completed Radiation Safety Questions**
  - All applicable questions are answered along with the applicant's signature and date

APP & AHP APPLICANT CHECKLIST - CONTINUED

☐ **Documentation of 5 Peer References**

- Writing must be legible
- Selected references adhere to the criteria outlined on page 10.
- The information must be documented on the form on page 11. A separate form will not be accepted.

☐ **Signed/Dated Authorization Form to conduct a Criminal Background and/or Fingerprint Process**

- Disclosure question answered and an explanation is provided if applicable

☐ **Verification of Practitioner Identification Form**

- Copy of driver's license or passport is clear and legible (including the photo)
- The date of the applicant's signature must be identical to the date the notary signed the form.
- Meets all requirements of the state where notarized
- Notary seal must be visible
- Electronic and on-line notarizations accepted

☐ **Verification of Employment History**

- Disclosure question is answered, and an explanation is provided if answered "yes"
- If applicable, a comprehensive listing of employers and corresponding malpractice carriers is included

☐ **Listing of Insurance Companies for Malpractice Claims History Verification**

- Documentation of all the malpractice carrier(s) that have insured the applicant in the past 5 years.
  - Carrier name, Phone, Fax, Policy Number and Policy Dates must be documented for each insurance company listed. Copies of past/current insurance face sheets will suffice in lieu of completing the form on page 16 if the face sheets account for a comprehensive list of the past 5 years.

☐ **Signed Malpractice Claims History Verification Release Form**

☐ **Interferon Gamma Release Assay (TB Blood Test), if applicable**

- Actual TB blood test results must be submitted. The result date of last TB blood test must be within 12 months from signed date of credentialing application.
- TB testing is not required for physicians/providers who do not work in a hospital or patient care setting and work remote only (e.g., teleradiology and other virtual health providers)

☐ **Signed/Dated OhioHealth Internet Use Agreement / Confidentiality Statement of Understanding**

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

AHP APPLICANT CHECKLIST - CONTINUED

☐ If applicable, **OhioHealthy (OhioHealthy PREFERRED and OhioHealthy NETWORK) provider agreement** is completed in its entirety

- There are a total of five signature pages that need to be completed and returned.
- The collaborating/supervising physician must be credentialed with/ will be credentialed with the same group listed on the form.

☐ If applicable, **OhioHealth Clinically Integrated Network provider addendum** is completed in its entirety

- Page 1: The date that needs to be populated on the first page of the addendum is the date that the applicant signs the addendum.
- Page 3 - check mark type of healthcare professional
  - APPs need to list all supervising or collaborating physicians that are credentialed or will be credentialed with the CIN. These physicians need to be a member of the CIN in order for the applicant to be credentialed.
  - Clinical Counselors need to list at least one collaborating physician in his/her practice.

☐ **Standard Authorization, Attestation and Release**

Voluntary Forms

☐ **Submission of Vaccination Records**

OhioHealth

Participation Selection

Place a checkmark in the box for <u>each entity</u> to which you are requesting to participate.

OhioHealthy Products

☐ **OhioHealthy PREFERRED and OhioHealthy NETWORK:** This is the network of providers for OhioHealth associates and/or employer groups. Applicants of certain specialties must be on the medical staff of a hospital contracted with the OhioHealthy PREFERRED.

OhioHealth Products

☐ **OhioHealth Clinically Integrated Network (CIN):** Applicants must be employed by a physician/group that participates in the CIN.

OhioHealth Hospitals (Membership and/or Clinical Privileges) *(check all that apply)*

- ☐ Berger Hospital
- ☐ Doctors Hospital
- ☐ Dublin Methodist Hospital
- ☐ Grady Memorial Hospital
- ☐ Grant Medical Center *(Includes Pickerington Methodist Hospital and Grove City Methodist Hospital)*
- ☐ Hardin Memorial Hospital
- ☐ Mansfield Hospital
- ☐ Marion General Hospital
- ☐ O'Bleness Hospital
- ☐ Riverside Methodist Hospital
- ☐ Shelby Hospital
- ☐ Southeastern Medical Center
- ☐ Van Wert Hospital

<u>Application Fee:</u> Application fee **MUST** be received in order for your application to be processed for any of the above hospitals. Fees listed below effective 7/1/2024.

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

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.
Please note the application fee is a one-time fee and is non-refundable once the primary source verification has been initiated.

OhioHealth

INTENDED PRACTICE PLAN

*Please check (✓) each hospital where you are applying for privileges. List your primary Supervising/Collaborating physician and the detail how you will practice at **each** hospital.*

NOTE: Primary Supervising/Collaborating physician(s) must be a member of the Medical Staff with appropriate privileges at the hospital(s) where you are seeking privileges. It is your responsibility to update the Medical Staff Services Office if your primary Supervising/Collaborating physician(s) changes.

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

If you have questions regarding this form, please contact the applicable Medical Staff Services Office at the hospital(s) where you are applying. Phone numbers for each hospital are listed on the first page of this packet.

Signature Date

Printed Name

COMPLETING THE CAQH APPLICATION

The CAQH application is an online service where practitioners can provide standardized credentialing information to multiple organizations without filling out multiple forms. By signing the CAQH Standard Authorization, Attestation and Release form you understand the term "Entity" applies to any of the entities that OHCS provides credentialing services on your behalf.

If you have any questions regarding your CAQH ID number, username, password, an incomplete application, unapproved document, etc., please refer to the CAQH website at https://proview.caqh.org or call the CAQH Help Desk at 1-888-599-1771. New users can also register on the CAQH website by clicking on "Self-Register." The CAQH ID Number will be sent to the email address provided during registration.

- If you are already a CAQH Provider, list your ID. **My CAQH Provider ID Number is: _____**
- If you do NOT have a CAQH ID number, you are able to self-register on the CAQH website. The Provider Registration Email with the ID Number will be sent to the primary method of contact email address set up at time of registering. Make sure to list your ID Number above.

THE CAQH ONLINE APPLICATION MUST BE COMPLETED IN ITS ENTIRETY OR THE APPLICATION WILL BE DEEMED INCOMPLETE BY OHIOHEALTH CREDENTIALING SERVICES. PLEASE MAKE SURE THAT THE CAQH APPLICATION IS REFLECTIVE OF ANY NEW ACTIVITY (PRACTICE LOCATION, CURRENT MALPRACTICE CLAIMS, HOSPITAL AFFILIATIONS, ETC.)

GENERAL STEPS TO COMPLETE THE CAQH APPLICATION

1. **General Info:** Enter identification information in every section of the online application.
2. **Credentialing Contact:** This is the person responsible for credentialing at the practice the applicant is joining (if a solo practice, please enter the applicant's information).
3. **Practice Info:** We need to know what group (Tax ID) the applicant is joining – specifically – start date, group name, Tax ID, and primary and billing addresses. If there are issues with the current practice's knowledge of the applicant leaving, please contact the OhioHealth Credentialing Services office at 614-566-0010 for assistance.
4. **Malpractice Claims:** List any pending and/or settled malpractice claims. All claims against the applicant within the last 10 years, regardless if they are pending or settled, must be listed on the CAQH Application.
5. **Review:** Once all data entry is complete, the data needs to be audited. If any required fields are missing information, these need to be completed before progressing.
6. **Attest:** Once the audit is complete, the applicant needs to attest the application. Then, the data will be "entered" and appear complete.
7. **Supporting Documents:** After completion, the applicant needs to upload any required supporting documents directly into the system. This includes the Attestation & Release and any other documents based on the data entry such as DEA and Malpractice.
8. **Activity Log:** Documents can also be uploaded as the application is being completed. To do so, follow these steps:
    a. The "Documents" or "Review" pages will inform the applicant what documents are needed to complete the application.
    b. Upload the supporting documents (ex. Attestation & Release, DEA certificates, Malpractice) directly to CAQH ProView by following the instructions.
9. **Completion:** Once the application is complete and the supporting documents are reviewed for accuracy, the applicant's information will become available to the organizations that were authorized. The applicant needs to check with each individual organization to determine his/her credentialing status. If a document is not approved, an email will be sent to the user, indicating that the application is incomplete.
10. **Re-Attesting:** The CAQH application needs to be **re-attested every 120 days** to retain a "current" status. If the application does not remain current, it will change to an "expired" status and any entity the applicant participates with will be unable to process the application. The profile can be updated by clicking on "Manage Information," upload new documents by clicking on "Documents," and finish by clicking on "Attest."

If the applicant is coming from out of state, he/she must also change the primary practice state to Ohio.
In the beginning of the application process, there is a section for the provider type and primary practice state. Please list Ohio. Some states have a state mandated application and in that instance we cannot credential the applicant until an Ohio application is accessible. Please note the applicant will be required to also sign/date and fax an updated Attestation & Release form if coming from out of state. ***Failure to do this will delay the credentialing process.***

OhioHealth

SUBMISSION OF A PROFESSIONAL PHOTOGRAPH

A professional photograph of the applicant is required.

- ☐ The photograph must meet the following requirements to be considered acceptable.
- ☐ Must be in color *and* be a recent photograph; plain or studio backdrop, natural lighting or from studio lighting
- ☐ Attire should be professional (i.e. suit, lab coat); body should be at a slight angle with head turned to lens
- ☐ Wallet size or larger (Passport photos are NOT acceptable)
- ☐ All photos should be saved and submitted in .jpg format.

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).

*Yes ◯ No ◯

*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?

*Yes ◯ No ◯

*If yes, please explain:_____

PROVIDER INFORMATION SPECIFIC TO CREDENTIALING

Fields that are highlighted on this page must be completed in its entirety.

Applicant Name_____Degree_____

Name of Your Current Primary Hospital _____

Will your primary hospital named above change once you are credentialed with this group? ___◯___NO ___◯___YES

*If yes, name of upcoming Primary Hospital_____

Practice Name: **Midwest Physician Anesthesia Services, Inc** Tax ID: **31-1039177**

Practice Manager: **Pam Brown**

Credentialing Contact: _____Phone Number: (___)**614-884-0641** ext. _____

Credentialing Contact's Email Address: _____

Preferred Mailing Address for Medical Staff Correspondence:

5151 Reed Rd, Ste 225-C, Columbus, Ohio 43220

Street Address City State Zip Code

OhioHealth

PROVIDER INFORMATION for the OHIOHEALTH CLINICAL DIRECTORY

The information requested below will be used to populate the OhioHealth Clinical Directory and to provide contact information for patient care purposes at OhioHealth Hospitals. This email address is NOT shared with outside organizations or with patients but may be shared within the organization.

Provider Name: _____
Last First MI Degree

Provider Email Address: _____ Specialty: _____ ☐ Specialist ☐ PCP

Office #: (___)614-566-4919 Fax #: (___)614-566-6993 Pager #: (___) _____
Preferred fax # for patient matters

Pager Type (circle one): Numeric or Alpha Name of Pager Vendor (i.e. USA Mobility): _____

*Cell Phone #: (___) _____ *(*Required in order to obtain remote access to OhioHealth computer systems)*

Please indicate the order in which you prefer to be contacted by hospital staff for patient care purposes: (Ex: *1. Cell 2.Office 3.Pager*)

Contact Preference: 1._____ 2._____ 3. _____

Indicate any contact numbers that are considered private. These numbers will only be accessed by the hospital operators, and will NOT be viewable by the clinical staff. ***Please note that you CANNOT list a private number as a contact preference.*** _____

Other Special Instructions/Miscellaneous Contact Information that is essential for contacting you:

_____

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.*

PRINTED NAME **SIGNATURE** **DATE**

INSTRUCTIONS FOR SUBMITTING FIVE (5) PROFESSIONAL REFERENCES

You are required to submit the names of 5 professional references. The specific references that are required for credentialing is dependent upon your training pathway. Please adhere to the following criteria when submitting the names of your professional references.

- An **acceptable reference** must have **observed your clinical practice as an advanced practice provider/allied health professional within the past 3 years and be able to attest to your current clinical competence.** An acceptable reference must also hold the same license (ex. Certified Nurse Practitioner for Certified Nurse Practitioner, Physician Assistant for a Physician Assistant, etc.) with similar clinical privileges.
- A registered nurse (RN) is not an acceptable peer.
- Physicians are considered to be appropriate references.
- Please note, friends and/or relatives are not an acceptable reference.
- If you are an advanced practice nurse who is currently working at a Hospital where you previously functioned as a RN, your references must have observed your clinical practice as an advanced practice nurse and not as a registered nurse.

REQUIRED REFERENCES

- **Program Director** – This is a required reference if you completed classroom or online training within the past twelve (12) months *OR* if you have not previously held clinical privileges in the past three (3) years from graduation.
- **Preceptor** – This is a required reference if you graduated from an online training program within the past twelve (12) months.
- **Supervising/Collaborating Physician** – This is a required reference if you have ever had either a Standard Care Arrangement or Supervision Agreement with a physician as an Advanced Practice Provider. You are required to submit the name of a current/most recent supervising or collaborating physician.
- If you have changed practices or employers within the past three years, one (1) reference must be from a supervising/collaborating physician from each of your previous practices or employers.

OTHER ACCEPTABLE REFERENCES IN ADDITION TO REQUIRED REFERENCES

REFERENCES MUST HAVE OBSERVED YOUR CLINICAL PRACTICE
AND BE ABLE TO ATTEST TO YOUR CURRENT CLINICAL COMPETENCY.

- **Peer** - A provider who works in the same discipline and holds the same license as you, and is knowledgeable about the quality of your performance.
- **Current Supervising/Collaborating Physician**
- **Preceptor**

OhioHealth

DOCUMENTATION OF FIVE (5) PROFESSIONAL REFERENCES

PLEASE WRITE LEGIBLY. IF THIS INFORMATION IS NOT LEGIBLE, THE APPLICATION WILL BE DEEMED INCOMPLETE.

ALL fields must be completed in its entirety and on this form. A separate page will not be accepted. An email address is required as the reference request is submitted electronically.

Reference #1 (REQUIRED REFERENCE)

First Name:	Last Name:	Degree :
Phone:		
Email Address		
Name of School/Hospital:		
Relationship: ☐ Program Director ☐ Supervising/Collaborating Physician		

Reference #2

First Name:	Last Name:	Degree :
Phone:		
Email Address		
Name of School/Hospital:		
Relationship: ☐ Program Director ☐ Preceptor ☐ Supervising/Collaborating Physician ☐ Peer with the same licensure & similar clinical privileges		

Reference #3

First Name:	Last Name:	Degree :
Phone:		
Email Address		
Name of School/Hospital:		
Relationship: ☐ Program Director ☐ Preceptor ☐ Supervising/Collaborating Physician ☐ Peer with the same licensure & similar clinical privileges		

Reference #4

First Name:	Last Name:	Degree :
Phone:		
Email Address		
Name of School/Hospital:		
Relationship: ☐ Program Director ☐ Preceptor ☐ Supervising/Collaborating Physician ☐ Peer with the same licensure & similar clinical privileges		

Reference #5

First Name:	Last Name:	Degree :
Phone:		
Email Address		
Name of School/Hospital:		
Relationship: ☐ Program Director ☐ Preceptor ☐ Supervising/Collaborating Physician ☐ Peer with the same licensure & similar clinical privileges		

CRIMINAL BACKGROUND INVESTIGATION

- All new applicants applying for membership or privileges at an OhioHealth hospital are required to provide fingerprints to a designated OhioHealth location. Applicants will be required to sign a consent form for this process (below). **Failure to sign the below consent form will terminate the application process.**
- OHCS will contact you regarding this requirement. A valid driver's license is required for this process.
- Please note that OhioHealth's fingerprint process is separate from the process you completed when obtaining your Ohio Professional License.

DISCLOSURE QUESTION

Failure to disclose will add processing time to your application. 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.

◯ No ◯ *Yes

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

_____

_____

AUTHORIZATION FORM TO CONDUCT A CRIMINAL BACKGROUND CHECK AND TO GATHER INFORMATION AS IT PERTAINS TO THE CREDENTIALING PROCESS

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.

CONSENT TO OBTAINING REPORTS

I have read the above "Notice to Applicants" and hereby authorize OhioHealth to obtain consumer reports and/or investigative reports as described at any time after receipt of this authorization and throughout my period of membership and/or privileges at an OhioHealth facility. I consent to and authorize OhioHealth throughout the tenure of my membership and/or privileges to share any consumer report or investigative report received with a related entity if I apply for or maintain privileges or membership at that OhioHealth facility. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by OhioHealth or another outside organization acting on behalf of OhioHealth. I understand that I have the right to make a written request within a reasonable amount of time to receive additional, detailed information about the nature and scope of any investigative report including the name, address and telephone number of the reporting agency.

I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original. I understand, to the extent permitted by law, this authorization will remain in effect throughout my membership or privileges at an OhioHealth facility.

By my signature below I acknowledge that I have read and understand all of the above statements.

Note: If you are located in a state that allows you to obtain a free report, check this box if you would like a free copy of your report.

_____

Signature **Date**

OhioHealth Office of the General Counsel 248864v1

VERIFICATION OF PRACTITIONER IDENTITY

The Joint Commission requires that the hospital verifies the practitioner requesting membership and/or privileges is the same practitioner identified in the credentialing documents. We therefore require that you provide a **clear and legible** copy of your government issued driver's license or passport. This notary form must be completed as requested. A separate notary form will not be accepted. Electronic and on-line notarizations accepted.

APPLICANT'S DRIVER'S LICENSE OR PASSPORT

The copy must be clear and legible, including the photo.

Failure to provide a legible copy will result in refusal of this form and a new form will be required.

DRIVER'S LICENSE OR PASSPORT HERE
(front side only)f

By signing and dating this document in the presence of a notary I attest that the image above, or on an attached page represents a true copy of my original government issued identification document.

Applicant's Signature _____ Date _____

STATE OF: _____ COUNTY OF: _____

Acknowledged and signed in my presence by: _____
(Applicant's Name)

the _____ of _____, _____

Notary Public _____ My Commission Expires _____

Notary Printed Name _____

Please note that the notary is attesting to the applicant's signature on this form and not the actual driver's license.

Notary: You must include your notary seal on documentation submitted.

VERIFICATION OF EMPLOYMENT HISTORY

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

○ NO ○ *YES

*If yes, please provide specific details:

_____

_____

_____

Please make sure that your resume and/or CAQH application document a comprehensive listing of every employer that you have worked for and/or are currently working for since your graduation from professional school or from the past 5years, whichever is less. Please note that you only need to provide employment information for jobs in which you functioned in a clinical capacity. Please note that failure to provide a complete timeline of your employment history, as well as hospital affiliations, will delay the credentialing process.

OhioHealth

VERIFICATION OF MALPRACTICE CLAIMS HISTORY - LISTING OF INSURANCE COMPANY



PLEASE READ CAREFULLY

There are two (2) separate steps that need to be completed in order to verify your malpractice claims history from the past 5 years.

Please document a comprehensive listing of all the malpractice carrier(s) that have insured you in the past 5 years. If you have graduated from professional school within the past 5 years, you only need to provide the names of those carriers that covered you *starting* after graduation from professional school. Copies of past/current insurance face sheets will suffice in lieu of completing this form **if** the face sheets account for a comprehensive list of the past 5 years.
Fields that are highlighted on this page must be completed in its entirety.

Take note of the following:

- If you were/ are insured by a self- indemnification fund at a Hospital/University, please document the necessary information about your employer/schooling below.
- Regardless of where you have worked/trained, all practitioners are required to have Malpractice coverage.
- If you have worked for the Federal Government, document below along with the start/end dates of your affiliation. No other information is needed.

Malpractice Carrier 1 **check which applies for the carrier: Employer ☐ Training Program ☐**

Carrier Name:	Employer/School Name:	
Phone:	Fax	
Contact Name ***(if known)***:	Email Address	
Policy Number:	Policy Dates:	Retroactive Date:

Malpractice Carrier 2 **check which applies for the carrier: Employer ☐ Training Program ☐**

Carrier Name:	Employer/School Name:	
Phone:	Fax:	d
Contact Name (***if known***):	Email Address	
Policy Number:	Policy Dates:	Retroactive Date:

Malpractice Carrier 3 **check which applies for the carrier: Employer ☐ Training Program ☐**

Carrier Name:	Employer/School Name:	
Phone:	Fax:	
Contact Name (***if known***):	Email Address	
Policy Number:	Policy Dates:	Retroactive Date:

***Make a copy of this form if additional carriers need to be listed.**

OhioHealth

VERIFICATION OF MALPRACTICE CLAIMS HISTORY – RELEASE FORM

PLEASE COMPLETE THE TOP PORTION OF THIS FORM. THE BOTTOM PORTION OF THE FORM NEEDS TO BE COMPLETED BY YOUR INSURANCE AGENT/CARRIER. ***PLEASE INCLUDE A SIGNED COPY of this form when returning your application.***

I have applied for clinical privileges at one or more of the following OhioHealth Hospitals: Berger Hospital, Doctors Hospital, Dublin Methodist Hospital, Grant Medical Center, Grady Memorial Hospital, Hardin Memorial Hospital, Mansfield Hospital, Marion General Hospital, O'Bleness Hospital, Riverside Methodist Hospital, Shelby Hospital, Southeastern Medical Center and/or Van Wert Hospital. Please provide my claims history information for the past five (5) years to OhioHealth Credentialing Services by completing this form and faxing it to **614-566-0401 or emailing to** claimshistory@ohiohealth.com. *By signing this form below, I authorize release of this information.*

Printed Name of Practitioner (must be legible) _____ Type of Degree (eg: MD, DO, DPM, DDS, PhD, PsyD) _____

Practitioner Signature (must be legible) _____ Date _____ Last 4 digits of SSN _____ Date of Birth _____

********The malpractice insurance company must complete this section*********

If submitting a separate form, response must be to the attention of OhioHealth Credentialing Services

Carrier Name: _____

Policy Number: _____ Employer/School: _____

Type: ☐occurrence ☐claims-made ☐other Retroactive Date: _____

Policy Amount: _____ Effective Dates/From: _____ Expired Dates/To: _____

Have any specific procedures been excluded from his/her coverage?	*YES ◯	NO ◯
Has your company defended this applicant in any liability suits in the past?	*YES ◯	NO ◯
Has your company paid any judgments or settlements on behalf of the applicant for any professional liability suits in the last 5 years?	*YES ◯	NO ◯
Does the applicant currently have any pending lawsuits?	*YES ◯	NO ◯

If the answer to any of these questions is YES please provide a full explanation of details and attach your response.

Printed name of insurance representative _____ Title _____ Phone _____

Signature of insurance representative _____ Date _____

OHIOHEALTH HEALTH EVALUATION FOR COMMUNICABLE DISEASE

TUBERCULOSIS

Interferon Gamma Release Assay (TB Blood Test) is required for all staff new to OhioHealth (i.e. all applicants who do not have current OhioHealth Hospital privileges)**.** TB testing is not required for physicians/providers who do not work in a hospital or patient care setting and work remote only (e.g., teleradiology and other virtual health providers).

- A tuberculin skin test (PPD) is not accepted as a screening test for tuberculosis at OhioHealth.
- TB blood test results are required and must be submitted as part of your initial application. The date of this TB blood test must be within the past 12 months.

There are 3 options for completing the TB Blood test requirement:

1. **OhioHealth Associate Health & Wellness (AH&W) location**
   a. AH&W locations listed in the table below.
   b. Complete and take the "OhioHealth Lab Requisition and Release Form"; available at https://www.ohiohealth.com/credentialing
   c. AH&W will provide the order for the TB blood test.
   d. The provider will take the order to an OhioHealth lab for completion of the blood draw.
   e. ***The physician or provider will have no fee and will not be required to cover the cost of the TB blood test if completed at an AH&W location.***

2. **OhioHealth WorkHealth location**
   a. Access the link below for WorkHealth locations and hours of operation. https://www.ohiohealth.com/locations/workhealth/
   b. Complete and take the "OhioHealth Lab Requisition and Release Form"; available at https://www.ohiohealth.com/credentialing
   c. WorkHealth will order and complete the testing process.
   d. ***The physician or provider will be required to cover the cost of the TB blood test if completed at a WorkHealth location***.

3. **Contact your Primary Care Provider for completion of the TB blood test requirement.**

OHIOHEALTH ASSOCIATE HEALTH & WELLNESS LOCATIONS

Campus	Phone	Location	Walk-In Hours	Notes
Berger Hospital	740-420-8354	210 Sharon Rd. Ste B, Circleville	M/T/F 7:30-4p	Closed 12-12:30
O'Bleness Hospital	740-331-7066	75 Hospital Dr, Ste 370 (Castrop Ctr) Athens	Mon-Friday 7:00-4:00	Closed 12-1p
Blom Admin Campus	614-955-2502	3430 OhioHealth Pkwy, Ste 1250 Columbus	Mon-Friday 7:30-4:00	Closed 12-12:30
Doctors Hospital	614-544-1008	5100 W. Broad St, Basement, Columbus	M/W/Th 7-3:30	Closed 12-12:30
Dublin Methodist	614-544-8044	7450 Hospital Dr, Suite 350, Dublin	M/W 7-3:30	Closed 12-12:30
Grady Memorial	740-615-1134	561 W. Central Ave, ground floor, Delaware	T/Th/F 7-3:30	Closed 12-12:30
Grant Medical Center	614-566-8349	340 E. Town Street, Ste 8-900, 8th fl. Columbus	Mon-Friday 7:30-4:00	Closed 12-12:30
Hardin Memorial	740-383-8959	TB testing completed at Specialty Center, located on first floor of hospital	Mon-Friday 8:00-4:00	Ask for Heather Heilman
Mansfield Hospital	419-526-8505	335 Glessner Ave, Ste 1440, 1st floor, Mansfield	Mon-Friday 6:30-3:00	Closed 11:30-12

Please note: Hours of operation are subject to change.

SUBMISSION OF VACCINATION RECORDS

BACKGROUND

Exposure to vaccine-preventable diseases continues to be a risk at OhioHealth. In the past few years in central Ohio, there have been several exposures to vaccine-preventable diseases, some including physicians. These incidents resulted in hundreds of associates and patients being potentially exposed.

As a result, we offer a voluntary Physician Immunization Program for all medical staff members at OhioHealth, similar to requirements of all OhioHealth associates, to evaluate immunity status for measles/mumps/rubella (MMR), hepatitis B, varicella, pertussis and influenza in order to ensure protection for all of our physicians, associates and patients.

Immunization records will be documented in a confidential database by Associate Health and Wellness where they can be easily and quickly accessed in the event of an exposure. By doing this, we can minimize the possibility of delays or stopping of work for our associates and/or physicians, which can occur during an exposure when immunization records are not readily available.

HOW DOES THE PROGRAM WORK?

OhioHealth offers the program through Associate Health and Wellness with the following objectives:

- To determine immunity status for all current medical staff members at OhioHealth through the review of vaccination records submitted by medical staff members.
- To provide necessary titers and/or immunizations and boosters to those physicians who need them.
- Associate Health and Wellness will document, track and update all physician immunization records for future reference.

This program is provided at no cost to all medical staff members as long as they have their titer drawn at one of OhioHealth's lab locations and are given any necessary vaccinations by Associate Health and Wellness.

3 WAYS TO SUBMIT YOUR IMMUIZATION RECORDS:

1. Fax your immunization records to OhioHealth Associate Health and Wellness at **(614) 533.1080**.
2. Scanned copies can be emailed to **AH_Immunization_Review@ohiohealth.com**.
3. You may include copies of your immunization records when submitting your credentialing application.

Once your records are received, a nurse will review them to confirm your immunity status. The nurse will notify you if any additional follow-up is needed.

REQUESTED VACCINE RECORDS:

- MMR – (Measles, Mumps, Rubella)
- Varicella – (Chicken Pox)
- Hepatitis B
- Pertussis
- Covid-19 Vaccine
    - Not mandated by OhioHealth as condition of medical staff membership. If you have received prior vaccination (including booster) please submit your Covid-19 vaccine information for documentation purposes.

Submission of vaccine records is voluntary and is not considered to be a required component of the credentialing application. Submitting vaccine records will NOT subject you to adverse treatment. The information you provide is confidential and will be kept separate from your other credentialing information. This information will not be considered in making any decisions regarding your credentialing.

OhioHealth Confidentiality Statement of Understanding and Internet Use Agreement

This statement summarizes the responsibilities and obligations of all persons who use, create or receive confidential information through any affiliation with OhioHealth, as set out in OhioHealth's Privacy Policy. This statement further serves to inform workforce members of the expectations and responsibilities regarding appropriate internet use when representing OhioHealth or utilizing OhioHealth resources. The scope of this statement covers all OhioHealth "workforce members" defined to include (but not limited to): employees, volunteers, trainees, contractors, employed physicians (including residents), non-employed physicians, and associated staff that may access OhioHealth confidential information for patient care or healthcare operations, and other persons whose conduct, in the performance of work for OhioHealth, is under the direct control of OhioHealth, whether or not the person is paid by OhioHealth.

I understand and acknowledge that:

- It is my legal and ethical responsibility to protect the privacy, confidentiality, and security of all confidential or sensitive information including, but not limited to, Protected Health Information (patient-identifiable information) and Health Care Business Information such as proprietary business, associate, or provider information.
- I will not, at any time during or after my employment or affiliation with OhioHealth, improperly use, disclose to any person, or store any confidential information, nor will I permit any unauthorized person to examine or make copies of any reports, documents, or on-line information that comes into my possession. Confidential information is made available on a need to know basis and is limited to the minimum necessary requirement, and thus, I will not access confidential information without authorization, and I will do so only when I am required to do so for specific business purposes.
- Unauthorized disclosure of confidential information is totally prohibited.
- Disclosure of or sharing of passwords, access codes, and hardware token devices assigned to me (my "Access Credentials") is prohibited. I am accountable for my Access Credentials and for any improper access to information gained through use of my Access Credentials. My Access Credentials are the equivalent of my legal signature, and I shall take all reasonable and necessary steps to protect my Access Credentials. I am responsible for all actions taken using my Access Credentials. If I have reason to believe that the confidentiality of my Access Credentials or the confidentiality of my staff's credentials has been broken, I shall immediately notify the OhioHealth Director of Information Security.
- If I utilize a personal electronic device to access confidential information, I will ensure that all confidential information accessed through the device will be afforded the protections required by federal, state, and local laws and regulations. It is my responsibility to apply the required and indicated technical, physical, and administrative safeguards to such devices. Such safeguards include but are not limited to: encryption, password protection, anti-virus software, not leaving my devices unattended, and locking and logging off the device after my use. Further guidance on such safeguards can be found in OhioHealth Policies and Procedures.
- OhioHealth assumes no responsibility for the use, maintenance, support, or potential damages that may be incurred with any personal devices used to access OhioHealth confidential information.
- If a personal device used to access Protected Health Information is lost or stolen, I will immediately report such incident to the OhioHealth Privacy Officer at 866-411-6181 or via mycompliancereport.com (Access ID: OHH).
- Internet access and use on an OhioHealth network should be limited to business purposes, and personal use should be minimized. Inappropriate activity includes but is not limited to: utilizing an OhioHealth internet connection for activities that are not directly related to a business purpose of OhioHealth; activities that are illegal or intended to circumvent applicable laws and regulations; activities that could lead to accusations of unethical behavior or damage OhioHealth's professional reputation.
- I will immediately report any suspicious activity (e.g. unexplained appearances of new files, corrupted files, access by unauthorized staff, access to inappropriate websites) or any computers that are suspected of being compromised by malicious attack to the OhioHealth Director of Information Security.
- I will not divulge confidential information to unknown sources without proper identification, authorization, and confirmation of identity.
- I understand that I may use "cloud" applications and servers (such as Evernote and Dropbox) only for educational purposes and presentations I am giving. In conjunction with my use of cloud applications, I may not use, upload, or share (i) any Protected Health Information or (ii) any confidential and proprietary business information of or from OhioHealth; and that I will not, at any time, identify OhioHealth Corporation as the source of such information.
- If I violate any of the above statements, I may lose my access privileges immediately and may be subject to corrective actions up to and including termination.

By signing below, I acknowledge I have read and understand the foregoing information, and I agree to comply with the above terms.

Full Name (Print First Name MI, Last Name)	**Signature:**	**Date:**

Physician and Allied Health Professional Ethics and Compliance Program Information

Background

OhioHealth Hospitals (Berger Hospital, Doctors Hospital, Dublin Methodist Hospital, Grant Medical Center, Grady Memorial Hospital, 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.

SIGNATURE_____

PRINTED NAME_____

DATE_____

OhioHealth

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 with- out 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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OhioHealth

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.

COMPREHENSIVE PAIN MANAGEMENT

The Joint Commission's current standards require that organizations establish policies and procedures that address comprehensive clinical assessment of pain; treatment or referral for treatment; and reassessment for patients as it designates, based on patient population and scope of services provided. They required that an organization:

- Establish a clinical leadership team
- Actively engage medical staff and hospital leadership in improving pain assessment and management, including strategies to decrease opioid use and minimize risks associated with opioid use
- Provide at least one non-pharmacological pain treatment modality
- Facilitate access to prescription drug monitoring programs
- Improve pain assessment by concentrating more on how pain is affecting patients' physical function
- Engage patients in treatment decisions about their pain management
- Address patient education and engagement, including storage and disposal of opioids to prevent these medications from being stolen or misused by others
- Facilitate referral of patients addicted to opioids to treatment programs

Pain can reveal a tremendous amount about the health status of your patient. Pain can affect the quality of life through its effect on such things as mood, activity, appetite and the ability to focus and concentrate. OhioHealth recognizes the priority of pain management in the overall wellbeing of the patient and that pain relief is important in the overall management of patient care. Pain should be managed to a level that is both safe and acceptable to the patient's clinical situation. If pain is identified, perform a pain assessment which may include but is not limited to the following components as warranted by the patient's condition and clinical setting:

- Location
- Pain Intensity Rating
- Description of pain (e.g., burning, dull, ache, etc.)
- Onset, duration, and pattern (e.g., constant, intermittent, radiating)
- Aggravating factors
- Alleviating factors
- Current pain management interventions
- Effects on function and quality of daily life
- Establish Comfort Goal with patient
- Screen for risk factors associated with opioid induced over sedation and respiratory depression
- Assess history of analgesic use or abuse, duration and possible side effects to identify potential opioid tolerance or intolerance
- Reconcile pain medications with patient including last dose taken
- Assess patient for presence of patch (e.g., Fentanyl or Lidocaine patch), implanted drug delivery or system or infusion pump prior to administration of new opioid

The standard pain rating tool for adults and appropriate pediatric patients is the 0-10 Numeric Pain Intensity scale with 0=no pain and 10=the worst pain possible. If the patient is unable to speak English, the 0-10 Numeric Pain Intensity scale is available in 19 different languages. If the patient is unable to use the 0-10 Numeric Pain Intensity scale, use alternative scales such as the Simple Descriptive Pain Intensity Scale; Visual Analogue Scale (VAS); Wong-Baker Faces Pain Rating Scale. Infants/Children: Wong-Baker Faces Scale for children, FLACC Face/ Legs/Activity/Cry/Consolability for children ages 2 months – 7 yrs of age, NIPS Neonatal Infant Pain Scale. For patients unable to provide self-reports of pain (e.g., confused, decreased level of consciousness) use the Critical-Care Pain Observation Tool (CPOT) to assess for pain.

Safety considerations should be made for patients receiving opioids and could include assessing risk factors such as age, obesity, renal/hepatic impairment, known or suspected sleep apnea, multiple coexisting conditions, concurrent central nervous system depressants, opiate nativity, smoking status, and post-operative/post-anesthesia complications.

For examples of the tools used in pain assessment, refer to Policy P-100.010 Pain Management on Compliance 360.

Allied Health Practitioner Delineation of Privileges

What is a Delineation of Privilege (DOP)?

A formal document that contains a list of privileges that an Advanced Practice Provider has been approved to perform when seeing patients in the hospital.

Types of DOPs

APRNs (CNP, CNS, CNM, CRNA) and PA-Cs all have DOPs. CNP, CNS, and PA-C DOPs have been standardized throughout the OhioHealth system. CNM and CRNA DOPs will be standardized in the future but are not currently standardized. There are general DOPs and specialty specific DOPs (e.g., Trauma/Critical Care APRN DOP, Cardiovascular PA-C DOP etc.). If a specialty specific DOP does not exist (e.g., Oncology, Infectious Disease, Gastroenterology, etc.) those providers will utilize the general DOP.

Initial DOP Completion

During the onboarding process, the APP will complete the DOP in collaboration with the APP's primary collaborating physician. General privileges and, if applicable, Category I or Category II privileges specific to the APP's area of practice are selected. For any Category II privileges, the need for proctoring is identified on the DOP. Proctoring can only be performed after the privileges have been granted.

While privileges are standardized across the system providers at a particular hospital should only select privileges they plan to exercise at their hospital, (i.e., neurocritical care is not available at all hospitals). A separate DOP must be completed for each OhioHealth hospital in which you plan to provide patient care.

Category I versus Category II Privileges

Category I privileges are basic clinical activities within a specialty that any appropriately trained provider should be competent to perform. Category I privileges do not require proctoring, nor do they require a certain number to be performed annually to maintain competence. This would include things such as minor suturing, drain removal, foley insertion, etc.

Category II privileges are more specialized and require significant education, proctoring, possibly an OhioHealth Learning Management System (LMS), or another online course, or an in-person course. Category II privileges typically have volume requirements and need to be performed with some frequency in order to maintain competence. Examples include intubation, surgical first assisting, line placement, ICP monitor placement, etc. **Category II privileges may only be requested by an APP if those privileges mirror those of their collaborating physician.**

Expectations

The APP is responsible for keeping track of the completion of any proctoring requirements, using the proctoring reporting forms, and turning the forms in to the hospital's medical staff office once the identified number have been completed.
The APP must also continue to keep a record of any Category II privileges exercised. These logs will be evaluated as part of Ongoing Professional Performance Evaluation (OPPE).

How are changes made to a DOP?

When there is a need for a correction, addition, or deletion to a DOP, the request must be submitted to the Allied Health Practitioner System DOP committee. This committee is charged with standardizing, where possible APP privileges throughout the OhioHealth system.

APPs or physicians who wish to make a change to an existing DOP or create a new DOP, should reach out to Paige Ford in the Medical Staff Office at Riverside to request the DOP change form. The change should be described and, if new, identified as Category I or Category II, and the training pathway described. The request should be reviewed by stakeholders including specialties that would have providers performing the requested privilege. Those stakeholders who have vetted the change must be listed on the request form. The completed form is then sent to Paige who will place the request on the Allied Health Practitioner System DOP Committee's agenda.

The requestor will be notified of the request being added to the agenda and invited to attend the meeting. They will need to be available for questions from the committee. The committee meets the 2nd Thursday of each month at 1pm, in person (not currently) and by Webex. Once committee approval is obtained, the change is sent to each impacted hospitals' Medical Executive Committee (MEC) and then to Quality of Care Committee (QCC) for final approval.

Individual Healthcare Professional Participation Addendum

This Individual Healthcare Professional Participation Addendum (this "Addendum") is hereby entered into as of this _____, 20____, by and among the undersigned healthcare professional ("Healthcare Professional"), the undersigned Participating Practitioner Group, and OhioHealth Group, Ltd. ("OHG").

Background Information

A. OHG entered into that certain Participating Practitioner Group Agreement (the "Group Agreement") with the Participating Practitioner Group (the "Group") of which Healthcare Professional is an employee or independent contractor.

B. Healthcare Professional is duly licensed and qualified under applicable state law to practice with the Group in one of the following capacities: (i) physician assistant, (ii) certified nurse midwife, (iii) certified nurse practitioner, (iv) clinical nurse specialist, (v) certified registered nurse anesthetist, (vi) master's level state certified or state licensed clinical counselor, (vii) audiologist, (viii) speech therapist, (viii) dietician, or (ix) school psychologist.

C. Healthcare Professional, Group, and OHG each acknowledges that, by executing this Addendum, Healthcare Professional becomes a Participating Provider as set forth in the Group Agreement.

D. All Terms capitalized in this Addendum, but not otherwise defined, shall have the respective meaning ascribed to them in the Group Agreement.

Statement of Agreement

For good and valuable consideration, the adequacy of which is hereby acknowledged, the parties hereto acknowledge the accuracy of the foregoing Background Information and agree as follows:

§1. Healthcare Professional hereby agrees that he or she will actively support the ongoing development and implementation of the Clinical Integration Program as may be reasonably requested by OHG from time to time, and will abide by the terms, conditions, standards and requirements of the Group Agreement and the Clinical Integration Program.

§2. Healthcare Professional hereby agrees that he or she will fully perform and observe all obligations to be performed or observed by a Participating Practitioner under the terms and conditions of the Group Agreement, provided, however, that such activity is limited by, and does not extend beyond, the scope of Healthcare Professional's license, and Healthcare Professional's obligation to satisfy any financial term or condition arising under the Group Agreement shall be limited to an amount representative of Healthcare Professional's level of participation under the Group Agreement as reasonably determined by OHG. The intent of the foregoing sentence is to

ensure that Healthcare Professional shall not have any personal obligation to OHG for the financial obligations of other members, shareholders, partners, employees, or independent contractors of the Group.

§3. Healthcare Professional shall only provide Covered Services as may be authorized by the following, as applicable to Healthcare Professional: (i) his or her supervision agreement approved by the appropriate State licensing board, (ii) his or her standard care arrangement approved by his or her collaborating physician(s), and/or (iii) applicable federal and state law.

§4. Healthcare Professional hereby authorizes OHG to pay to the Group (rather than to Healthcare Professional) any CI Payments, or portions thereof, that may arise from payments received by OHG from a Payor pursuant to the terms of a Clinical Integration Service Agreement and that OHG determines in its sole discretion are payable to the Group or Healthcare Professional.

§5. Healthcare Professional hereby agrees this Addendum: (A) is effective as of the latter of (i) the Effective Date of the Group Agreement, or (ii) the date set forth above; (B) will terminate upon (i) termination of the Group Agreement or earlier termination of this Addendum by OHG, or (ii) earlier termination of his or her employment or independent contractor agreement with the Group; and (C) is entered into for the benefit of OHG and that OHG shall have the right fully to enforce Healthcare Professional's personal obligations arising under this Addendum.

§6. Healthcare Professional hereby acknowledges, understands and agrees that he or she will have no rights to any review, hearing or appeal as may otherwise be provided to a practitioner under OHG's Credentialing Plan or OHG's Credentialing Policy for Healthcare Professionals following termination of this Addendum as provided in Section 4 above.

Healthcare Professional:	**Participating Group Name:**
_____	_____
Printed Name	Group Name Printed
_____	_____
Signature	Signature of Group Representative

OhioHealth Group, Ltd.

By: _____
Its: _____

Category of Healthcare Professional – Please check one:

Advanced Practice Provider:

__☐__Nurse Practitioner __☐__ Nurse Midwife

__☐__ Physician Assistant __☐__ Clinical Nurse Specialist

__☒__Certified Registered Nurse Anesthetist

Allied Health Professional:

__☐__Audiologist

__☐__ Dietician

__☐__Speech Therapist

__☐__ School Psychologist

Clinical Counselor:

__☐__Licensed Independent Social Worker (LISW)

__☐__ Licensed Professional Clinical Counselor (LPCC)

__☐__Licensed Independent Chemical Dependency Counselor (LICDC)

__☐__Licensed Independent Marriage and Family Therapist

List your Supervising or Collaborating Physician(s) below (as applicable). If more than one, please list in order from most frequently supervises/collaborates to least frequently supervises/collaborates.

Please Print Clearly. Attach additional sheets if necessary:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____