



3535 Southern Blvd., Kettering, OH 45429

TO: Allied Health Professional Member

FROM: Melissa Walters, MHA, CPMSM, CPCS
Manager, Medical Staff Services

RE: BIENNIAL REAPPOINTMENT

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

Please provide Medical Staff Services with any changes in office and/or home information (this includes: addresses, phone/fax/cell numbers, email, etc.

Reappointment Application Packet

- Complete and sign.
- Please complete the Professional Sanctions Form, if applicable.
- Please complete the Malpractice Claims Assessment form, if applicable.
- Complete Updated Profile Information

Authorization for the Release of Information and Liability

- Sign and date.

Clinical Privilege Profile

- Download, complete, sign and date Clinical Privileges Profile for your designated 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 or other GDAHA Hospital.
- If requesting additional privileges, please attach documentation attesting to your training and experience.

CME Hours (Category I)

- List hours or attach documentation

Application Fee

- Be sure to enclose the appropriate non-refundable application fee of **\$150**, made payable to Kettering Medical Center in care of Medical Staff Services Department. **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.



AHP REAPPOINTMENT APPLICATION PACKET

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"/> Children's Hospital (Dayton)
<input type="checkbox"/> Clinton Memorial
<input type="checkbox"/> Community Hospital
<input type="checkbox"/> Dayton Eye Surgery Center
<input type="checkbox"/> Dayton Heart Hospital
<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"/> Lincoln Park Surgery Center
<input type="checkbox"/> Mercy Hospital (Springfield)
<input type="checkbox"/> Miami Valley Hospital
<input type="checkbox"/> Middletown (Atrium) Regional Hospital
<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. APPLICANT'S STATEMENT

STAFF STATUS REQUESTED: AHP Active

In making this application, 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 manuals of the Hospital. I agree to be bound by the terms of said Bylaws and associated manuals as may from time to time be enacted 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 through government sponsored health care entitlement programs. Consistent therewith, I have read the information provided in the HIPAA Review for Physicians and I agree to abide with the principles of this document. I further expressly agree to abide by the policies and procedures of Kettering Medical Center as applicable to my professional practice and will also abide by those requirements of third party accreditation entities, including but not limited to JCAHO.

I agree to submit my clinical performance to, and faithfully participate in the hospital's performance improvement program and I agree to hold members of the medical staff and other authorized representatives of the Hospital engaged in these quality activities free from all liability for their actions performed in good faith/connection herewith. I hereby consent that the Hospital shall notify the Montgomery County Medical Society, other hospitals, licensing board, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the Hospital may have concerning me as well as releasing the Hospital representative from liability for so doing. I further specifically acknowledge that the provisions of said bylaws relating to confidentiality and release from civil liability are express conditions to my application for, and acceptance of medical staff membership and the continuation of such membership and to exercise of my clinical privileges. I pledge to provide for continuous care for my patients.

I certify that I have completed the minimum specified hours of CME/continuing education hours required for maintaining Ohio licensure, with at least fifty (50) percent of the minimum related to the privileges requested.

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 qualification for membership and clinical privileges as well as resolving any doubts about such qualifications. I further understand that any significant misstatements in or omissions from this application constitute cause for denial of appointment or cause for dismissal from the Medical Staff. I agree to accept the clinical privileges appointed by the Medical Executive Committee and the Board of Trustees.

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

Signature of Applicant: _____

Date _____

Print Name: _____

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 that Kettering Medical Center, the members of the Medical Staff, and the agents and representative thereof to consult with Administrators and members of the Medical Staff and credentialing institutions, other hospitals, healthcare institutions, and healthcare providers with whom I have been associated and/or previously applied for privileges from the Medical Staff, and with others, including past and present malpractice carriers, licensing agencies, peers, educational institutions and government programs, and credentialing reporting agencies which may have information bearing on my professional activities, competence, character, and ethical qualifications.

I acknowledge that the Medical Staff at Kettering Medical Center is comprised of licensed physicians, podiatrists and dentists who practice their respective specialty in and around Dayton, Ohio and who have been granted privileges with Kettering Medical Center. The members of the Medical Staff at Kettering Medical Center are not, for purposes of the credentialing and peer review processes and functions, employees of the Hospital, but rather, are licensed independent practitioners participating in the credentialing and peer review processes.

I consent to the inspection by Kettering Medical Center, the members of the Medical Staff, and its 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 privileges and/or scope of service to be granted by the Medical Staff.

I hereby release from liability all agents and representatives of Kettering Medical Center and the members of the Medical Staff for its acts performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications. I further release from any liability any individuals or organizations who provide information to Kettering Medical Center and the members of the Medical Staff, in good faith and without malice 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.

I understand and acknowledge that Kettering Medical Center, the members of the Medical Staff, and the agents and representatives thereof may be required to report to licensing agencies, State Medical Licensing Board, the National Practitioners' 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 which may otherwise be protected from disclosure as confidential peer review information. I hereby release from and agree to hold Kettering Medical Center, the members of the Medical Staff, and the agents and representatives thereof harmless for any liability for the release of such information when Kettering Medical Center and/or the members of the Medical Staff, by and through their/its respective agents and representatives, discloses such information in good faith in compliance with such laws, regulations and applicable governing requirements.

I further understand that, pursuant to written authorization by me or a duly entered court order, Kettering Medical Center, the members of the Medical Staff, and the agents and representatives thereof may provide to other hospitals, organization, insurers, healthcare providers, reporting and accrediting agencies and other persons information concerning my professional competence, character, ethics, credentials and credential status, clinical privileges and/or scope of service status, appointment and other peer review information. I hereby release from and agree to hold Kettering Medical Center, the members of the Medical Staff and the agents and representatives thereof harmless for any liability for release of such information, pursuant to my written authorization or a duly entered court order, when made in good faith.

A copy of this 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****

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 appointment, clinical privileges and/or scope of service at Kettering 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
Manager, Medical Staff Services
Kettering Medical Center
3535 Southern Blvd.
Kettering, OH 45429
937-395-8324 (phone)
937-395-8357 (FAX)

The above named person and facility 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 a consent to this inquiry and to your response, and releases you from liability if you observe certain conditions of good faith and reasonableness in reporting your observation and knowledge to representatives of Kettering Medical Center.

Sincerely,

Signature of Applicant/Insured

Date