



Central Credentialing Office
3535 Southern Blvd., Kettering, OH 45429

TO: Allied Health Professional

FROM: Melissa Walters, MHA, CPMSM, CPCS
Central Credentialing Office

RE: BIENNIAL REAPPOINTMENT

It is time for your reappointment to the Medical Staff at Kettering Medical Center and/or Sycamore Medical Center. Please follow the instructions below for completing the enclosed *Reappointment Application Packet* and submit any other information, which maybe required for your application for reappointment.

Please provide the Central Credentialing Office with any changes in office and/or home information (this includes: addresses, phone/fax/cell numbers, email, etc.

Reappointment Application Packet

- Complete and sign.
- Updated PHOTO (No driver's license)
- Complete Annual TB Evaluation
- Complete Annual Safety Education (**download from KHN Physician's Only website**)
- Please complete the Professional Sanctions Form, if applicable.
- Please complete the Malpractice Claims Assessment form, if applicable.

Authorization for the Release of Information and Liability

- Sign and date.

Clinical Privilege Profile

- Download, complete, sign and date Clinical Privileges Profile/Scope of Practice for your designated hospital, specialty.
- If requesting **moderate sedation (conscious and/or procedural sedation)**, please provide a current copy of your ACLS, ATLS, PhyAmerica or Airway Management course provided by Kettering Medical Center/Sycamore Medical Center or other GDAHA Hospital.
- If requesting additional privileges, please attach documentation attesting to your training and experience.

Continuing Education Hours (10 hours minimum reflective of the privileges granted)

- List hours or attach documentation

Application Fee

- Be sure to enclose the appropriate non-refundable application fee (**\$100 – AHP Active**), made payable to Kettering Medical Center in care of Central Credentialing Office. **A LATE FEE will be assessed per departmental policy for any application not received in a timely manner.**

Prior to submitting your packet, please review to ensure all necessary forms and documents are completed and signed. Should you have any questions, please call 937-395-8324.



REAPPOINTMENT APPLICATION PACKET

Kettering Medical Center Sycamore Medical Center
(Please mark all facilities for which you are applying)

A. PERSONAL INFORMATION

Applicant Name : _____ Applicant's Email : _____

B. PROFESSIONAL REFERENCE

Please provide one reference, preferably within your clinical specialty. This reference **SHOULD NOT** be your current clinical service chairperson. Reference will be evaluated according to the extent of their direct clinical observation of your work and other knowledge of you. **NOTE:** This reference must be a "peer", i.e. MD/DO to MD/DO, DPM to DPM, RN to RN, PA to PA, etc.

Name : _____ Specialty : _____
 Address : _____ Phone : _____
 City, State, Zip : _____ Fax : _____

C. UPDATED PROFILE INFORMATION

Board Specialty: Board Certified Yes No (If NO, I understand that current Bylaws of KMC require that I secure board certification within six years of completion residency).

I plan on fulfilling this requirement by: _____

Applicant Signature: _____

If you have obtained board certification, re-certification or additional certification(s) within the past two years, please indicate.

	Status	
Name of Board _____	Expiration	_____

Name of Board _____	Status	_____
	Expiration	_____

Hospital Affiliation: Please mark ALL hospital/surgery center affiliations:

- | | |
|---|---|
| <input type="checkbox"/> Atrium Regional Hospital
<input type="checkbox"/> Children's Hospital (Dayton)
<input type="checkbox"/> Clinton Memorial
<input type="checkbox"/> Dayton Eye Surgery Center
<input type="checkbox"/> Dayton Rehab Hospital
<input type="checkbox"/> Far Hills Surgery Center
<input type="checkbox"/> Good Samaritan Hospital
<input type="checkbox"/> Good Samaritan Surgery Center
<input type="checkbox"/> Grandview/Southview Hospitals
<input type="checkbox"/> Greater Dayton Surgery Center
<input type="checkbox"/> Greene Memorial Hospital | <input type="checkbox"/> Kindred Hospital
<input type="checkbox"/> Lifecare
<input type="checkbox"/> Medical Center at Elizabeth Place
<input type="checkbox"/> Miami Valley Hospital
<input type="checkbox"/> Springfield Regional Medical Center
<input type="checkbox"/> Upper Valley Medical Center
<input type="checkbox"/> VA Medical Center (Dayton)
<input type="checkbox"/> Wayne Hospital
<input type="checkbox"/> Wilson Memorial Hospital
<input type="checkbox"/> Wright Patterson AFB
<input type="checkbox"/> Other _____
_____ |
|---|---|

Please provide any additional hospital affiliations (not listed above) obtained within the past two years.

D. PROFESSIONAL SANCTIONS

Please answer each of the following questions in full. If the answer to any of the following is "YES", please complete the Professional Sanctions Reporting Form.

1. In the past two years have any disciplinary actions been initiated or are any pending against you by any state licensure board? Yes No
2. In the past two years has your license to practice in any state been (voluntarily or involuntarily) denied, limited, suspended, reprimanded, revoked, relinquished, or is your license to practice in any state under current challenge? Yes No
3. In the past two years have you been suspended, sanctioned, or otherwise restricted from participating in any private, federal or state health insurance program? (for example Medicare or Medicaid) Yes No
4. In the past two years have you been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program? Yes No
5. In the past two years has your narcotics registration certificate and/or DEA been (voluntarily or involuntarily) limited, suspended, revoked, relinquished, or is it currently being challenged or reviewed? Yes No
6. In the past two years has your employment, staff appointment, clinical privileges and/or scope of practice ever been (voluntarily or involuntarily) suspended, limited, revoked, not renewed, or refused at any hospital or other healthcare facility? Yes No
7. In the past two years have you ever withdrawn your application for appointment, reappointment, clinical privileges and/or scope of practice, or resigned before a decision by a hospital's or healthcare facility's governing body was rendered? Yes No
8. In the past two years have you been the subject of disciplinary proceedings or investigation at any hospital or healthcare facility? Yes No
9. Is your staff appointment or clinical privileges and/or scope of practice at any hospital or other healthcare facility currently under investigation? Yes No
10. In the past two years have you been denied membership or renewal thereof, or been subject to disciplinary proceedings in any professional organization? Yes No
11. In the past two years have you entered into any agreement (voluntarily or involuntarily) with any licensing organization or accrediting board to limit your medical practice as a result of any condition, mental or physical, which you suffer, including but not limited to alcoholism or substance abuse? Yes No
12. In the past two years have you been charged or convicted of a felony or a misdemeanor other than a minor traffic violation? Yes No

Please answer each of the following questions in full. If the answer to any of the following is yes, please provide a full explanation of the details on a separate sheet and attach.

1. In the past two years has your professional liability insurance coverage been terminated by action of the insurance company? Yes No
2. In the past two years have you been denied professional liability insurance coverage? Yes No
3. In the past two years has any professional liability insurance carrier excluded any specific procedures from your coverage? Yes No
4. In the past two years have you practiced medicine without professional liability insurance? Yes No

If the answer to any of the following is yes, please complete Malpractice Claims Assessment Form (Form B)

5. In the past two years have any professional liability suits been filed against you or have you received written notice of intent to file such a suit? Yes No
6. In the past two years have any professional liability suits been filed against you, which are presently pending? Yes No
7. In the past two years have any judgments been made against you or settlements rendered on your behalf in any professional liability cases? Yes No

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1. If you are granted clinical privileges and/or scope of practice, do you agree to notify the Hospital of any change to the foregoing answers upon the occurrence of any event, which would or does render any of the foregoing answer(s) incorrect or incomplete? Yes No
 2. Do you understand and acknowledge that it is an express condition to ongoing clinical privileges and/or scope of practice to notify the Hospital of any occurrence/event which renders the foregoing answers incorrect or incomplete when notice of the same is received by you? Yes No

E. HEALTH STATUS

Do you have any physical or mental conditions, which could affect your ability to exercise the clinical privileges requested or would require an accommodation in order for you to exercise the privileges requested safely and competently? To answer this question appropriately, please report any condition, which is infectious, which affects motor skills, cognitive ability or judgment, or which may adversely affect your ability to care for patients or to interact with other caregivers?

Yes No

Do you know of any reason that would prevent you from performing all the essential functions required by the privileges you requested without posing a substantial risk of serious harm to yourself, your patients, or others?

Yes No

F. CONTINUING MEDICAL EDUCATION

Please provide/attach documentation of a minimum of 10 Category I hours annually of CME/CEU directly related to the clinical privileges requested.

G. STAFF STATUS REQUESTED

KMC: AHP Active*

SMC: AHP Active*

**those applicants whose supervising/sponsoring physician has Active staff appointment at KMC or SMC, per the Medical Staff Bylaws, the AHP will be automatically granted appointment/scope of practice at the other Hospital.*

H. APPLICANT'S STATEMENT

In applying for Medical Staff membership and/or clinical privileges at Kettering Medical Center (KMC) and/or Sycamore Medical Center (SMC), I hereby signify my willingness to appear for interviews in regard to my application. I acknowledge that I have received and read the Medical Staff Bylaws and associated Medical Staff manuals of the Hospital(s). I agree to be bound by the terms of said Bylaws and associated manuals as such Bylaws and manuals may from time to time be enacted/amended if I am granted membership or clinical privileges and/or scope of service and in all matters relating to the consideration of my application for appointment to the medical staff and clinical privileges.

I also acknowledge my obligation as a licensed health care professional to engage in my profession in a manner which is consistent with and in compliance with all applicable federal and state laws. This includes, but is not necessarily limited to, all federal and state laws addressing the obligation to comply with conditions of participation for government sponsored health care entitlement programs. Consistent therewith, I have read the information provided in the HIPAA Review for Practitioners and I agree to abide by the principles set forth in that document. I further expressly agree to abide by the policies and procedures of the hospital as applicable to my professional practice and will also abide by the requirements of the Hospitals' third party accreditation entities.

I agree to submit my clinical performance to, and faithfully participate in the Hospitals' performance improvement program(s) and I agree to hold the Hospitals, their Medical Staffs, and their directors, officers, members/employees, representatives and agents engaged in such quality activities free from all liability for their actions performed in connection therewith. I hereby consent for the Hospitals to notify the Montgomery County Medical Society, other hospitals, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the Hospitals may have concerning me and release the Hospitals, their Medical Staffs, and their directors, officers, members/employees, representatives and agents from liability for so doing. I further specifically acknowledge that the provisions the Medical Staff Bylaws and/or associated manuals relating to confidentiality and release from civil liability are express conditions to my application for, and acceptance/ continuation of Medical Staff membership and/or to the exercise of clinical privileges. I pledge to provide for continuous care for my patients and to fulfill such other responsibilities as may be required in the event I am granted Medical Staff membership and/or clinical privileges

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 and other qualifications for membership and clinical privileges as well as resolving any doubts about such qualifications. I attest that the information that I have provided in correct and complete, and understand that any significant misstatements in or omissions from the CAQH Application or this addendum constitute cause for denial of appointment/privileges or cause for dismissal from the Medical Staff/termination of privileges. If appointment/privileges are granted, I understand that my initial Medical Staff appointment/privileges will be provisional for a period of one (1) year and, if necessary, may be extended another year. I understand and agree that if Medical Staff membership and/or requested privileges are denied or terminated based upon my quality of care or professional conduct/competence, I may be subject to reporting to the National Practitioner Data Bank and/or applicable State authorities. I further agree that in the event an adverse recommendation or action is made with respect to Medical Staff members and/or privileges, I will exhaust the administrative remedies afforded by the Medical Staff Bylaws, if applicable, before resorting to formal legal action. I agree to immediately notify the Hospitals if any information contained in my CAQH application or this addendum changes. I further agree that the foregoing obligation shall be a continuing obligation so long as I hold Medical Staff membership and/or privileges are the Hospital(s).

ALL INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE BY MY BEST KNOWLEDGE AND BELIEF.

Signature of Applicant _____ Date _____

As the employing/sponsoring physician who will be supervising the applicant named herein, I state that the foregoing information provided is complete and accurate to the best of my knowledge and belief, and I hereby accept the responsibility for all activities performed at Kettering Medical Center.

Signature Employing/Sponsoring Physician Date



AUTHORIZATION FOR THE RELEASE OF INFORMATION AND LIABILITY

I hereby authorize and expressly consent for Kettering Medical Center (KMC), Sycamore Medical Center (SMC) hereinafter called "Hospital(s)", the members of Hospitals' Medical Staffs, and the Hospitals' employees, agents and representatives to consult with administrators and members of the medical staff and credentialing organizations, other hospitals, healthcare institutions, and healthcare providers with whom I have been associated and/or previously applied for medical staff appointment and/or privileges and with others, including past and present malpractice carriers, licensing agencies, peers, educational institutions, government programs, and credentialing reporting agencies which may have information bearing on my professional activities, competence, character, and/or ethical qualifications.

I acknowledge that the Medical Staffs of the Hospitals are comprised of licensed physicians, podiatrists, psychologists and dentists who practice their respective specialty in and around Dayton, Ohio and who have been granted medical staff appointment and/or clinical privileges at the Hospitals. The members of the Medical Staffs of the Hospitals are not, for purposes of credentialing and peer review processes and functions, employees of the Hospitals; but, rather, are licensed independent practitioners participating in Hospitals' credentialing and peer review processes.

I consent to the inspection by Hospitals, the members of its Medical Staffs, and its employees, agents, and representatives of all documents, including but not necessarily limited to peer review evaluation records, educational records, clinical competency evaluations, and credentialing files maintained by other hospitals or other healthcare institutions, that may be material to an evaluation of my personal and professional activities, professional qualifications and competence to perform and carry out the clinical privileges as requested, as well as my moral and ethical qualifications for medical staff membership and/or clinical privileges at Hospitals.

I hereby release from and agree to hold Hospital, the members of their Medical Staffs, and the directors, officers, employees, agents, and representatives thereof harmless from and for any liability for performed in connection with evaluating my credentials, qualifications, and application for medical staff membership and/or privileges. I further release from any liability, and hold harmless, any individuals or organizations who provide information to the Hospitals and the members of Hospitals' Medical Staffs, concerning my past personal and professional activities, professional competence, ethics, character, and other qualifications for appointment and/or granting of clinical privileges and/or scope of service.

I am willing to appear, if requested, for interviews in reference to my application or addendum..

I understand and acknowledge that Hospitals, the members of Hospitals' Medical Staffs, and employees, agents and representatives thereof may be required to report to licensing agencies, (e.g. the State Medical Board), the National Practitioner Data Bank, and other credentialing and accrediting agencies or government entities information regarding my appointment, clinical privileges and/or scope of service, disciplinary action (if any) and professional conduct/competence which may otherwise be protected from disclosure as confidential peer review information. I hereby release from and agree to hold Hospitals, the members of Hospitals' Medical Staffs, and employees, agents and representatives thereof harmless from and for any liability for the release of such information when Hospitals and/or its Medical Staffs, by and through their/members, employees, agents and/or representatives, disclose such information in compliance with such laws and regulations.

I further understand that, pursuant to written authorization by me or a duly entered court order, the Hospitals, Medical Staffs, And the employees, members, agents and representatives thereof may provide to other hospitals, organizations, insurers, healthcare providers, reporting and accrediting agencies and other persons information concerning my professional competence, character, ethics, credentials and credentialing status, clinical privileges and/or scope of service status, appointment and other peer review information. I hereby release from and agree to hold Hospitals, Hospitals' Medical Staffs and the members, employees, agents and representatives thereof harmless from and for any liability for release of such information, pursuant to my written authorization or a duly entered court order. I agree to sign such additional authorizations and release of information consent forms as may be necessary in conjunction with my application for medical staff membership or privileges at Hospital(s).

A copy of this sign and dated authorization shall have the same effect as the original.

Applicant's Signature

Date

Print Name

MALPRACTICE CLAIMS ASSESSMENT FORM

Name:		Date
Patient Name:		DOB:
Civil Action #:		Date of Incident:
Date filed:	Date Settled/Closed:	Professional Involvement: Attending/Resident/Other
Diagnosis:		
Allegations:		
Case Summary:		
CASE RESOLUTION		
Dismissed:	Settled out-of-court:	Litigated:
Venue:		
Settlement paid on your behalf:	Total Settlement:	
PROFESSIONAL LIABILITY INFORMATION		
Name of Insurance Carrier:		Policy Number:
Address:		
PLAINTIFF'S COUNSEL		
Name of attorney		Phone Number:
Address:		
OTHER APPLICABLE INFORMATION		

PROFESSIONAL SANCTIONS REPORTING FORM

Name: _____	Dept./Section: _____	Date: _____
Facility Name: _____		
Contact Person: _____	Phone: _____	
Date incident occurred: _____	Status (check one): <input type="checkbox"/> Pending <input type="checkbox"/> Closed	
Substance of allegations: _____		
If closed, disposition (check one): <input type="checkbox"/> Dismissed <input type="checkbox"/> Disciplinary Action Taken		
Substance of findings: _____		
Additional Information (optional): _____		

Name: _____	Dept./Section: _____	Date: _____
Facility Name: _____		
Contact Person: _____	Phone: _____	
Date incident occurred: _____	Status (check one): <input type="checkbox"/> Pending <input type="checkbox"/> Closed	
Substance of allegations: _____		
If closed, disposition (check one): <input type="checkbox"/> Dismissed <input type="checkbox"/> Disciplinary Action Taken		
Substance of findings: _____		
Additional Information (optional): _____		

******SEND DIRECTLY TO YOUR PROFESSIONAL LIABILITY INSURANCE CARRIER****
(this includes both recent past and current carrier)**

STATEMENT OF AUTHORIZATION AND RELEASE FROM LIABILITY

Name and Address of Professional Liability Insurance Carrier:

POLICY #: _____

To Whom It May Concern:

I, _____, am applying for Medical Staff appointment, clinical privileges and/or scope of service at Kettering Medical Center/Sycamore Medical Center and hereby authorize my professional liability insurance carrier to release to the individual and facility listed below all information regarding my claims history, including, but not limited to:

- Judgments entered
- Claims settled
- Cases pending
- Procedures not covered by my policy

This information shall be submitted to:

Melissa Walters, MHA, CPMSM, CPCS
Central Credentialing Office
Kettering Medical Center
3535 Southern Blvd.
Kettering, OH 45429
937-395-8324 (phone)
937-395-8357 (FAX)

The above named person and Kettering Medical Center or Sycamore Medical Center, as appropriate, is to hereinafter be listed as a Certificate Holder and shall be notified of the amount of my coverage and any future changes in my insurance status.

Your prompt and full response will be appreciated. My signature below constitutes consent to this inquiry, authorizes your response thereto, and releases you from liability for reporting/providing the requested information as specified above.

Sincerely,

Signature of Applicant/Insured

Date

KETTERING MEDICAL CENTER

TB Evaluation for Medical Staff Members & Allied Health Professionals

The following information on all individuals working or providing care to patients at Kettering Medical Center and/or Sycamore Medical Center must be obtained. Please complete the following questions and return to the Central Credentialing Office at 3535 Southern Blvd., Kettering, OH 45429 or via fax to 937-395-8357:

TB Skin Test

Test Date: _____

Date Read: _____

Positive Negative

BAMT

Test Date: _____

Date Read: _____

Positive Negative

If you are a positive TB skin test positive and if not BAMT negative, you must answer the following questions:

DO YOU NOTE ANY OF THE FOLLOWING?

YES

NO

1. Persistent cough for longer than three weeks?
2. Chest Pain?
3. Shortness of breath
4. Presently coughing up phlegm, sputum or blood?
5. Noted fever, chills or night sweats?
6. Persistent tiredness, weakness or generally not feeling well?
7. Loss of appetite?
8. Noted weight loss not related to dieting or exercise?

Chest x-ray Date: _____

Positive Negative

If you are a recent converter, contact your physician for advice on TB prophylaxis.

9. Have you had any health problems or infectious diseases in the last 12 months which would affect with the practice of your clinical privileges at Kettering Medical Center and/or Sycamore Medical Center?

YES*

NO

*If you answer yes, please provide a detailed description of the health problem.

Appointee Signature

Printed Name

Date