— Medical Credentials Check —

Request for Allied Health Privileges

Information must be typed or printed legible.

Name ____________________ Date ____________________

Where do you desire privileges?	In what specialty do you desire allied health privileges?	Fees
❏ Cheyenne Surgical Center	____________________	-0-
❏ Cincinnati Health Department	____________________	-0-
❏ Crossroad Health Center	____________________	-0-
❏ Digestive Health and Endoscopy Center	____________________	$205
❏ Digestive Health Center of Indiana	____________________	$205
❏ Episcopal Retirement Homes, Inc.	____________________	-0-
❏ Four Seasons Endoscopy Center	____________________	$220
❏ Hyde Park Health Center	____________________	-0-
❏ Leo R. McCafferty Plastic Surgery	____________________	-0-
❏ Mandell-Brown Plastic Surgery Center	____________________	$205
❏ McCandless Endoscopy Center	____________________	$205
❏ Neighborhood Health Care	____________________	-0-
❏ NorthKey Community Care	____________________	$205
❏ North Shore Endoscopy Center	____________________	$205
❏ Northwest Ohio Endoscopy Center	____________________	-0-
❏ Southwestern Endoscopy Center	____________________	$205
❏ The Center of GI Endoscopy	____________________	$205
❏ Topeka Surgery Center	____________________	$205
❏ Vincent Surgical Arts	____________________	$205

Fees: Please make check payable to MedChek and include the applicant's name on the check. This non-refundable processing fee must accompany the application before processing begins.

Attachments: The following must be attached to this request:

1. Recent wallet-sized photograph of yourself, one for MedChek and one for each hospital at which you desire privileges.
2. Copy of all current state licenses/certificates.
3. Copy of DEA certificate (if applicable)
4. Copy of current malpractice insurance with name, expiration date, and limit amounts.
5. Copy of your current Curriculum Vitae.
6. Copy of your diploma(s)/certificates.
7. Copy of ACLS, BLS/CPR.
8. Copy of state driver's license/state ID.

Send completed forms and attachments to:

MedChek; Academy of Medicine; 2300 Wall Street, Suite F; Cincinnati, OH 45212-2794; Phone (513) 721-4377 • FAX (513) 721-4378

MedChek Application for Allied Health Professional Credentials Check

Release of Information/Statement of Applicant

Please read carefully before signing.

I fully understand that falsification by omission from this application constitutes cause for denial of appointment or cause for immediate termination of privileges. All information submitted by me in the application is true, correct, and complete to my best knowledge and belief.

By applying for appointment/reappointment, I hereby signify my willingness to appear for interviews in regard to my application and authorize the health care facility, its medical staff, and their representatives to consult with other hospitals or employers with which I have been associated as well as other persons or entities who may have information concerning my professional competence, character and ethical qualifications.

I hereby further consent to the examination by the health care facility, its medical staff, and its representatives of all records and documents, including medical records, that may be pertinent to the evaluation of my professional, moral and ethical qualifications and competence to carry out the privileges I request.

I hereby release from liability all representatives of the health care facility, its medical staff, and its representatives for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the health care facility, its medical staff, and its representatives, in good faith and without malice concerning my professional competence, ethics, character and other qualifications pertaining to the application including otherwise privileged or confidential information, and I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by this health care facility, its medical staff, or its representatives to other employers and/or medical associations on request regarding any information the health care facility may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability this health care facility, its medical staff, and its representatives for so doing.

I understand and agree that I have the burden of producing adequate information for proper evaluation of my professional competence, continued physical competency, and moral conduct, and mental and emotional stability, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

If approved by the health care facility for medical staff membership or clinical for privileges requested, I agree to engage in the professional practice as defined by the appropriate state licensing board.

Name ______________________________ Date ____________________
(Please type)

Signature ____

MedChek Application for Allied Health Medical Credentials Check

Information must be typed or printed legibly. **Date**____________________________

Estimated Starting Date ____________________________

Personal Information

Name____
Last First Middle Maiden Degree

Date of birth ______________________________Place of birth_____________________________________

US Citizen? ❑ yes ❑ no If no, indicate status of your visa at the present time ___________________________

Social Security Number ________-______-________ Marital Status (please circle one): M S W D

Residence Address: ____
Street Address

____ E-mail Address _____________________________________

Phone____FAX____

Office Address: ____
Street Address

____ E-mail Address _____________________________________

Phone____FAX____

Preferred Mailing Address: _____Home _____Office Contact Person Regarding this Form__________________________

Education

Colleges, universities, or other schools attended:

Name	Address	City/State/Zip	Dates	Major/Degree
Name	Address	City/State/Zip	Dates	Major/Degree
Name	Address	City/State/Zip	Dates	Major/Degree

Licensing/Registration/Certification

Licensing Body	Type	Number	Expiration Date
Licensing Body	Type	Number	Expiration Date
Registering/Certifying Body	Type	Number	Expiration Date
Registering/Certifying Body	Type	Number	Expiration Date

DEA Registration (Narcotic License)____
Number Expiration Date

Professional Status

Each applicant must answer all of the following questions. If you answer yes to any of the questions, please provide a full explanation on a separate sheet with the details.

1) Has your license to practice medicine in any jurisdiction been surrendered, limited, denied suspended, revoked or subject to probationary conditions, or have proceedings towards one of these ends been instituted voluntarily or involuntarily or is such action pending? yes ❑ no ❑

2) Has your DEA registration ever been voluntarily or involuntarily refused, limited, suspended, or revoked, or is your DEA registration currently being challenged in any jurisdiction? yes ❑ no ❑

3) Have your clinical privileges with any health care entity been suspended, diminished, revoked, or not renewed – voluntarily or involuntarily – or is such action pending? yes ❑ no ❑

4) Have you been denied membership or renewal thereof, or been subject to disciplinary action, i.e. suspension or revocation, either voluntarily or involuntarily in any medical organization – or is such action pending? yes ❑ no ❑

5) Have you voluntarily or involuntarily relinquished any medical staff membership, clinical privilege(s), medical organization or professional society membership, professional license(s), or narcotics registration? yes ❑ no ❑

6) Have you ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the medical staff before a decision was made by the medical staff of the health care facility's governing board regarding the application/privileges? yes ❑ no ❑

7) Have you resigned – voluntarily or involuntarily – from a hospital medical staff to avoid disciplinary action? yes ❑ no ❑

8) Have you been subject to probationary conditions or investigation or have proceedings towards those ends been instituted or recommended by a committee or governing body at any hospital or health care entity? yes ❑ no ❑

9) Have you been subject to disciplinary action by the Board of Medical Quality Assurance – or is such action pending? yes ❑ no ❑

10) Have you ever been convicted of a felony (other than a motor vehicle citation)? yes ❑ no ❑

11) Have you ever had professional liability insurance declined, cancelled, issued on special terms, or renewal refused? yes ❑ no ❑

12) Have Medicare, Medicaid, PSRO, or PRO authorities or any other medical reimbursement plan ever brought formal charges or imposed sanctions against you for alleged inappropriate fees or quality of care issues limited to voluntary/involuntary restrictions, limitations, denial, revocation, suspension, surrender, or cancellation in any state? yes ❑ no ❑

13) Have you ever had your provider number voluntarily or involuntarily terminated, suspended, restricted or revoked by a third party payor (including Medicare and Medicaid in any state) or are you currently under investigation by any third party? yes ❑ no ❑

If you answered "yes" to any of the above questions, please provide a full explanation of the details on a separate sheet and attach.

Employment History

List Chronologically, since completion of professional school graduation, professional experience, i.e. **past employment, paid teaching assignments, and military service.** Attach a separate sheet if more space is needed. (**Note:** Attached C.V. is not acceptable in lieu of completion of this form.)

1. Dates: ____________________to ________________________
month year month year

Professional Experience ____

Address: ____
Street City State Zip

Telephone: ( ) ____________________ Fax: ( ) _________________ Job Title: ____________________________

2. Dates: ____________________to ________________________
month year month year

Professional Experience ____

Address: ____
Street City State Zip

Telephone: ( ) ____________________ Fax: ( ) _________________ Job Title: ____________________________

3. Dates: ____________________to ________________________
month year month year

Professional Experience ____

Address: ____
Street City State Zip

Telephone: ( ) ____________________ Fax: ( ) _________________ Job Title: ____________________________

4. Have you ever been employed at this health care facility? ❑ yes ❑ no

5. Please list all current and previous hospital appointments including specific privileges granted.

____
Hospital Name Complete Address

____
Privileges Granted Date

____
Hospital Name Complete Address

____
Privileges Granted Date

____
Hospital Name Complete Address

____
Privileges Granted Date

Professional Liability

Have you been the subject of a malpractice claim or a defendant in a malpractice suit? yes ❑ no ❑

If you answered "yes" to this question, please provide the following information for each claim or suit (attach an additional sheet if necessary):

a) Nature of allegation:____

____

b) Was a suit filed? yes ❑ no ❑ If yes, when (month, year)______________________

c) Disposition or current status of claim or suit: Open ❑ Closed ❑ Suit withdrawn ❑

d) On a separate sheet, provide a narrative description of the medical facts (must include, but not be limited to, the type or treatment and/or surgery; your involvement, i.e., consultant, primary surgeon, etc.). A full statement of explanation must be attached.

Health Status

Do you have any physical or mental conditions that would affect your ability to carry out your responsibilities as delineated by the by-laws, rules, and regulations of the hospital you are applying to or would affect your ability to exercise the clinical privileges requested, or which would require an accommodation in order for you to exercise the privileges requested, safely and competently? If yes, please provide explanation.

yes ❑ no ❑

References

Please list three (3) persons in your same specialty who can attest to your professional ability. Do not list relatives, current or former employers.

Name____

Street Address ____

City, State, Zip ____

Phone ______________________________

Name____

Street Address ____

City, State, Zip ____

Phone ______________________________

Name____

Street Address ____

City, State, Zip ____

Phone ______________________________

This Section to be Completed by Supervising Physician

Name of Employer, please print ____________________

1. Is this applicant covered by your liability insurance carrier? ❑ yes ❑ no
2. Is this applicant covered by his/her own insurance carrier? ❑ yes ❑ no

Statement of Supervising Physician

I hereby verify that ____________________
(name of applicant)

is under my supervision in the capacity of ____________________
(job title)

He/she will be under my direction at all times, and I agree to assume full responsibility for his/her actions in dealing with patients who are hospitalized at facilities at which I currently hold privileges.

I also agree to immediately notify entity(ies) to which he/she has applied if this person should no longer be under my supervision.

Signature ____________________ Date ____________________