AKRON REGIONAL HOSPITAL ASSOCIATION

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
330-834-4760	Affinity Medical Center	erica.miller@affinitymedicalcenter.com
330-543-8113	Akron Children's Hospital	ssimms@chmca.org
330-543-8024	Akron Children's Hospital	tfrishgesell@chmca.org
330-344-6565	Cleveland Clinic Akron General	
	Akron General Medical Center and	stephanie.hahn@akrongeneral.org
	Edwin Shaw Rehab, LLC	debbie.bunn@akrongeneral.org
330-948-5501	*Cleveland Clinic Akron General Lodi Hospital*	Rachel.Smith4@akrongeneral.org
		linda.fitzgerald@akrongeneral.org
330-688-1874	Aris Teleradiology	haseleyj@arisrad.com
330-363-6255	Aultman Hospital	jbortz@aultman.com
330-721-5182	Cleveland Clinic Medina Hospital	mfunk@ccf.org
330-297-2460	U.H. Portage Medical Center	mindy.mcelfresh@UHhospitals.org
330-297-2461	U.H. Portage Medical Center	michelle.circelli@Uhhospitals.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*	draganp@summahealth.org
		brookshl@summahealth.org
330-331-1339	*Summa Barberton Hospital*	dsukie@summahealth.org
330-331-1339	*Summa Health Wadsworth-Rittman Medical Center*	tlenart@summahealth.org

Akron Regional Hospital Association
Medical Staff Credentialing Application

APPLICATION FOR MEDICAL STAFF MEMBERSHIP AND PRIVILEGES

ALL BLANK SPACES MUST BE FILLED IN

INCOMPLETE INFORMATION WILL RESULT IN THIS APPLICATION BEING RETURNED

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

NPI Number		

Office Manager _____	Credentialing Specialist _____
Phone Number ( ) _____ Fax Number ( ) _____	Phone Number ( ) _____ Fax Number ( ) _____
Email	Email

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. ⇦ ⇦

Medical or Professional Education

Name of College or University	
Complete Address	Phone Number
	Fax 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 ( )	Email
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 ( )	Email
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 ( )	Email
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 ( )	Email
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.

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

[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, HMDs, nursing homes, free standing ambulatory care clinics, etc.

Primary Admitting Facility in Northeastern Ohio

Name of hospital/health care entity[1] ______________________________

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
Phone Number			
Fax Number	From / /	To / /	
Staff Level/Status	Department Chairman/Supervisor		

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

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

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

Name of Hospital/Health Care Entity[1] or Organization			
Complete Address	City	State	Zip Code
Phone Number			
Fax 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.

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
Phone ( )	Fax ( )
Amount of Coverage: $	Coverage Period / / to / /
Name of Prior Carrier:	
Complete Address	Policy Number
Phone ( )	Fax ( )
Amount of Coverage: $	Coverage Period / / to / /
Name of Additional Prior Carrier:	
Complete Address	Policy Number
Phone ( )	Fax ( )
Amount of Coverage: $	Coverage Period / / to / /

CONFIDENTIAL ATTESTATION

If you do not believe a question is applicable to you, please answer the question "No".
ALL questions require a response; any unanswered question(s) will cause processing delays.

Licensure	
1. Has your license, registration, or certification to practice in your profession ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing registration or certification board?	☐ Yes ☐ No
2. Has there been any challenge to your licensure, registration, or certification?	☐ Yes ☐ No
Hospital Privileges and Other Affiliations	
3. Have your clinical privileges or medical staff membership at any hospital or healthcare institution voluntarily or involuntarily ever been denied, suspended, revoked, restricted or denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?	☐ Yes ☐ No
4. Have you voluntarily or involuntarily surrendered, limited your privileges, not reapplied for privileges, requested leave of absence or withdrawn application in lieu of investigation?	☐ Yes ☐ No
5. Have you ever been terminated for cause or not renewed for cause from participation or been subject to any disciplinary action by any managed care organizations (including HMOs, PPOs or provider organizations such as IPAs, PHOs)?	☐ Yes ☐ No
Education, Training, and Board Certification	
6. Were you ever placed on probation, disciplined, formally reprimanded, suspended, or asked to resign during an internship, residency, fellowship, preceptorship, or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended, or asked to resign?	☐ Yes ☐ No
7. Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?	☐ Yes ☐ No
8. Have any of your board certifications or eligibility ever been revoked?	☐ Yes ☐ No
9. Have you ever chosen not to recertify or voluntarily surrendered your board certification(s) while under investigation?	☐ Yes ☐ No

DEA or State Controlled Substance Registration	
10. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?	☐ Yes ☐ No
Medicare, Medicaid, or Other Governmental Program Participation	
11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified, or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?	☐ Yes ☐ No
Other Sanctions or Investigations	
12. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?	☐ Yes ☐ No
13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?	☐ Yes ☐ No
14. Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.?)	☐ Yes ☐ No
15. Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined, or resigned in exchange for no investigation or adverse action within the last 10 years for sexual harassment or other illegal misconduct?	☐ Yes ☐ No
16. Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?	☐ Yes ☐ No
17. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?	☐ Yes ☐ No
18. In the past 10 years, have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse, or a sexual offense or sexual misconduct?	☐ Yes ☐ No
19. Have you ever been court-martialed for actions related to your duties as a medical professional?	☐ Yes ☐ No

Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made based upon all the relevant circumstances, including the nature of the crime.

Professional Liability Insurance Information and Claims History	
20. Has your professional liability coverage ever been cancelled, restricted, declined, or not renewed by the carrier based on your individual liability history?	☐ Yes ☐ No
21. Have you ever been assessed a surcharge or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?	☐ Yes ☐ No
22. Have you had a professional liability actions (pending, settled, arbitrated, mediated, or litigated) within the past 10 years? If "Yes," provide information for each case using the Professional Liability Insurance Claim Form.	☐ Yes ☐ No

Ability to Perform	
23. Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that is has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. Section 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)	☐ Yes ☐ No
24. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?	☐ Yes ☐ No
25. Do you have any reason to believe that you would pose a risk to the safety or wellbeing of your patients?	☐ Yes ☐ No
26. Are you able to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?	☐ 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
Influenza Vaccine / / Date of last vaccine	Location Administered	

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:

Current Photo Here

Copy of Current Government Issued Photo ID Here
(Example: Driver's license, passport)

ADDITIONAL INFORMATION/COMMENTS

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.

FLUOROSCOPY / X-RAY OPERATOR TRAINING

☐ I will operate fluoroscopy equipment and have already completed the fluoroscopy/X-ray operator training.

At which hospital(s) did you obtain fluoroscopy training? (PLEASE LIST BELOW AND ATTACH PROOF)

☐ I will operate fluoroscopy equipment and will complete fluoroscopy/X-ray operator training before I use the fluoroscopy equipment. (If you check this option, you will be notified shortly regarding the required fluoroscopy training)

☐ I will NOT operate fluoroscopy equipment.