



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

Dear Allied Health Professional:

Thank you for your interest in joining the Medical Staff of Kettering Medical Center (KMC) and/or Sycamore Medical Center (SMC) hereinafter referred to as Hospital(s). As recommended by the Ohio Department of Insurance, the Hospitals utilize the Council for Affordable Quality Healthcare's (CAQH) standardized provider application. Information on how to access the application is attached, along with instructions on completing the form. Please take time to thoroughly review your application, making sure to complete all relevant information fields, including dates, names, complete mailing addresses and telephone/fax numbers. This will help to ensure that your application is processed in a timely manner.

Please note that your references should have recent experience in observing and working with you and should be able to provide adequate information pertaining to your present professional competence and character. The Central Credentialing Office personnel will forward a "Confidential Practitioner Evaluation Form" to each of your references, as well as to the appropriate program directors, department chiefs, medical directors and other associates with whom you may have practiced.

A checklist of required enclosures is attached to this letter.

Once your application is received by the Central Credentialing Office it will be reviewed for completeness. Should your application be deemed incomplete (unanswered questions or omissions, including signatures, on the application or if any of the required documentation is not submitted) the central credentialing office personnel will notify you in writing of the incomplete application and outstanding information. Your application will also be deemed incomplete if the need arises for new, additional or clarifying information at any time during the application process.

Accreditation standards require that we verify certain data with the primary source. This is accomplished by requesting verification directly from the individual or institution and requiring that their response be returned directly to our office. Information requiring primary source verification includes, but is not limited to, professional school graduation, postgraduate training, professional references, hospital affiliations, malpractice history and professional licenses. In addition, we query the National Practitioner Data Bank and the Office of Inspector General's List of Excluded Individuals as part of consideration of any applicant. In order for your application to be considered complete, all information must be verified. Please remember that it is the applicant's ultimate responsibility to ensure that all information has been received.

Your completed and verified application will be reviewed by the appropriate Clinical Service Chief(s). Your application will then be reviewed by the Credentials Committee(s) and the Medical Executive Committee(s). The MEC makes its recommendations to the Hospital Board of Directors, which takes final action regarding your application. You will be notified of the Board's decision. We anticipate that this complete process will take approximately 60 to 90 days.

Expedited Process - The Hospitals are pleased to offer an expedited credentialing process. The fee for this process is an additional **\$250.00** to the current application fee. Upon receipt of your completed application (which includes, names, addresses, phone and fax numbers), the verification process will be implemented within one (1) business day (24 hours). Your involvement in this process is imperative as it is the applicant's ultimate responsibility to ensure that all information has been received. We anticipate that this process will take approximately 14 to 30 days.

If you have any additional questions, please contact your assigned representative at 937-395-8324.

Sincerely,

Melissa

Melissa Walters, MHA, CPMSM, CPCS
Director, Medical Staff Services & Network Credentialing

State of OHIO Standardized Credentialing Form

EFFECTIVE September 25, 2008

Utilization of the CAQH Application

Instructions

1. ACCESS:

- The State of Ohio standardized credentialing form may be accessed via the Internet. Click on <http://www.caqh.org> . This will take you to the CAQH website to complete the provider application as required for the insurance payers.

How do physicians and other practitioners complete the Universal Provider Datasource Data Collection Process?

- 1) Registering
- 2) Completing the UPD Online Form
- 3) Authorizing UPD-participant Plan Access to the information
- 4) Verifying data entry/Attesting
- 5) Submitting supporting documentation

How do you register to use the UPD Service?

- 1) Go online to <https://upd.caqh.org/OAS/>
- 2) Click "logging in for the first time?"
- 3) Enter CAQH Provider ID
- 4) Enter authentication data
- 5) Create a username and password

2. COMPLETE:

- Complete each section thoroughly and truthfully, and complete all fields. If an item is not applicable, indicate N/A.
- You are responsible for providing current information at all times and to update substantial changes throughout the credentialing period. Please remember that you must sign and date a new Affirmation of Information page each time your form is submitted.
- Modification to the wording and format of the form will invalidate the application.
- Attach additional sheets where necessary. (*Indicate clearly your name on each attachment.*)
- Complete KMC/SMC Addendum – Hospital Required Information; sign and date.

3. SUBMIT:

- Submit the following to the Hospitals' System Central Credentialing Office:
 1. CAQH Application
 2. KMCS Addendum – Hospital Required Information
 3. Additional required documents and/or items listed as required by KMC/SMC Addendum
 4. Delineation of Privileges – designated specialty and/or subspecialty

APPLICANT CHECKLIST

In addition to those items required with the CAQH Application, please enclose the following:

- Application fee (non-refundable) in the amount of **\$250.00** (Active) and **\$300.00** (Courtesy/Associate).
- If requesting the expedited process, please include an additional **\$250.00** (non-refundable).
- Recent professional **color** photo (passport size - driver's license NOT acceptable – proof of identification is required either upon attending orientation or obtaining Hospital identification badge)
- If not U.S. citizen, provide documentation of VISA status and/or employment authorization, including ECFMG certification
- Listing of all medical and/or other professional licenses and DEA or controlled substance certificates (active and inactive)
- Verification of professional liability insurance in at least the amounts specified in the Medical Staff Bylaws (minimum of \$1 million/\$1 million). Certificate of Insurance and Declaration Page required.
- Complete clinical privileges profile
- If requesting fluoroscopic procedures, please complete the Fluoroscopy Attestation, which is also available at www.khnetwork.org "physicians only" section.
- If requesting moderate sedation please complete the competency test (accessible via website) and provide a current copy of your ACLS, ATLS, PhyAmerica, documentation of approval for procedural sedation privileges from a local GDAHA hospital, or airway management course provided by KMC/SMC.
- Curriculum Vitae
- Documentation of your current clinical competence for those procedures requested (50 **DE-IDENTIFIED** operative reports and/or a comprehensive case log are required for invasive procedures, including pump perfusionist, surgical, endoscopy, cardiac cath, and/or angioplasty procedures.)
- TB documentation/Attestation (available on website)
- Safety education (available on website)

Also, be sure to submit the following documents provided to you with your application:

- Medicare/Champus Attestation Form
- Medical Malpractice Insurance Agreement Form
- Emergency Department Preference Form
- Statement of Authorization and Release from Liability
- Disclosure and Authorization Form



**KMC/SMC ADDENDUM
HOSPITAL REQUIRED INFORMATION**

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

A. PERSONAL INFORMATION

Applicant Name :	Applicant's Personal Email :
Marital Status :	Spouse's Name :
<p>In addition to the three (3) Professional Peer References required by CAQH, please provide one <u>additional</u> reference, preferably with your clinical specialty. This reference MAY NOT be your residency director, fellowship director, current clinical department chairperson, current partners or associates in practice.</p>	
Name : _____	Specialty : _____
Address : _____	Phone : _____
City, State, Zip : _____	Fax : _____

B. DISCLOSURE INFORMATION

1. Have you ever withdrawn your application for appointment, reappointment, clinical privileges and/or scope of service, or resigned before a decision by a hospital's or healthcare facility's governing body was rendered? Yes No
2. Have you ever been the subject of disciplinary proceeding or investigation at any hospital or healthcare facility? Yes No
3. Are your staff appointment or clinical privileges and/or scope of service at any hospital or other healthcare facility currently under investigation? Yes No

If the answer to any of the questions above is YES, please complete the Professional Sanctions Reporting Form included with this packet.

4. Has any (current or past) professional liability insurance carrier excluded any specific procedures from your coverage? Yes No
5. Have you ever practiced without professional liability insurance? Yes No

If the answer to any of the questions above is YES, provide a full explanation on a separate sheet, including the name of the carrier, the date and specific information concerning limitation or termination.

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

If the answer to any of the questions above is YES, please complete the Malpractice Claims Assessment Form. Even if this information is available from the National Practitioner Data Bank, you must provide it in order to complete your application.

9. If you are granted medical staff membership, clinical privileges and/or scope of service, do you agree to notify the Hospitals 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? This includes answers provided in the CAQH application. Yes No
10. Do you understand and acknowledge that it is an express condition to ongoing medical staff membership, clinical privileges and/or scope of service to notify the Hospitals of any occurrence/event which renders the

foregoing answers incorrect or incomplete when notice of the same is received by you? This includes answers provided in the CAQH application. Yes No

Provide information for all time frames of one (1) month or more that are not covered in Education, Hospital Affiliations or Prac History sections of the CAQH application such as extended travel, maternity leave, relocation, etc. If necessary, please attach additional sheet.

Dates	From	To	Explanation:

C. MISCELLANEOUS

1. To which staff category do you wish to apply?

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.*

2. Clinical Service to which you are applying : (check only one)

- | | | | |
|---------------------------------------------|--------------------------------------------|--------------------------------------|----------------------------------|
| <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Medical Imaging | <input type="checkbox"/> Orthopedics | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Pathology | |
| <input type="checkbox"/> Family Practice | <input type="checkbox"/> Ob/Gyn | <input type="checkbox"/> Pediatrics | |

Clinical Specialty/Subspecialty : _____

D. APPLICANT'S ATTESTATION

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).

I have submitted a passport size photograph and give the right and my permission for Kettering Health Network ("KHN") and any of its affiliated hospitals, clinics and health centers with which I am associated to use and distribute this photograph and other professional biographical information for purposes of identification, world wide web publication, and other general public distributions in connection with educational, public relations, media relations, marketing, promotional, communications, and other charitable purposes.

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 Hospitals.

Signature Employing/Sponsoring Physician

Date

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



MEDICARE PHYSICIAN ACKNOWLEDGEMENT STATEMENT

By signing this document, I attest that I have received and read the following statement:

Medicare/TriCare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his/her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds may be subject to fine, imprisonment or civil penalty under applicable federal laws.

Signature

Date

Print Name



AGREEMENT

I understand that it is a condition of Medical Staff membership/privileges at Kettering Medical Center/Sycamore Medical Center (“Hospital(s)”) that each practitioner has malpractice insurance coverage in the amounts of \$1,000,000 per incident \$1,000,000 aggregate.

I hereby agree to notify the Hospitals’ Central Credentialing Office at once if my current coverage is canceled, terminated or restricted in any way.

SIGNATURE: _____

PRINT NAME: _____

DATE: _____

MANDATORY: MUST BE COMPLETED IN ORDER TO RECEIVE PRIVILEGES

KETTERING MEDICAL CENTER SYSTEM

PLEASE FAX TO 937-395-8247

Attn: Rebecca Sauer

In an effort to update the Emergency Department "**Authorization for Treatment**" records and expedite medical care of your private patients, please complete this form.

Name (please print) _____ Office Name _____

Office Address _____ City _____ Zip _____

Office # _____ Home # _____ Private Office # _____

Fax Number # _____ Beeper # _____

Cell Phone # _____ Med Society # _____

Email: _____

AUTHORIZATION:

Please indicate preference after initial Emergency Department screening:

Contact me for routine notification of admission and/or referral.

Contact me upon arrival of patient.

Contact me after workup of patient.

Special Instructions: _____

REFERRALS: (Print legibly)

List specialists to be called in the event specialist services are indicated.

*****If NO PREFERENCE is listed, the specialist on the ED call rotation schedule will be utilized.*****

Acute/Critical Care _____ Oral Surgery _____

Cardiology _____ Orthopedics _____

Colorectal _____ Otolaryngology _____

Gastroenterology _____ Pediatrics _____

General Surgery _____ Plastic Surgery _____

Hand Surgery _____ Psychiatry _____

Neurology _____ Pulmonology _____

Neurosurgery _____ Thoracic Surgery _____

OBGYN _____ Urology _____

Ophthalmology _____ Hospitalist _____

HIPAA REVIEW FOR PHYSICIANS

WHAT IS RELEVANT TO A KETTERING MEDICAL CENTER NETWORK PRACTITIONER

Introductory

This review addresses the requirements of the Privacy and Security rules under the Health Insurance and Portability and Accountability Act of 1996 (HIPAA).

While reference is mainly made to the Privacy provisions, the Privacy and Security rules work in tandem in strengthening patient rights and privacy protections. The regulations boil down to 1) for the practitioner – more responsibility to protect the patient’s privacy, and 2) for the patient – more control.

Primary reasons we comply with these requirements:

- *It’s the law*
- *HIPAA supports our institution’s commitment to respect patient privacy and confidentiality*
- *Privacy violation complaints can jeopardize the hard earned reputation and respect of the institution and the individual practitioner*
- *It is part of the good care and services we provide our patients*

Secondary reasons we comply with these requirements:

- *Patients can file complaints directly with the Department of Health and Human Services (HHS)*
- *Violations are subject to both civil and criminal penalties*

What are we protecting, and how?

Protected Health Information (PHI), which is any information about a patient that we (KMCN) create or collect which can be linked back to an individual.

We protect PHI from uses (internal) or disclosures (external) that are not authorized by the patient or are not for appropriate use in treatment, payment or KMCN operations.

Internally we must use PHI only to conduct the duties for which we are responsible. This is why only certain individuals have access to PHI and the level of access is controlled to minimize the ability to see certain PHI. This is what is called Minimum Necessary and Need-to-Know. This also applies to access in restricted areas of the hospital. Minimum Necessary also impacts:

- Looking only at the PHI of the patients for which you are involved in treating
- Do not look at your own PHI, your family member, or a friend. Unless you are participating in the care of this individual.
- Even when sharing information for treatment or payment purposes, make sure it is only what is necessary and appropriate

Safeguards

Safeguarding PHI can be time consuming and costly. For this reason, the regulations refer to **reasonable measures** for protection of PHI. Here are a few tips:

- Although being overheard by others when talking to patients/family members in non-private rooms, small waiting areas, or other areas can be considered an *incidental disclosure (this is an allowed type of disclosure under the regulation)*, we must make every effort to:
 - Speak softly
 - Move to an area of the room where the most privacy is available
 - Use private rooms to communicate with family or patients, when available
 - Ask the family or patient if they feel comfortable discussing this information at the current location you have chosen

- Close and lock doors of/leading to rooms that hold PHI
- Do not leave documents with PHI where they can be accessed by others
- Do not discuss PHI in public areas (e.g.hallways, elevators, etc.)
- Keep your laptop or personal digital assistant's (PDA) secure, and with passwords if possible
- Dispose of documents with PHI in the available bins, not the regular trash
- Do not share your computer password or access to restricted areas with anyone under any circumstances

Patient rights

Accounting of Disclosures

- Patients can request a list of the individuals/entities to which you disclosed their information. This means that you or your staff will have to log and track the disclosures you make to external entities for purposes other than treatment, payment or certain healthcare operations and for which no patient authorization was obtained.

Access to Medical Record

- Although the patient has always had this right, HIPAA enforces their ability to access the record in a timely manner.

Request to Amend Medical Record

- A patient can request in writing to have their medical record amended if they feel the information is incorrect. The practitioner responsible for the information in question determines if in fact a correction is or is not required. Even if the change is not made, a copy of the request is kept in the medical record.

Facility Directory

- A patient can choose to be excluded from the facility directory. At KMCN this classification is known as a Do Not Announce (DNA). As a DNA the patient will appear to anyone calling or stopping by, as if he/she were not at our facility. This classification can be found on LastWord and several census reports. A patient who is not DNA, and therefore part of our directory can be reached by someone asking for him/her by full name. We can then provide patient location, and general condition of a non-DNA patient.

Family / Friend Involvement

- The patient chooses whom we can and cannot communicate with regarding their care. At KMCN we ask the patient to provide one or two names that we can share information with. This person(s) then becomes our point of contact and we direct anyone else asking detailed information about the patient to the person(s).

Alternate Means of Communications and Restrictions to Use and Disclose PHI

- A patient can request to be contacted via an alternate route (e.g. temporary number, different address, cell phone, etc.) The patient can also request that their information not be used or disclosed in a certain way. These requests must be evaluated individually to verify that KMCN can assure 100% compliance before it is agreed to.

File a Complaint

- Patients can file a complaint regarding their privacy directly with the US Department of Health and Human Services. That information is provided to them in our Notice of Privacy Practices or they can contact the KMCN Privacy Officer to file their complaint.

Contact Information

For Privacy or Information Security related questions, please contact the Information Security and Privacy Officer at (937) 395-8581 or e-mail: privacy.officer@khnetwork.org.



KETTERING HEALTH NETWORK MED STAFF # 8637 PRACTITIONER DISCLOSURE & AUTHORIZATION

800.999.9861
713.861.5959
info@precheck.com
www.PreCheck.com

APPLICANT'S FULL NAME _____
Any Other Names Used _____
Social Security No. ____/____/____ Date of Birth¹ _____
Current Address _____
City _____ State _____ Zip _____
Driver's License State _____ No. _____
Address: _____

Have you ever been convicted of a crime? Yes No
Offense _____ County _____ State _____ When _____

Please provide all locations where you have resided or practiced for the past ten (10) years, starting with your current residency.

	City	State	Dates	From:	To:
1.	_____ / _____	_____	_____	_____	_____
2.	_____ / _____	_____	_____	_____	_____
3.	_____ / _____	_____	_____	_____	_____
4.	_____ / _____	_____	_____	_____	_____
5.	_____ / _____	_____	_____	_____	_____
6.	_____ / _____	_____	_____	_____	_____
7.	_____ / _____	_____	_____	_____	_____
8.	_____ / _____	_____	_____	_____	_____

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Kettering Health Network may obtain information about you from a consumer reporting agency made in connection with your application for employment, contract or privileges. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews. These reports may contain information regarding your criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888)PreCheck [1-888-773-2432] or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment, contract, privileges or appointment to the extent permitted by law.

¹ The Age Discrimination in Employment Act of 1987 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is necessary for the proper processing of a consumer report.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout the term of my employment, contract or privileges, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888) PreCheck [1-888-773-2432] another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

STATE LAW NOTICES

Minnesota or Oklahoma applicants or employees only: Please mark an X in the designated field if you would like to receive a free copy of a consumer report if one is obtained by the Company. The report will be mailed to the current address you indicated on this form. _____

California applicants or employees only: Please mark the following field if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. The report will be mailed to the current address indicated above. _____

California applicants or employees only: By marking an X in the designated field, you will receive and are acknowledging receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. _____

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Client by directly contacting PreCheck Inc. Additionally, please mark this field to receive and acknowledge receipt of a copy of Article 23-A of New York Correction Law. _____

Maine applicants or employees only: Under Chapter 210 Section 1314 of Maine Revised Statutes, you have the right, upon request, to be informed within 5 business days of such request of whether or not an investigative consumer report was requested. If such report was obtained, you may contact the Consumer Reporting Agency and request a copy.

Massachusetts applicants or employees only: If you ask, you have the right to a copy of any background check report concerning you that the Company has ordered. You may contact the Consumer Reporting Agency for a Copy.

Washington State applicants or employees only: You have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from the Company a complete and accurate disclosure of the nature and scope of the investigation we requested. You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act. |

I have read and understand the above information and assert that all information provided by me is true and accurate.

Signature _____ Date _____ |