



— Medical Credentials Check —

Request for Allied Health Privileges [Information must be typed or printed legible.]

Name _____ Date _____

<u>Where do you desire privileges?</u>	<u>In what specialty do you desire allied health privileges?</u>	<u>Fees</u>
<input type="checkbox"/> Center for Advanced Eye Surgery	_____	\$236
<input type="checkbox"/> Cincinnati Health Department	_____	-0-
<input type="checkbox"/> Crossroad Health Center	_____	-0-
<input type="checkbox"/> Digestive Health and Endoscopy Center	_____	\$236
<input type="checkbox"/> Digestive Health Center of Indiana	_____	\$236
<input type="checkbox"/> Elite Surgery Center	_____	-0-
<input type="checkbox"/> Episcopal Retirement Homes, Inc.	_____	-0-
<input type="checkbox"/> Four Seasons Endoscopy Center	_____	\$236
<input type="checkbox"/> Gamma Surgery Center	_____	-0-
<input type="checkbox"/> Heart of Ohio Family Health Centers	_____	-0-
<input type="checkbox"/> Hyde Park Health Center	_____	-0-
<input type="checkbox"/> Leo R. McCafferty Plastic Surgery	_____	-0-
<input type="checkbox"/> Mandell-Brown Plastic Surgery Center	_____	\$236
<input type="checkbox"/> McCandless Endoscopy Center	_____	\$236
<input type="checkbox"/> NorthKey Community Care	_____	\$236
<input type="checkbox"/> North Shore Endoscopy Center	_____	\$236
<input type="checkbox"/> Northwest Ohio Endoscopy Center	_____	-0-
<input type="checkbox"/> Peter's Township Surgery Center	_____	-0-
<input type="checkbox"/> Seven Hills Women's Health Centers	_____	-0-
<input type="checkbox"/> Southwestern Endoscopy Center	_____	\$236
<input type="checkbox"/> Topeka Surgery Center	_____	\$236
<input type="checkbox"/> Vincent Surgical Arts	_____	\$236
<input type="checkbox"/> Wexford Surgery Center	_____	-0-

Fees: Please make check payable to MedChek and include the applicant's name on the check. This non-refundable processing fee must accompany the application before processing begins.

Attachments: The following must be attached to this request:

1. Recent wallet-sized photograph of yourself, one for MedChek and one for each hospital at which you desire privileges.
2. Copy of all current state licenses/certificates.
3. Copy of DEA certificate (if applicable).
4. Copy of current malpractice insurance with name, expiration date, and limit amounts.
5. Copy of your current Curriculum Vitae.
6. Copy of your diploma(s)/certificates.
7. Copy of ACLS, BLS/CPR.
8. Copy of state driver's license/state ID.
9. Copy of PPD within the last year.
10. Copy of State Controlled Substance Registration from State Board of Pharmacy (if applicable).

Send completed forms and attachments to:

MedChek; Academy of Medicine; 7265 Kenwood Road, Suite 315; Cincinnati, OH 45236-4411; Phone (513) 721-4377 • FAX (513) 721-4378



MedChek Application for Allied Health Professional Credentials Check

Release of Information/Statement of Applicant

Please read carefully before signing.

I fully understand that falsification by omission from this application constitutes cause for denial of appointment or cause for immediate termination of privileges. All information submitted by me in the application is true, correct, and complete to the best of my knowledge and belief.

By applying for appointment/reappointment, I hereby signify my willingness to appear for interviews in regard to my application and authorize the health care facility, its medical staff, and their representatives to consult with other hospitals or employers with which I have been associated as well as other persons or entities who may have information concerning my professional competence, character and ethical qualifications.

I hereby further consent to the examination by the health care facility, its medical staff, and its representatives of all records and documents, including medical records, that may be pertinent to the evaluation of my professional, moral and ethical qualifications and competence to carry out the privileges I request.

I hereby release from liability all representatives of the health care facility, its medical staff, and its representatives for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the health care facility, its medical staff, and its representatives, in good faith and without malice concerning my professional competence, ethics, character and other qualifications pertaining to the application including otherwise privileged or confidential information, and I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by this health care facility, its medical staff, or its representatives to other employers and/or medical associations on request regarding any information the health care facility may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability this health care facility, its medical staff, and its representatives for so doing.

I understand and agree that I have the burden of producing adequate information for proper evaluation of my professional competence, continued physical competency, and moral conduct, and mental and emotional stability, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

If approved by the health care facility for medical staff membership or clinical for privileges requested, I agree to engage in the professional practice as defined by the appropriate state licensing board.

Name _____ Date _____
(Please type)

Signature _____



MedChek Application for Allied Health Medical Credentials Check

Information must be typed or printed legibly.

Date _____



Personal Information

Estimated Starting Date _____

Name _____
Last First Middle Maiden Degree

Date of birth _____ Place of birth _____

US Citizen? yes no If no, indicate status of your visa at the present time _____

Social Security Number _____ - _____ - _____ Marital Status (please check one): M S W D

Residence Address: _____
Street Address City, State, Zip

E-mail Address: _____

Phone _____ - _____ - _____ FAX _____ - _____ - _____

Office Address: _____
Street Address City, State, Zip

E-mail Address: _____

Phone _____ - _____ - _____ FAX _____ - _____ - _____

Preferred Mailing Address: Home Office Contact Person Regarding this Form _____



Education

Colleges, universities, or other schools attended:

Name Address City/State/Zip Dates Major/Degree

Name Address City/State/Zip Dates Major/Degree

Name Address City/State/Zip Dates Major/Degree



Licensing/Registration/Certification

Licensing Body Type Number Expiration Date

Licensing Body Type Number Expiration Date

Registering/Certifying Body Type Number Expiration Date

Registering/Certifying Body Type Number Expiration Date

DEA Registration (Narcotic License) _____
Number Expiration Date



Professional Status

Each applicant must answer all of the following questions. If you answer yes to any of the questions, please provide a full explanation on a separate sheet with the details.

- 1) Has your license to practice medicine in any jurisdiction been surrendered, limited, denied suspended, revoked or subject to probationary conditions, or have proceedings towards one of these ends been instituted voluntarily or involuntarily or is such action pending? yes no
- 2) Has your DEA registration ever been voluntarily or involuntarily refused, limited, suspended, or revoked, or is your DEA registration currently being challenged in any jurisdiction? yes no
- 3) Have your clinical privileges with any health care entity been suspended, diminished, revoked, or not renewed – voluntarily or involuntarily – or is such action pending? yes no
- 4) Have you been denied membership or renewal thereof, or been subject to disciplinary action, i.e. suspension or revocation, either voluntarily or involuntarily in any medical organization – or is such action pending? yes no
- 5) Have you voluntarily or involuntarily relinquished any medical staff membership, clinical privilege(s), medical organization or professional society membership, professional license(s), or narcotics registration? yes no
- 6) Have you ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the medical staff before a decision was made by the medical staff of the health care facility's governing board regarding the application/privileges? yes no
- 7) Have you resigned – voluntarily or involuntarily – from a hospital medical staff to avoid disciplinary action? yes no
- 8) Have you been subject to probationary conditions or investigation or have proceedings towards those ends been instituted or recommended by a committee or governing body at any hospital or health care entity? yes no
- 9) Have you been subject to disciplinary action by the Board of Medical Quality Assurance – or is such action pending? yes no
- 10) Have you ever been convicted of a felony (other than a motor vehicle citation)? yes no
- 11) Have you ever had professional liability insurance declined, cancelled, issued on special terms, or renewal refused? yes no
- 12) Have Medicare, Medicaid, PSRO, or PRO authorities or any other medical reimbursement plan ever brought formal charges or imposed sanctions against you for alleged inappropriate fees or quality of care issues limited to voluntary/involuntary restrictions, limitations, denial, revocation, suspension, surrender, or cancellation in any state? yes no
- 13) Have you ever had your provider number voluntarily or involuntarily terminated, suspended, restricted or revoked by a third party payor (including Medicare and Medicaid in any state) or are you currently under investigation by any third party? yes no

If you answered "yes" to any of the above questions, please provide a full explanation of the details on a separate sheet and attach.



Employment History

List Chronologically, since completion of professional school graduation, professional experience, i.e. **past employment, paid teaching assignments, and military service**. Attach a separate sheet if more space is needed. (**Note:** Attached C.V. is not acceptable in lieu of completion of this form.)

1. Dates: _____ to _____
month year month year

Professional Experience _____

Address: _____
Street City State Zip

Phone _____ - _____ - _____ FAX _____ - _____ - _____ Job Title: _____

2. Dates: _____ to _____
month year month year

Professional Experience _____

Address: _____
Street City State Zip

Phone _____ - _____ - _____ FAX _____ - _____ - _____ Job Title: _____

3. Dates: _____ to _____
month year month year

Professional Experience _____

Address: _____
Street City State Zip

Phone _____ - _____ - _____ FAX _____ - _____ - _____ Job Title: _____

4. Have you ever been employed at this health care facility? yes no

5. Please list all current and previous hospital appointments including specific privileges granted.

Hospital Name Complete Address

Privileges Granted Date

Hospital Name Complete Address

Privileges Granted Date

Hospital Name Complete Address

Privileges Granted Date



Professional Liability

Have you been the subject of a malpractice claim or a defendant in a malpractice suit? yes no

If you answered "yes" to this question, please provide the following information for each claim or suit (attach an additional sheet if necessary):

a) Nature of allegation: _____

b) Was a suit filed? yes no If yes, when (month, year) _____

c) Disposition or current status of claim or suit: Open Closed Suit withdrawn

d) On a separate sheet, provide a narrative description of the medical facts (must include, but not be limited to, the type or treatment and/or surgery; your involvement, i.e., consultant, primary surgeon, etc.). A full statement of explanation must be attached.



Health Status

Do you have any physical or mental conditions that would affect your ability to carry out your responsibilities as delineated by the by-laws, rules, and regulations of the hospital you are applying to or would affect your ability to exercise the clinical privileges requested, or which would require an accommodation in order for you to exercise the privileges requested, safely and competently? If yes, please provide explanation.

yes no



References

Please list three (3) persons in your same specialty who can attest to your professional ability. Do not list relatives, current or former employers.

Name _____

Street Address _____

City, State, Zip _____

Phone _____ - _____ - _____ FAX _____ - _____ - _____ E-mail _____

Name _____

Street Address _____

City, State, Zip _____

Phone _____ - _____ - _____ FAX _____ - _____ - _____ E-mail _____

Name _____

Street Address _____

City, State, Zip _____

Phone _____ - _____ - _____ FAX _____ - _____ - _____ E-mail _____

This Section to be Completed by Supervising Physician

Name of Employer, please print _____

1. Is this applicant covered by your liability insurance carrier? yes no

2. Is this applicant covered by his/her own insurance carrier? yes no

Statement of Supervising Physician

I hereby verify that _____
(name of applicant)

is under my supervision in the capacity of _____
(job title)

He/she will be under my direction at all times, and I agree to assume full responsibility for his/her actions in dealing with patients who are hospitalized at facilities at which I currently hold privileges.

I also agree to immediately notify entity(ies) to which he/she has applied if this person should no longer be under my supervision.

Signature _____ Date _____