APPLICATION FOR MEDICAL STAFF APPOINTMENT AND CLINICAL PRIVILEGES

APPLICATION FOR MEDICAL STAFF APPOINTMENT TO THE FOLLOWING PREMIER HEALTH PARTNERS HOSPITAL(S): (Check all that apply)

☐ Atrium Medical Center One Medical Center Drive Middletown, OH 45005	☐ Good Samaritan Hospital 2222 Philadelphia Avenue Dayton, OH 45406	☐ Miami Valley Hospital One Wyoming Street Dayton, OH 45409	☐ Upper Valley Medical Center 3130 N. County Road 25A Troy, OH 45373

Please denote which hospital will be your PRIMARY facility:_____

Applicant Name:_____

Instructions:

1. Please type or print legibly in ink.

2. If more space is needed for any item, attach additional sheets to the application and make reference to the question being answered.

3. Please attach copies of the following documents to this application:

   (1) Current Federal Narcotics Registration Certificate (DEA)
   (2) Professional liability insurance policy certificate of coverage from current insurance carrier showing your name, amount of coverage, dates of coverage, address of insurance company, and agent signature on certificate of insurance (COI)
   (3) Internship, Residency, and Fellowship Certificates, if applicable
   (4) Evidence of Board Certification and Recertification, if applicable
   (5) Evidence of current and previous licensure in other states, if applicable
   (6) Copy of continuing professional education activities for the past two years, if applicable
   (7) Evidence of certification by the Educational Commission for Foreign Medical Graduates, if applicable
   (8) Copy of Immigration VISA card/certificate, if applicable
   (9) Wallet size photograph (color or black/white). Photo MUST be provided in order to process application. Color photocopy only acceptable in lieu of original photograph.
   (10) Copy of driver's license card.
   (11) Evidence of competency/training for procedures identified within delineation of privileges. A clinical/procedural activity profile/surgical procedure log (current 24 month period) from primary base hospital is acceptable. Applicants post residency/fellowship completion within past 12 months should submit the training procedure log/summary report. See specialty delineation of privileges for additional specific requirements.
   (12) Current curriculum vitae.

4. A non-refundable processing fee of $400.00 is required for all applicants to the PRIMARY facility. If applying at more than one hospital, the application fee is reduced to $200.00 for each additional facility. Checks should be made payable to the Premier Health Partners hospital(s) where you are applying as follows:

Atrium Medical Center	Payable to:	Atrium Medical Center
Good Samaritan Hospital	Payable to:	Chief of Staff Fund
Miami Valley Hospital	Payable to:	Miami Valley Hospital
Upper Valley Medical Center	Payable to:	Medical Staff Dues/UVMC

   Please mail the application materials and processing fee(s) to the PRIMARY facility checked above, Attention: Medical Staff Services Department. Should you decide to apply for membership and/or privileges at another Premier Health Partners hospital greater than six (6) months post initial application, the $400.00 application fee would apply.

5. Include completed Delineation of Privileges Form(s).

Premier Health Partners – Initial Application

APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF

ALL INFORMATION MUST BE TYPED OR PRINT LEGIBLY IN INK!

IDENTIFYING INFORMATION

Last Name	First Name	Middle Name	Birthplace		Date of Birth
Office Address	City	State	Zip Code	Area Code Area Code	Telephone Office Fax Number
Home Address	City	State	Zip Code	Area Code	Telephone
Cell Phone	Pager Number		Social Security Number		
Citizenship	If not U.S. Citizen, Status & Visa Number		_____Male _____Female		Marital Status M S W D
Maiden or Other Names Used			Name of Spouse		
E-mail Address			NPI Identifier		
Group Name/Alternate Coverage			Medicare/Medicaid Identifier		
PRACTICE SPECIALTY/ SUBSPECIALTY					

EDUCATIONAL DATA

College or University	Degree	
Address		Date of Graduation
Graduate Education (medical, dental, podiatric, psychological)	Degree	
Address		Date of Graduation
First Post Doctoral Year (Hospital)	Address	
Type		Date to Date
List ALL Residencies, Fellowships, Preceptorships, Teaching Appointments, Postgraduate Education. List in chronological order.		
Program Type & Full Address & Phone # and Name of Training Program Director		Date to Date
Program Type & Full Address & Phone # and Name of Training Program Director		Date to Date
Program Type & Full Address & Phone # and Name of Training Program Director		Date to Date
Program Type & Full Address & Phone # and Name of Training Program Director		Date to Date
Program Type & Full Address & Phone # and Name of Training Program Director		Date to Date
ECFMG Certificate No.		Date Issued

CURRENT AND PREVIOUS AFFILIATIONS

List ALL present and previous hospital and other health care institution affiliations in chronological order (include assistantships and appointments). These include, but are not limited to, ambulatory surgical centers and urgent care centers.	
Facility Name, Full Address, Chief of Staff or Facility Director, Phone # & FAX	Date to Date
Facility Name, Full Address, Chief of Staff or Facility Director, Phone # & FAX	Date to Date
Facility Name, Full Address, Chief of Staff or Facility Director, Phone # & FAX	Date to Date
Facility Name, Full Address, Chief of Staff or Facility Director, Phone # & FAX	Date to Date
Facility Name, Full Address, Chief of Staff or Facility Director, Phone # & FAX	Date to Date

MEMBERSHIP IN PROFESSIONAL SOCIETIES (Academy, College, Fellow status)

County/State
National
International

BOARD CERTIFICATION

Name of professional certifying board(s) and specialty certification(s)	Date of Initial Certification: Expiration Date:
	Date of Initial Certification: Expiration Date:
	Date of Initial Certification: Expiration Date:
Are you board admissible? _____ Do you plan to take examination? _____ If yes, when? _____	

CONTINUING EDUCATION

On separate sheet, list all postgraduate activities which you have attended or for which you have received credit in the past two (2) years.

LICENSING

STATE LICENSES	OHIO License	Date Issued	License No.
	Other License (Name of state)	Date Issued	License No.
	Other License (Name of state)	Date Issued	License No.
	Other License (Name of state)	Date Issued	License No.
NARCOTICS LICENSE (DEA)	Registration Number	Date Issued	

PROFESSIONAL REFERENCES

Please list names of three (3) preceptors or previous medical associates within the past two (2) years who have personal knowledge of your current clinical ability, ethical character, ability to work cooperatively with others and who will provide specific written, substantive comments on these matters upon request. At least one reference must be of the same specialty and one reference should be a current medical staff member of a Premier Health Partners hospital. (Do not include family members)

Doctor	Address	Telephone & FAX
Doctor	Address	Telephone & FAX
Doctor	Address	Telephone & FAX

PREVIOUS PRACTICE / EMPLOYMENT

Include all professional practice experience /employment (including group and solo practice) since completion of post graduate education.

Name/Location/Address	Nature of Affiliation	Reason for leaving	Date to Date
Name/Location/Address	Nature of Affiliation	Reason for leaving	Date to Date
Name/Location/Address	Nature of Affiliation	Reason for leaving	Date to Date

PROFESSIONAL LIABILITY INSURANCE

Do you have professional liability insurance coverage? ___ Yes ___ No

Carrier which will be providing coverage at the Premier Heath Care Facility(s) where you are requesting privileges:

Name of Insurance Carrier :

Address of Insurance Company:

Limits per occurrence:

Annual Aggregate Limits:

Policy Number:

Name of present carrier, if different from above:

Are any professional liability claims or lawsuits currently asserted or filed against you? **___ Yes ___No**

Have any professional liability claims or lawsuits been asserted or filed against you in the past ten (10) years? **___Yes ___ No**

If "Yes" is the answer to either of the above questions, please provide a full explanation of the details of each specific claim or lawsuit on a separate sheet. The explanation must include the name of the company, specific information concerning any limitations, and if filed, the court in which the suit was filed, the caption and docket number of the case, the name and address of the attorney defending you, all relevant dates, the disposition of the case or its current status, and all other relevant details.

PROFESSIONAL SANCTIONS AND ACTIONS

Indicate whether any of the following have ever been, or are in the process of being, denied, revoked, suspended, renewed, limited, modified, not renewed, excluded, voluntarily or involuntarily relinquished, or whether you have ever been investigated, reprimanded or placed on probation. **If the answer to any of the following questions is "Yes", "False" or "Pending," please provide complete details on a separate attachment.**

A. License to practice any profession in any jurisdiction	☐Yes ☐No ☐Pending
B. Narcotics registration (DEA License) in any jurisdiction (i.e. any states, other countries outside United States (USA), Puerto Rico, District of Columbia or commonwealth)	☐Yes ☐No ☐Pending
C. Staff appointment status or clinical privileges at any hospital or other health care institution	☐Yes ☐No ☐Pending
D. Membership/fellowship or renewal thereof in any local, state, or national professional organization	☐Yes ☐No ☐Pending
E. Specialty board certification or eligibility	☐Yes ☐No ☐Pending
F. Malpractice insurance	☐Yes ☐No ☐Pending
1. Are you currently or have you been required to have your privileges or professional conduct monitored or proctored at any health care institution or health care practice group with which you have been or are presently affiliated? This does not include routine, focused, or on-going review required for initial, on-going, or acquisition of a new privilege.	☐Yes ☐No ☐Pending
2. Are you currently or have you ever been investigated or notified of concerns about your staff appointment or clinical privileges at any other health care institution or health care practice with which you are or have been associated?	☐Yes ☐No ☐Pending
3. Have you ever withdrawn your application for appointment or reappointment, or have you ever resigned from a medical staff before a decision could be made by a hospital's or health care facility's governing board?	☐Yes ☐No ☐Pending
4. Are you currently under investigation or have you been sanctioned or terminated by any third party carrier or managed care entity, including insurance companies, HMOs, PPOs, MSOs, or PHOs, for reasons relating to your competency or professional misconduct?	☐Yes ☐No ☐Pending
5. Are you currently or have you been investigated, sanctioned, excluded, or terminated from participation with Medicare, Medicaid or any other federally funded health care programs?	☐Yes ☐No ☐Pending
6. Have you ever been investigated, formally disciplined, suspended, placed on probation, or asked to resign by an educational institution during your academic career, including during your residency/internship/fellowship or other training, for any reason?	☐Yes ☐No ☐Pending
7. Have you ever been convicted of any criminal charge other than minor traffic offenses?	☐Yes ☐No ☐Pending
8. Are there currently pending against you any state or federal misdemeanor or felony charge(s)?	☐Yes ☐No ☐Pending
9. Are you aware of any actions contemplated or pending against you by any hospital, licensing board, law enforcement agency or professional society that could impact upon the accuracy of your answers to any inquiries within this application?	☐Yes ☐No ☐Pending
10. To the best of my knowledge, I attest there are no health problems that exist that could affect my ability to perform the privileges that I am requesting.	☐True ☐False

MEDICAL STAFF CATEGORY OF APPOINTMENT

NOTE: Please refer to definition of categories for each hospital provided with application.

ATRIUM MEDICAL CENTER	____Active	____Affiliate		
GOOD SAMARITAN HOSPITAL	____Active	____Affiliate	_____Courtesy	_____Consulting
MIAMI VALLEY HOSPITAL	____Active	____Courtesy	_____Academic	
UPPER VALLEY MEDICAL CENTER	____Active	____Affiliate	_____Courtesy	

PREMIER HEALTH PARTNERS
APPLICATION FOR APPOINTMENT/ REAPPOINTMENT
TO THE MEDICAL/DENTAL STAFF

In making this application for appointment/ reappointment at any Premier Health Partners Hospital, I attest to the completeness and conciseness of all information furnished. I agree to appear for interviews in regard to this application. I authorize the Hospital to consult with members of the medical staff of other hospitals with which I have been associated and with others who may have information bearing on my competence, character, physical and mental health status, ethics and any other qualifications deemed necessary to make an informed judgment on this application.

I consent to the Hospital's inspection of all records and documents that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges I am requesting, documents and records relating to my moral and ethical qualifications for staff membership, and any information from my present or past malpractice insurance carriers that relates to my involvement in claims of professional malpractice.

I release from liability all representatives of the Hospital and its Medical Staff for their acts in connection with evaluating me and my credentials, and I release from liability all individuals and organizations who provide information to the Hospital in good faith and without malice concerning my competence, ethics, character and other qualifications for staff appointment and clinical privileges, including information which may be otherwise privileged or confidential.

In making this application, I acknowledge that, I have received the Bylaws, Rules and Regulations of the Medical Staff, and I agree to be bound by the terms thereof. I also agree that I will abide by the Hospital's Bylaws, Code of Regulations, Policies and Procedures, Corporate Compliance plan, State and Federal Law, The Joint Commission Standards, the Notice of Privacy Practices prepared and distributed to patients as required by the Federal Patient Privacy Regulations (i.e. HIPAA). I acknowledge my obligation as a member of the Medical Staff to provide for the continuous care and supervision of my patients and my obligation to accept committee assignments when appropriate. I certify that the alternate provider named herein has agreed to serve in this capacity and has the same or substantially similar clinical privileges as I am requesting, and is qualified to provide medical care and treatment to my patients.

I understand that a condition of this application is that any misrepresentation, misstatement, or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application and may result in a determination not to process my application further. Upon subsequent discovery of such misrepresentation, misstatement, or omission, the Hospital may immediately terminate my appointment and privileges. I agree to immediately notify the Medical Staff Services Department of any changes made or proposed in the status of my professional liability insurance, professional licensure or DEA. I agree to immediately notify the Medical Staff Services Department of any changes on my application at any time during my appointment/reappointment to the Medical Staff. I further acknowledge that the burden is upon me to establish to the satisfaction of the governing body and the Medical Staff of the Hospital that I am qualified in all respects to be a member of the staff and to the clinical privileges requested.

I agree to exhaust the administrative remedies afforded by the Medical Staff Bylaws before resorting to formal legal action if an adverse ruling is made with respect to my application for Medical Staff appointment, Medical Staff status, or clinical privileges or if there is an adverse ruling as to my Medical Staff appointment, Medical Staff status, or clinical privileges.

AUTHORIZATION AND RELEASE

I, _____ hereby acknowledge that I have made application for appointment/ reappointment to the Medical Staff of Hospital. I authorize Hospital through its representatives, to contact anyone who they believe would be helpful in providing information about my qualifications for staff membership. I authorize anyone contacted by Hospital to submit to Hospital any information that may have bearing on my competence, character, physical or mental health status, ethics, ability to work with others in a cooperative manner, and any other qualification deemed necessary to make an informed judgment on my application. Furthermore, I knowingly, willingly and voluntarily release to the fullest extent allowed by law from any and all liability anyone who provides information in good faith to Hospital regarding this application. In addition, if I elect to apply or reapply to another Premier Health Partners affiliate, Hospital may release all information relevant to that application/ reapplication to the other Premier Health Partners affiliate.

_____ _____
Date Signature

FAIR CREDIT REPORTING ACT DISCLOSURE
SELECTION.COM INQUIRY RELEASE

In conjunction with my application for medical staff and/or allied health privileges (including contract services) with you, a Premier Health Partners facility, I understand that you intend to hire Selection.com to obtain "Consumer Reports" about me as defined in the Fair Credit Reporting Act (FCRA). These "Consumer Reports" may include information concerning my, character, academic background, credentials, work habits, work performance, work experience, reasons for work termination, general reputation, personal characteristics. You also may seek information concerning my employment history, motor vehicle record, education background, civil litigation history and/or criminal record.

I understand that you may rely on any or all of the above referenced information in determining whether to extend an offer of privileges to me. If you contemplate making an adverse privilege-related decision that will affect me based, in whole or in part, upon a "Consumer Report" obtained from Selection.com, I will be provided with a copy of the "Consumer Report" and a written summary of my "Consumer Rights" under the FCRA before you finalize that decision.

I have read the above disclosure and I hereby authorize you, Selection.com or its authorized agents to obtain the above referenced information about me. I also authorize all agencies, bureaus, employers, information service organizations and individuals to provide any of the above referenced knowledge or information they have concerning me. If I am granted privileges, this authorization shall remain on file and shall serve as an ongoing authorization for you to obtain "Consumer Reports" about me from Selection.com at any time during my tenure with you. A photocopy or facsimile of this authorization shall be as valid as the original. I agree that any and all disputes arising from this "Consumer Report" shall be brought only in state or federal court in the State of Ohio and shall be governed by, and construed in accordance with, the laws of the State of Ohio.

Print Name: _____

Signature _____ Date _____

Note to Applicants living in CA, OK or MN:

By checking this box, I request to receive a free copy of any consumer report ordered on me. ☐

*Email address: _____

* By entering my email address, I authorize Selection.com to deliver my report via email.

Notice to California Residents:

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by Selection.com during normal business hours. You may also obtain a copy of this file, either in person or by mail, by submitting proper identification and paying the costs of duplication services. You may also receive a summary of the file by telephone by being able to provide adequate identification as to allow Selection.com to determine with reasonable certainty that you are the subject of the report. Selection.com is required to have personnel available to explain your file to you and must explain to you any coded information appearing in your file. If you appear in person, another person of your choice may accompany you, providing that this additional person furnishes proper identification.

THIS FORM IS FOR PERMANENT RETENTION IN MEDICAL STAFF OFFICE FILES