☑ MedChek

— Medical Credentials Check —

Request for Medical Staff Privileges [Information must be typed or printed legibly.]

Name _____ Date _____

Where do you desire privileges?	For what department?	For what category?	Fees
❑ Center for Advanced Eye Surgery	NA	NA	$236
❑ Cincinnati Health Department	NA	NA	-0-
❑ Crossroad Health Center	NA	NA	-0-
❑ Digestive Health and Endoscopy Center	NA	NA	-0-
❑ Digestive Health Center of Indiana	NA	NA	$236
❑ Elite Surgery Center	NA	NA	-0-
❑ Episcopal Retirement Homes, Inc.	NA	NA	-0-
❑ Four Seasons Endoscopy Center	NA	NA	$236
❑ Gamma Surgery Center	NA	NA	-0-
❑ Heart of Ohio Family Health Centers	NA	NA	-0-
❑ Hyde Park Health Center	NA	NA	-0-
❑ Leo R. McCafferty Plastic Surgery	NA	NA	-0-
❑ Mandell-Brown Plastic Surgery Center	NA	NA	$236
❑ McCandless Endoscopy Center	NA	NA	$236
❑ NorthKey Community Care	NA	NA	$236
❑ North Shore Endoscopy Center	NA	NA	$236
❑ Northwest Ohio Endoscopy Center	NA	NA	-0-
❑ Peter's Township Surgery Center	NA	NA	-0-
❑ Seven Hills Women's Health Centers	NA	NA	-0-
❑ Southwestern Endoscopy Center	NA	NA	$236
❑ Topeka Surgery Center	NA	NA	$236
❑ Vincent Surgical Arts	NA	NA	$236
❑ Wexford Surgery Center	NA	NA	-0-
Additional Services			
❑ Academy of Medicine of Cincinnati	See Attached		

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

Attachments (**Note:** Attached C.V. is not acceptable in lieu of completion of application.) The following must be attached to this request:

1. Recent wallet-sized photograph(s) of yourself, one for MedChek and one for each facility at which you desire privileges.
2. Copy of all current state medical licenses.
3. Copy of current malpractice insurance face sheet.
4. Copy of your current DEA certificate.
5. Copy of your medical school diploma(s), residency certificate, and board certification.
6. Copy of your state driver's license/state ID.
7. Copy of PPD within last year.
8. Copy of notarized ECFMG certificate, if applicable.
9. Copy of ACLS, BLS/CPR, if applicable.
10. Copy of State Controlled Substance Registration from State Board of Pharmacy (if applicable)

Send completed forms and attachments to:

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

MedChek Application for Professional Credentials Check

Release of Information/Statement of Applicant

Please read carefully before signing.

All information submitted by me in this application is true, correct, and complete to the best of my knowledge and belief. I fully understand that any misstatement in, or omission from, this application may constitute cause for denial of appointment or reappointment, or cause for summary dismissal from the health care facility(ies).

By applying for appointment or reappointment to the health care facility(ies) listed on this application, I acknowledge that I have the responsibility to read the bylaws and rules and regulations of each such facility. I agree to be bound by the terms of such documents and all other applicable policies of such facility as may from time to time be in effect if I am granted medical staff membership or clinical privileges. I agree to conduct my practice in accordance with the ethical principles of my profession and I pledge to provide continuous care for my patients. In making this application I simultaneously apply for affiliation with MedChek for the use of its application services in medical appointments and reappointments when applicable.

By applying for appointment or reappointment to such health care facility(ies), I hereby signify my willingness to appear for interviews in regard to my application. I hereby authorize MedChek, the health care facility(ies), their staff(s), and their representatives to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with other entities or persons, including past and present malpractice carriers, who may have information bearing on my professional training, competence, character, mental & physical health status, and ethical qualifications. I hereby further consent to the inspection by MedChek, the health care facility(ies), their medical staff(s), and their representatives of all documents that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral, mental health and ethical qualifications for staff membership.

I hereby consent to and authorize MedChek and all health care facilities where I have staff privileges or have made application for privileges to report, release or exchange information among themselves and to the Secretary of the Department of Health and Human Services, the Medical Board of the State of Ohio, and the Kentucky Board of Medical Licensure, relating to the following: (1) any payments made for the applicant's benefit under a policy of insurance, self-insurance, or otherwise in settlement or partial settlement of, or in satisfaction of a judgement in, a medical malpractice action or claim; (2) any professional review action or formal disciplinary procedure that adversely affects the clinical privileges including the reduction, restriction, suspension, revocation, denial or failure to renew such privileges, of the applicant for a period longer than 30 days for reasons relating to the applicant's professional competence or conduct; (3) any surrender of clinical privileges of the applicant accepted by a health care entity relating to possible incompetence or improper professional conduct or any surrender of clinical privileges accepted by a health care facility in return for not conducting such investigation or proceeding; (4) any professional review action of a professional society which adversely affects the membership of the applicant in the society; and (5) any surrender of applicant's license or censure, reprimand or probation of applicant by the Board of Medical Examiners of any state for reasons relating to the applicant's professional competence or professional conduct.

I hereby further release from liability all representatives of MedChek, the health care facility(ies), their medical staff(s), and any other persons providing information for their acts performed in good faith, without malice and in reasonable belief that any information gathered or exchanged is warranted by the facts known to them.

I understand and agree that this consent is irrevocable (a) for so long as I am an applicant for or have privileges at any health care facility which is a party to the Memorandum of Understanding between it and MedChek regarding the exchange of information, or, if later in time, (b) for as long as MedChek or any health care facility may be under a duty to report information regarding the applicant pursuant to the Health Care Quality Improvement Act of 1986, Pub. L 99-660.

I understand and agree that I, as an applicant for medical staff membership and/or clinical privileges, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, health status, and other qualifications and for resolving any doubts about such qualifications. I certify that I have made full disclosure of all relative information.

I also understand and agree that no action will be taken on this application until it is complete and all outstanding questions with respect to the application have been resolved. A photocopy of this waiver shall be as effective as the original when so presented.

Name_____ Date_____

(Please type)

Signature_____

MedChek Application for Medical Staff Credentials Check

Information must be complete and typed or printed legible. 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 _____-_____-_____ Tax Identification Number_____

Marital Status (Please check one): M ☐ S ☐ W ☐ D ☐ Spouse's name_____

Residence Address: _____
Street address

_____ Phone_____-_____-_____
City/State/Zip

E-mail Address: _____

Current Practice Information (If joining a new group, please list that address.)

Specialty_____ Contact Person regarding this form_____

Name(s) of Partner(s) or Associate(s)_____

_____

Group Practice Name_____

Primary Office Address

a) _____
Street address

_____ Phone_____-_____-_____
City/State/Zip

FAX _____-_____-_____ E-mail Address:_____

Date Started: _____

Secondary Office Address

b) _____
Street address

_____ Phone_____-_____-_____
City/State/Zip

FAX _____-_____-_____ E-mail Address:_____

Preferred Mailing Address: Home ☐ Office a ☐ Office b ☐

Night/Beeper Number, Answering Service _____

☑ Medical/Dental Licensure

A copy of **all** current licenses must accompany this application along with a copy of your DEA certificate.

Ohio State Board of Medical Examiners: License Number_____

Date issued_____ Expiration date_____ Granted by: Reciprocity____ Examination____

Kentucky Board of Medical Licensure: License Number_____

Date issued_____ Expiration date_____ Granted by: Reciprocity____ Examination____

Other State License(s): State_____ Number_____

Date issued_____ Expiration date_____ Granted by: Reciprocity____ Examination____

Other State License(s): State_____ Number_____

Date issued_____ Expiration date_____ Granted by: Reciprocity____ Examination____

Other State License(s): State_____ Number_____

Date issued_____ Expiration date_____ Granted by: Reciprocity____ Examination____

DEA Registration [narcotic license]: Number_____

Date issued_____ Expiration date_____

ECFMG: Date_____ Certificate Number_____[Attach copy of a notarized certificate]

Medicare Provider #_____ Medicaid #_____ BWC#_____ NPI#_____
(formerly UPIN#)

(To receive information on how to obtain these numbers, please check here ❑)

☑ Educational Information

Medical /Dental Education (Please attach copies of your medical school diploma (s), residency certificate (s) and any other special training certificates).

a) Institution_____

Complete Address_____

Degree_____ Dates attended_____-_____ Date of Graduation_____

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

If you attended more than one medical/dental school, attach sheet listing complete information on each.

Internship

Institution_____ Program Director_____

Complete Address_____

Type of Internship_____ Specialty_____ Dates_____
Attended/Completed

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

If more than one internship, attach sheet listing complete information on each.

Residencies

a) Institution_____

Complete Address_____

Type of Residency_____ Dates_____
Attended/Completed

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

Name of Chairman of Department or Chief of Service_____

b) Institution_____

Address_____

Type of Residency_____ Dates_____
Attended/Completed

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

Name of Chairman of Department or Chief of Service_____

If more than two residencies, attach sheet listing complete information on each.

Postgraduate Education (fellowships etc.). If necessary, attach a separate sheet.

_____
Name Dates Experience

_____
Complete Address Program Director

_____
Name Dates Experience

_____
Complete Address Program Director

Certification by American Board of Specialty

a) If you are certified by a specialty board, indicate the name of the board and the date of certification (attach copy of certificate with application):

_____

b) Have you been recertified? yes ☐ no ☐ If yes, date recertified_____

c) If you have applied to a specialty board for examination, give the name of the board and the date of application.

_____

d) If status is one of eligibility, give year when eligibility will terminate: _____
(Attach copy of letter attesting eligibility)

e) Have you ever been examined by a specialty board but failed to pass? yes ☐ no ☐ If yes, please explain.

_____

f) Fellow of the American College of _____ Date_____

☑ Medical Practice Background

List Chronologically, since completion of professional school graduation (medical, dental, etc.), professional experience, i.e. **past employment, private practice, 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. Dates: _____ to _____
month year month year

Professional Experience _____

Address: _____
Street City State Zip

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

5. Dates: _____ to _____
month year month year

Professional Experience _____

Address: _____
Street City State Zip

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

☑ Hospital Affiliation Background

Indicate category of privileges (i.e. active, courtesy, etc.) for all past and current hospital affiliations. Please give dates of membership, hospital address and department. **Please list primary hospital first.**
(**Note:** Attached C.V. is not acceptable in lieu of completion of this form.)

1. Name of Hospital: _____

Address: _____
Street City State Zip

Department _____ Chairperson _____

Phone: _____-_____-_____ FAX: _____-_____-_____ Dates: _____ to _____

Category _____ Admissions/month _____ Restrictions _____

2. Name of Hospital: _____

Address: _____
Street City State Zip

Department _____ Chairperson _____

Phone: _____-_____-_____ FAX: _____-_____-_____ Dates: _____ to _____

Category _____ Admissions/month _____ Restrictions _____

3. Name of Hospital: _____

Address: _____
Street City State Zip

Department _____ Chairperson _____

Phone: _____-_____-_____ FAX: _____-_____-_____ Dates: _____ to _____

Category _____ Admissions/month _____ Restrictions _____

4. Name of Hospital: _____

Address: _____
Street City State Zip

Department _____ Chairperson _____

Phone: _____-_____-_____ FAX: _____-_____-_____ Dates: _____ to _____

Category _____ Admissions/month _____ Restrictions _____

☑ 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.

☑ 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.

☑ Malpractice Insurance Coverage

Name of Company_____

Address_____

_____

Policy Number_____ Amount of Coverage_____ Renewal Date_____

Agent's Name_____

Address _____

Excess Liability Coverage

Name of Company_____

Attach to this application, written verification in the form of Certificate of Insurance.

☑ Health Status

Do you have any physical or mental conditions that would affect your ability to carry out your responsibilities as delineated by the bylaws, 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

List **peer references** from three practitioners having the same degree who have worked extensively with you or have been responsible for professional observation of your work. (Do not include educational program directors, relatives, current partners or associates in practice.) Note: MDs and DOs can serve as peer references for each other.

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_____

☑ Reminder

Please attach the following to your completed application:

1) Recent photograph of yourself, one copy for MedChek and one for each hospital
2) Copy of all current state medical licenses
3) Copy of current malpractice insurance face sheet
4) Copy of your current DEA certificate
5) Copy of your medical school diploma(s), residency certificate, and board certification
6) Copy of your state driver's license/state ID
7) Copy of PPD within last year
8) Copy of ECFMG certificate, if applicable
9) Copy of ACLS, BLS/CPR, if applicable.
10) Copy of State Controlled Substance Registration from State Board of Pharmacy (if applicable)