Medical Staff Credentialing Application

IF YOU ARE APPLYING TO MORE THAN ONE OF THE HOSPITALS LISTED BELOW, PLEASE CONTACT EACH HOSPITAL TO OBTAIN THE APPROPRIATE HOSPITAL SPECIFIC FORMS PRIOR TO SUBMITTING YOUR APPLICATION.

This application may be used at the hospitals listed below. The Medical Staff office phone numbers of the participating hospitals are as follows:

Phone	Hospital	Email
330-837-7499	Affinity Medical Center	leah.hoskins@affinitymedicalcenter.com
330-543-8113	Akron Children's Hospital	ssimms@chmca.org
330-344-6565	Akron General Health System	
	Akron General Medical Center	dbunn@agmc.org or ngroves@agmc.org
	Edwin Shaw Rehab, LLC	dbunn@agmc.org or ngroves@agmc.org
330-948-5501	*Lodi Community Hospital*	kflegel@lodihospital.com
330-655-3800	Aris Teleradiology	haseleyj@arisrad.com
330-363-6255	Aultman Hospital	jbortz@aultman.com
330-721-5182	Medina Hospital - a Cleveland Clinic hospital	mfunk@ccf.org
330-861-2086	Regency Hospital of Akron/Ravenna	ksanders@regencyhospital.com
330-297-2460	Robinson Memorial Hospital	mmcelfresh@rmh2.org
330-761-7574	Select Specialty Hospital-Akron	csvoboda@selectmedicalcorp.com
330-489-8175	Select Specialty Hospital-Canton	
330-375-7100	Summa Health System	
330-375-7100	*Summa Akron City Hospital/St. Thomas Hospital*	pdragan@summahealth.org
		conlinm@summahealth.org
		brookshl@summahealth.org
330-615-3109	*Summa Barberton Hospital*	dsukie@barbhosp.com
330-335-6940	*Summa Wadsworth Rittman Hospital*	StephS@wrhhs.org

Akron Regional Hospital Association

Medical Staff Credentialing Application

ALL BLANK SPACES MUST BE FILLED IN

INCOMPLETE INFORMATION WILL RESULT IN THIS APPLICATION BEING RETURNED

APPLICATION FOR MEDICAL STAFF MEMBERSHIP AND PRIVILEGES

ALL INFORMATION MUST BE PRINTED OR TYPED: DO NOT USE WHITE OUT OR CORRECTION FLUID

General Information

Last Name	First Name	Middle Name	Title
Indicate any other name(s) you have practiced under (First Name, Last Name):			
☐ Male ☐ Female		Maiden Name	Social Security Number
Practicing with whom and nature of affiliation:			
Business Mailing Address	City	State	Zip Code
Phone Number ( )		Fax # ( )	
Additional Business Mailing Address	City	State	Zip Code
Phone Number ( )		Fax # ( )	
Residence Mailing Address	City	State	Zip Code
Phone Number ( )		Fax # ( )	
Business Email Address		Residence Email Address	
Date of Birth	City/State of Birth	Citizenship	Visa Status
Language other than English		ECFMG Number	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Name of Significant Other:			
Beeper/Pager Number	Cell Phone Number	Answering Service Number	
Emergency Contact Name/Relationship			Phone Number
Medicaid Provider Number		Medicare Provider Number	
UPIN Number	Tax ID Number	NPI Number	

EACH page must be dated & initialed
EACH TIME you submit this form to a hospital

Date ____________ Initials ____________

⇨ ⇨ In the following sections you must provide a complete chronology of your training and practice history. Any dates not accounted for on the application must be explained on an attached CV. ⇦ ⇦

Undergraduate Education

Name of College or University	
Complete Address	
Date of Graduation	Degree

Medical or Professional Education

Name of College or University	
Complete Address	Fax Number
	Phone Number
Date of Graduation	Degree

Internship

Name of Hospital/Health Care Entity[1]		From / / To / / Program Completed: ☐ Yes ☐ No	
Complete Address	City	State	Zip Code
Phone Number ( )		Fax Number ( )	
Type		Current Program Director	

Residencies (List in Chronological Order)

Name of Hospital/Health Care Entity[1]		From / / To / / Program Completed: ☐ Yes ☐ No	
Complete Address	City	State	Zip Code
Phone Number ( )		Fax Number ( )	
Type of Residency		Current Program Director	

Name of Hospital/Health Care Entity[1]		From / / To / / Program Completed: ☐ Yes ☐ No	
Complete Address	City	State	Zip Code
Phone Number ( )		Fax Number ( )	
Type of Residency		Current Program Director	

Name of Hospital/Health Care Entity[1]		From / / To / / Program Completed: ☐ Yes ☐ No	
Complete Address	City	State	Zip Code
Phone Number ( )		Fax Number ( )	
Type of Residency		Current Program Director	

[1]For the purpose of this application, a health care entity that provides or arranges for the provision of health care services including, but not limited to hospitals, managed care organizations, HMOs, nursing homes, free-standing ambulatory care clinics, etc.

Date ________________ Initials ____________

Fellowships, Preceptorships, Postgraduate Education (List in Chronological Order)

Name of Hospital/Health Care Entity[1]	From / / To / / Program Completed: ☐ Yes ☐ No		
Complete Address	City	State	Zip Code
Phone Number ( )	Fax Number ( )		
Type	Current Program Director		
Name of Hospital/Health Care Entity[1]	From / / To / / Program Completed: ☐ Yes ☐ No		
Complete Address	City	State	Zip Code
Phone Number ( )	Fax Number ( )		
Type	Current Program Director		

List three (3) professional/medical references from licensed individuals in your general field of practice (i.e. dentist-to-dentist; surgeon-to-surgeon) who have worked extensively with you or who have been responsible for professional observation of your work within the last three years. Only one reference can be a current partner or associate. Do not include graduate medical education director, department chairperson, or relatives.

Name		Title	
Complete Address	City	State	Zip Code
Phone Number ( )		Fax Number ( )	

Name		Title	
Complete Address	City	State	Zip Code
Phone Number ( )		Fax Number ( )	

Name		Title	
Complete Address	City	State	Zip Code
Phone Number ( )		Fax Number ( )	

(Optional) Name		Title	
Complete Address	City	State	Zip Code
Phone Number ( )		Fax Number ( )	

Primary Admitting Facility in Northeastern Ohio

[1]For the purpose of this application, a health care entity that provides or arranges for the provision of health care services including, but not limited to hospitals, managed care organizations, HMOs, nursing homes, free-standing ambulatory care clinics, etc.

Date ________________ Initials ______________

Hospital/Health Care Entity[1] Appointments and/or Professional Employment: List all current, past or pending Hospital/Health Care Entity[1] affiliations and/or professional employment. Use an additional sheet, if necessary. List primary first.

Name of Hospital/Health Care Entity[1] or Organization			
Complete Address	City	State	Zip Code
Fax Number			
Phone Number	From / /	To / /	
Staff Level/Status	Department Chairman/Supervisor		

Name of Hospital/Health Care Entity[1] or Organization			
Complete Address	City	State	Zip Code
Fax Number			
Phone Number	From / /	To / /	
Staff Level/Status	Department Chairman/Supervisor		

Name of Hospital/Health Care Entity[1] or Organization			
Complete Address	City	State	Zip Code
Fax Number			
Phone Number	From / /	To / /	
Staff Level/Status	Department Chairman/Supervisor		

Name of Hospital/Health Care Entity[1] or Organization			
Complete Address	City	State	Zip Code
Fax Number			
Phone Number	From / /	To / /	
Staff Level/Status	Department Chairman/Supervisor		

Name of Hospital/Health Care Entity[1] or Organization			
Complete Address	City	State	Zip Code
Fax Number			
Phone Number	From / /	To / /	
Staff Level/Status	Department Chairman/Supervisor		

Board	Date Certified	Last Date Recertified	Certification Expires
	/ /	/ /	/ /
	/ /	/ /	/ /
	/ /	/ /	/ /
	/ /	/ /	/ /

If not certified, state your intent with respect to becoming certified and describe the status of your efforts and eligibility, including past efforts and failures* of written oral exams, if any. **Please provide additional information* .

[1]For the purpose of this application, a health care entity that provides or arranges for the provision of health care services including, but not limited to hospitals, managed care organizations, HMOs, nursing homes, free-standing ambulatory care clinics, etc.

Date ______________ Initials ______________

Licensing: List all past and current

Professional License Number	State	Date Issued	Expiration Date
		/ /	/ /
		/ /	/ /
		/ /	/ /
Other (Nature of License, County, and State		/ /	/ /
Federal Narcotics Registration Number (DEA No.)		/ /	/ /

Professional Liability Insurance History (PAST FIVE YEARS): Include a copy of your current certificate of insurance. Use Additional Information Sheet if necessary.

Name of Present Carrier:	
Complete Address	Policy Number
Amount of Coverage: $	Coverage Period / / to / /
Name of Prior Carrier:	
Complete Address	Policy Number
Amount of Coverage: $	Coverage Period / / to / /
Name of Additional Prior Carrier:	
Complete Address	Policy Number
Amount of Coverage: $	Coverage Period / / to / /

Disclosure Information

IF YOU ANSWER YES TO ANY OF THE QUESTIONS BELOW, PLEASE EXPLAIN ON A SEPARATE SHEET OF PAPER

Question	Answer
1. In the last five (5) years have there been or are there currently pending any malpractice settlements, claims, suits, judgements, or arbitrations involving your professional practice? If yes to the above, please complete the enclosed Professional Liability Claim Form.	☐ Yes ☐ No
2. Have you ever been denied malpractice liability insurance or has any malpractice liability insurance ever been canceled?	☐ Yes ☐ No
3. Has your present professional liability insurance carrier placed any limitations/exclusions on your coverage?	☐ Yes ☐ No
4. Have you requested or been granted a Leave of Absence from any hospital affiliate/health care entity in order to avoid possible revocation, suspension or reduction of privileges at any hospital or institution?	☐ Yes ☐ No
5. Have you ever been denied appointment to the medical staff of any Hospital or Health Care Entity or denied advancement in medical staff category or has such a denial been recommended by a medical staff committee or hospital/health care governing body?	☐ Yes ☐ No
6. Has your request for any specific clinical privilege(s) been denied or granted with stated limitations (aside from ordinary and initial requirements related to professional practice evaluation) or has such a denial or limitation ever been recommended by medical staff committee or governing body of a hospital or health care entity?	☐ Yes ☐ No
7. Has your request for any specific clinical privilege(s) ever been denied or granted with stated limitations (aside from ordinary and initial requirements of proctorship) or has such a denial or limitation ever been recommended by a medical staff executive/governing body?	☐ Yes ☐ No
8. Has your license, or application for license, to practice your profession in any jurisdiction ever been suspended, revoked, denied, or subject to probationary conditions, voluntarily or involuntarily relinquished, or have proceedings toward any of these ends ever been instituted?	☐ Yes ☐ No
9. Has your Drug Enforcement Agency registration or other controlled substances authorization ever been suspended, revoked, reduced, not renewed, or voluntarily or involuntarily relinquished?	☐ Yes ☐ No
10. Have you ever been convicted, arrested, or charged with a felony or misdemeanor (other than minor traffic offenses)? Include crimes related to children, adolescents, and adults.	☐ Yes ☐ No
11. Have you ever been terminated or placed on probation or otherwise limited by an HMO, PPO, or other managed care organizationi in which you have had a medical or professional staff appointment or privilege?	☐ Yes ☐ No

Date ____________ Initials ____________

12. Have you ever been suspended or terminated from participating in a Federal Health Care Program including, without limitation Medicare/Medicaid; have you been subject to, or are you under investigation by a Federal Health Care Program; or have you ever been named as a defendant in any lawsuit alleging inappropriate conduct in a Federal Health Care Program?	☐ Yes ☐ No
13. Have you ever withdrawn an application for medical staff appointment and/or privileges to any hospital or health care entity during or in lieu of investigation or to avoid denial of specific request?	☐ Yes ☐ No
14. Have you ever had any action taken against you that has been reported to the NPDB? If yes, attach a copy of the report.	☐ Yes ☐ No
15. Have you had any professional sanctions related to appointment/fellowship in local, state, national organizations; board certification or eligibility; or faculty appointment at any professional school?	☐ Yes ☐ No

Ability to Perform

1. Are you currently capable, with or without reasonable accommodation, of fully, competently, and safely carrying out the clinical privileges and medical staff responsibilities for which you have applied? *If "No", please provide details on a separate sheet.*	☐ Yes ☐ No
IF THE ANSWER IS YES TO ANY OF THE FOLLOWING QUESTIONS, PLEASE PROVIDE FULL DETAILS INCLUDING NAME AND ADDRESSES OF PHYSICIANS/HOSPITALS/HEALTH CARE ENTITIES INVOLVED ON A SEPARATE SHEET	
2. Do you currently use any illegal drugs (or prescriptive drugs for reasons other than treating a medical condition); or do you currently abuse or excessively consume alcoholic beverages?	☐ Yes ☐ No
3. Are you currently under any consent decree or any other type of agreement with any professional licensing board and/or state or local professional association, the terms of which, if violated, would result in the suspension, restriction, or revocation of your professional license to practice?	☐ Yes ☐ No

Health

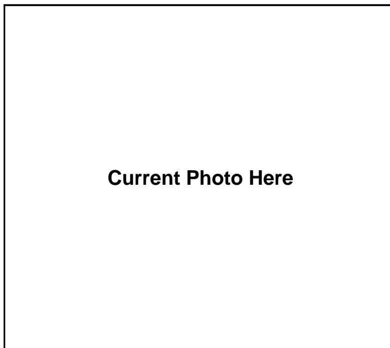
Have you had the Hepatitis B Vaccine? ☐ No ☐ Yes Date: / /	
PPD Date: / /	Results: ☐ Positive ☐ Negative
PPD Not Done (Reason):	
If new positive, date CXR was done: / /	Results: ☐ Positive ☐ Negative

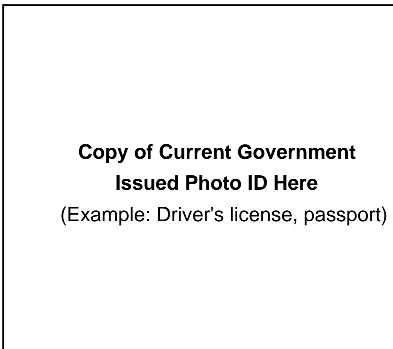
Continuing Education

Have you maintained continuing education in the amounts expected by your licensing and certification boards?	☐ Yes ☐ No
Have you maintained continuing education in your specialty/subspecialty?	☐ Yes ☐ No
Note: Proof of attendance and program content must be submitted upon request.	

**DO NOT
SEND COMPLETED APPLICATIONS TO THE
AKRON REGIONAL HOSPITAL ASSOCIATION**

Two (2) photos are required as indicated below:





Date ____________ Initials ________

ADDITIONAL INFORMATION/COMMENTS

Date ______________ Initials ______________

Provider Name (Please Print)

PROFESSIONAL LIABILITY CLAIM FORM

(Important: Each claim[1] reported must be on a separate form. Photocopy as needed.)

Please supply adequate responses in sufficient clinical detail to allow proper reviewand evaluation by the Credentials Committee of your application.

Please report all claims, pending, settled, and dismissed.

Patient Name ______________________ Age ____________ Sex: ☐ Male ☐ Female

Incident Date: ______________________

Describe alleged injury and clinical outcome: ______________________

Patient's condition and diagnosis at the time of incident: ______________________

Alleged basis for claim, if known: ______________________

County where filed: ______________________

Names of additional defendants, if known: ______________________

Claim Disposition:

______ Pending ______ Closed with no payment

______ Closed with payment, by verdict or settlement

If closed, please give date: ______________________

If closed with payment, please indicate the amount paid on your behalf: ______________________

I UNDERSTAND THAT ALL INFORMATION SUBMITTED HEREIN BECOMES PART OF MY APPLICATION, AS SUBMITTED

Provider Signature: ______________________ **Date:** ____________

[1]Claim is defined as being named as defendant in a malpractice lawsuit.

Date ____________ Initials ____________