ALLIED HEALTH PROFESSIONAL
APPLICATION FOR CREDENTIALED STATUS

APPLICATION FOR ALLIED HEALTH PROFESSIONAL STATUS AND SCOPE OF PRIVILEGES TO THE FOLLOWING PREMIER HEALTH PARTNERS HOSPITAL(S): (Check all that apply)

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

Please denote which hospital will be your PRIMARY facility: _____

Applicant's 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, if applicable:

   (1) Evidence of current licensure or certification in Ohio, where applicable, or by other entities (e.g. certificate or registration, certificate of authority, licensure certificate)
   (2) Current Federal Narcotics Registration Certificate (DEA)
   (3) 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)
   (4) Evidence of professional training (including any post-graduate professional training) and/or training for certification
   (5) Evidence of Certification and Recertification
   (6) Evidence of current and previous licensure in other states
   (7) Copy of Immigration VISA card/certificate
   (8) Copy of continuing professional education activities for the past two years
   (9) Current Supervisory Plan, Supervision Agreement, or Standard Care Arrangement Plan
   (10) 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.
   (11) Copy of driver's license card.
   (12) Evidence of competency/training for procedures identified within scope of privileges. A clinical/procedural activity profile/surgical procedure log (current 24 month period) from primary base hospital is acceptable. Applicants post professional training completion within past 12 months should submit the training procedure log/summary report. See specific scope of privileges or job description for additional specific requirements.
   (13) Current resume or curriculum vitae.

4. A non-refundable processing fee of $150.00 is required for all applicants to the PRIMARY facility. If applying at more than one hospital, the application fee is reduced to $75.00 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 privileges at another Premier Health Partners hospital greater than six (6) months post initial application, the $150.00 application fee would apply.

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

Premier Health Partners – Initial Application

APPLICATION FOR APPOINTMENT TO THE ALLIED HEALTH PROFESSIONAL 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/Employer Name			Medicare/Medicaid Identifier		
PRACTICE SPECIALTY/ SUBSPECIALTY					

EDUCATIONAL DATA – ALLIED HEALTH PROGRESSIONAL PROGRAM

Name of Certificate Program, College or University	Type of Credential/Degree Awarded & Specialty
Address Telephone & FAX	Date of Graduation
Additional Undergraduate & Graduate Education - Name of Program and School	Type of Credential/Degree Awarded & Specialty
Address Telephone & FAX	Date of Graduation
Additional Graduate & Post-Graduate Education – Name of Program and School	Type of Credential/Degree Awarded & Specialty
Address Telephone & FAX	Date of Graduation

CURRENT AND PREVIOUS AFFILIATIONS

List ALL present and previous hospital and other health care institution affiliations in chronological order. These include, but are not limited to, ambulatory surgical centers and urgent care centers.	
Facility Name, Full Address, Facility Supervisor, Telephone & FAX	Date to Date
Facility Name, Full Address, Facility Supervisor, Telephone & FAX	Date to Date
Facility Name, Full Address, Facility Supervisor, Telephone & FAX	Date to Date
Facility Name, Full Address, Facility Supervisor, Telephone & FAX	Date to Date

PROFESSIONAL ORGANIZATIONS

County/State
National
International

CERTIFICATION

Name of professional certifying organization(s) and specialty certification(s)	Date of initial certification Expiration Date:
	Date of initial certification Expiration Date:

CONTINUING EDUCATION

Are you accumulating continuing education credits at the rate required for your profession? Yes_____ No_____ If no, please explain below.

On a separate sheet, list all postgraduate activities which you have attended or for which you have received educational 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 discipline and one reference should be a current medical staff member of a Premier Health Partners hospital. (Do not include family members)

Professional Reference	Address Information	Telephone & FAX
Professional Reference	Address Information	Telephone & FAX
Professional Reference	Address Information	Telephone & FAX

PREVIOUS PRACTICE / EMPLOYMENT

List in chronological order all prior employment or practice affiliation from completion of professional education until the present. Include health care institutions where you served in a professional health care capacity. Attach additional sheets if necessary.

Name of Employer Address Information, Telephone & FAX	Type of Position	Reason for leaving	Date to Date
Name of Employer Address Information, Telephone & FAX	Type of Position	Reason for leaving	Date to Date
Name of Employer Address Information, Telephone & FAX	Type of Position	Reason for leaving	Date to Date

SUPERVISORY PLANS & STANDARD CARE ARRANGEMENT PLANS

If applicable, please attach the supervisory plan(s), supervision agreement, or standard care arrangement plan with your current employing physician/group, under which you will provide health care services at the designated Hospital campus. Your authority to perform the functions and/or procedures at the Hospital is contingent upon the Hospital Board of Directors final approval. At its discretion, the Board of Directors may authorize you to perform all, some, or none of the functions and/or procedures identified in your supervisory plan, supervision agreement, or standard care arrangement plan.

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 years? **___Yes ___ No**

If "Yes" is your 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/certificate/registration to practice any profession in any jurisdiction	☐Yes ☐No ☐Pending ☐ N/A
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 ☐ N/A
C. Staff appointment status or clinical privileges at any hospital or other health care institution	☐Yes ☐No ☐Pending ☐ N/A
D. Membership/fellowship or renewal thereof in any local, state, or national professional organization	☐Yes ☐No ☐Pending ☐ N/A
E. Specialty certification or eligibility	☐Yes ☐No ☐Pending ☐ N/A
F. Malpractice insurance	☐Yes ☐No ☐Pending ☐ N/A
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 professional program 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

PREMIER HEALTH PARTNERS
APPLICATION FOR APPOINTMENT/ REAPPOINTMENT
TO THE ALLIED HEALTH PROFESSIONAL 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/professional 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 understand that appointment as an Allied Health Professional is not a right of every licensed, certified or registered professional who makes application for the same.

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 Allied Health Professional 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 employing or collaborating physician provider named herein has agreed to serve in this capacity 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 acknowledge that the approval of my application/reapplication for appointment to the Allied Health Professional Staff is subject to the sole discretion of the Board of Directors. In addition, I acknowledge that as an Allied Health Professional, I am neither a member of the Medical Staff nor entitled to any rights that come with membership.

I agree to immediately notify the Medical Staff Services Department of any changes made or proposed in the status of my employment, 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 Allied Health Professional 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 Allied Health Professional staff and to the clinical privileges requested.

AUTHORIZATION AND RELEASE

I, _____ hereby acknowledge that I have made application for appointment/ reappointment to the Allied Health Professional 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