AKRON REGIONAL HOSPITAL ASSOCIATION

ARHA STANDARDIZED FORM
REQUEST FOR TEMPORARY CLINICAL DISASTER PRIVILEGES

(Final approval 10-21-08)

NAME (Printed)_____TITLE_____(i.e. MD, DO, DDS, DPM, CNM, CRNA, PA, APN, etc.)
Last First

DATE OF BIRTH___/___/_____SOCIAL SECURITY NUMBER_____SEX_____ (M/F)

OFFICE NAME_____ NPI NUMBER_____

OFFICE PHONE NUMBER_____ PAGER_____

CELL PHONE_____ HOME PHONE_____

MEDICAL SPECIALTY_____TITLE_____

LICENSE NUMBER (if known)_____STATE OF LICENSURE_____

PRIMARY HOSPITAL AFFILIATION (A facility where the practitioner holds Active Staff privileges)

AKRON REGIONAL HOSPITAL ASSOCIATION (ARHA) MEMBER HOSPITAL _____YES _____NO

NAME OF FACILITY_____

City_____State_____Zip_____

WERE YOU SENT HERE BY MEDICAL RESERVE CORPS? _____YES _____NO IDENTIFY GROUP_____

MALPRACTICE CARRIER/AGENT_____Amount_____

I understand completely that disaster privileges are only good through the duration of the disaster and are terminated automatically when the disaster is over as determined by _____(hospital name) President or designee.

I will not perform any procedures for which I am not qualified. I am familiar with the laws of the State of Ohio governing the practice of medicine (dentistry, podiatry, psychology, allied health professionals), and pledge to abide by these laws.

I attest to carrying current Malpractice Insurance and I will provide a copy of my Certificate of Liability to complete this file.

I hereby request, authorize, and consent to any hospital or medical staff where I now have medical staff privileges who may have information which is deemed necessary for the evaluation of my application for disaster privileges, to provide such information to designated representatives of _____ (hospital name) upon their request.

Signature, Practitioner Applicant Date

Signature, Authorizing Authority Date

HOSPITAL OFFICE USE ONLY

Credentials Office Personnel Checklist

_____State License Verification (must be done within 72 hours or as situation allows) _____DEA Verification
_____Malpractice verified _____Application completed
_____National Practitioner Data Bank checked (may be done at a later date) _____ARHA Hospital Credentialed Physician
_____Photo Identification: verified and/or attached (government or hospital issued ID)