OhioHealthGroup

APPLICATION FOR INITIAL CREDENTIALING
Advanced Practice Providers & Allied Health Professionals

The credentialing process for the OhioHealth hospitals is managed by OhioHealth Group Credentialing Services (OHGCS), which is OhioHealth's central verification office. OHGCS will be your main contact for information regarding the non-hospital specific portion of your application. Once a completed application is received, it can take OHGCS up to 60 days to complete the background and verification process**. Please note that this timeframe does NOT include applicable Hospital committee approval, which can be an additional 30-60 days.**

There are three (3) main parts to the credentialing process. Each part must be completed in its entirety. Your application will initially be processed by OHGCS and will then be passed on to each hospital to which you are applying for further processing.

1) **CAQH Application:**
   (a) Located at **https://proview/caqh.org.** See attached instructions for completion.
   (b) CAQH ID must be submitted with this paperwork. Refer to page 6 for details.
   (c) Be sure to authorize access to OhioHealth Group.

2) **OhioHealth Supplemental Documents**:
   (a) Completion of the attached documents is required even if you already have privileges at another OhioHealth hospital.
   (b) Submit these documents even if your Ohio license and/or DEA are pending.
   (c) **Return completed one-sided documents by mail to: OhioHealth Group Credentialing Services, 155 East Broad Street, Suite 1700, Columbus, OH 43215 or via email at OhioHealthCredentialing@ohiohealthgroup.com**

3) **Hospital-Specific Documents/Information**:
   (a) Hospital-specific documents, e.g., delineation of privileges and governing documents will be sent to you directly from the respective Medical Staff Offices of the hospitals to which you are applying.
   (b) OhioHealth uses Epic, referred to as CareConnect, for our electronic medical record (EMR). If you plan to treat patients in any of the OhioHealth Hospital(s), where CareConnect has been implemented, you will be required to complete the necessary CareConnect training. You will be contacted by a CareConnect representative to schedule your training.
   (c) OhioHealth uses OhioHealth University for various on-line education. It is mandatory to complete the Initial Provider Patient Safety course. Please note that even though instructions are provided on pages 18-19 of this packet, ***the course cannot be completed until your OhioHealth Personal Identification (OPID) is issued***. Your OPID and temporary password will be provided to you by the Medical Staff Office.
   (d) Questions related to this information should be directed to:

Doctors Hospital: (614) 544-2236
Dublin Methodist Hospital: (614) 544-8040
Grant Medical Center: (614) 566-9346
Grady Memorial Hospital: (740) 615-1045
Hardin Memorial Hospital: (740) 383-8659
Mansfield Hospital: (419) 526-8581
Marion General Hospital: (740) 383-8665
O'Bleness Hospital: (740) 592-9492
Riverside Methodist Hospital: (614) 566-5052
Shelby Hospital: (419) 526-8581

PLEASE NOTE: It is ultimately your responsibility to ensure that all required documents are obtained and verified. Your application will remain pending until all required information is received.

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APP & AHP APPLICANT CHECKLIST

Please utilize this checklist as a tool for completing the application. The detailed notes are meant to assist you with the pertinent information that must accompany the application. The **documents listed below** are considered to be, in **their entirety**, your credentialing **application**. Please note that your **application will not be considered or processed until all of these documents are completed, as instructed, and received;** except those noted as voluntary forms.

- ❑ **CAQH on-line application is complete**
  - The CAQH has been updated and re-attested within the past 4 weeks from the date the applicant applied for credentialing at OHG.
    - In addition to completing the entire application, please ensure that the CAQH application documents what group (Tax ID) the applicant is joining/getting credentialed for.
  - CAQH includes all state license(s) numbers, DEA Registration numbers and current and past insurance policies. *The CAQH application must indicate if any of these documents are pending.*
    - The applicant's DEA must have an Ohio address and considered to be "fee paid" before the applicant is scheduled to start working. (This rule does not apply to locum tenens and telemedicine physicians)
  - Gap in Timeline – all gaps in the applicant's professional timeline that span greater than 3 months require an explanation

- ❑ **Participation Selection Page** is completed

- ❑ **Application Fee** (refer to page 5 of the application for details). Proof of upcoming payment will be accepted in lieu of the actual check

- ❑ **Unique Provider Email address –** Needs to be documented on either the CAQH application or the resume. OhioHealth communicates pertinent information via email. This email address is NOT shared with patients. Providing a unique email address is a requirement for getting credentialed. Failure to provide a unique email address will result in your application being deemed incomplete.

- ❑ **Current Malpractice Insurance Face Sheet (if available at the time of submitting the application) –** the policy must document the provider's name on either the actual face sheet or an attached roster. Documentation of current malpractice insurance is necessary in order to complete the file but not required at the time of submission.

- ❑ **Current copy of the Curriculum Vitae/Resume**
  - Timeline for education and work history must contain both **month/year**

- ❑ **Portrait Quality Color Professional Photograph** (PASSPORT photo/selfie is not acceptable)

- ❑ **Completed Conflict of Interest Questions**
  - Both questions are answered and an explanation is provided if applicable

- ❑ **Completed Provider Information Specific to Credentialing**

- ❑ **Completed OhioHealth Clinical Directory**

- ❑ **Completed Radiation Safety Questions**
  - All applicable questions are answered along with the applicant's signature and date

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APP & AHP APPLICANT CHECKLIST - CONTINUED

- ❑ **Documentation of 5 Peer References**
  - Writing must be legible
  - Selected references adhere to the criteria outlined on page 9.
  - The information must be documented on the form on page 10. A separate form will not be accepted.

- ❑ **Signed/Dated Authorization Form to conduct a Criminal Background and/or Fingerprint Process**
  - Disclosure question answered and an explanation is provided if applicable

- ❑ **Verification of Practitioner Identification Form**
  - Copy of driver's license or passport if clear and legible (including the photo)
  - The date of the applicant's signature must be identical to the date the notary signed the form.
  - Meets all requirements of the state where notarized
  - Notary seal must be visible

- ❑ **Verification of Employment History**
  - Disclosure question is answered and an explanation is provided if answered "yes"
  - If applicable, a comprehensive listing of employers and corresponding malpractice carriers is included

- ❑ **Listing of Insurance Companies for Malpractice Claims History Verification**
  - Documentation of all the malpractice carrier(s) that have insured the applicant in the past 5 years.
    - Carrier name, Employer/School Name, Phone, Fax, Policy Number and Policy Dates must be documented for each insurance company listed. Copies of past/current insurance face sheets will suffice in lieu of completing the form on page 14 if the face sheets account for a comprehensive list of the past 5 years.
  - This information must be documented for the applicant's Residency and/or Fellowship training if this occurred within the past 5 years.

- ❑ **Signed Malpractice Claims History Verification Release Form**

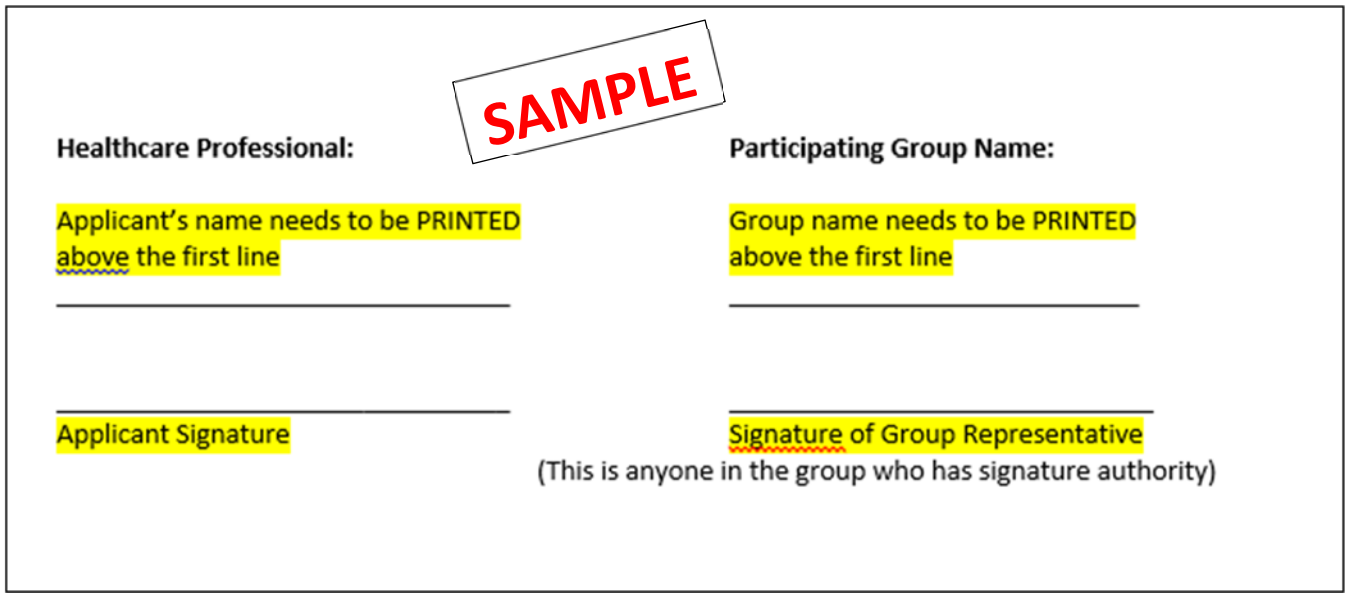
- ❑ **Current TB Skin Test & Health Assessment Form** (Both are required)
  - The TB testing itself can be completed on any form. Section Two on the OhioHealth form is a broader screening for communicable diseases. The questions in section two must be completed on the OhioHealth form even if the TB test is completed on another form.

- ❑ **Signed/Dated OhioHealth Internet Use Agreement / Confidentiality Statement of Understanding**

- ❑ If applicable, **OhioHealth Group Managed Care Product (HealthReach/HealthReach Preferred) provider agreement** is completed in its entirety
  - There are a total of three signature pages that need to be completed and returned.
  - The collaborating/supervising physician must currently be/going to be credentialed with the same group listed on the form.

APP & AHP APPLICANT CHECKLIST - CONTINUED

- ❑ If applicable, **OhioHealth Group Clinically Integrated Network provider addendum** is completed in its entirety
  - Page 1: The date that needs to be populated on the first page of the addendum is the date that the applicant signs the addendum.
  - Page 2: The fields highlighted in yellow provide instructions on what needs to be completed on page 2 of the addendum.



  - Page 3 - check mark type of healthcare professional
    - APPs need to list of all supervising or collaborating physicians that are credentialed or will be credentialed with the CIN. These physicians need to part of the same group to which the applicant is getting credentialed for.
    - Clinical Counselors do need list at least one collaborating physician in his/her practice

Voluntary Forms

- ❑ **Submission of Vaccination Records**
- ❑ **OhioHealth Self-Disclosure of Race and Ethnicity**

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Participation Selection

Place a checkmark in the box for <u>each entity</u> to which you are requesting to participate.

OhioHealth Group Managed Care Products

Participation in the Health Plan(s) is only eligible for **Physician Assistants** and **Advance Practice Nurses** (Certified Nurse Practitioners, Certified Nurse Midwife, Certified Registered Nurse Anesthetist and Clinical Nurse Specialists)

❒ **HealthReach/HealthReach Preferred:** This is the PPO network of providers for OhioHealth associates. Applicant must be practicing with a group practice that is currently contracted with HealthReach/HealthReach Preferred.

❒ **OhioHealth Group Clinically Integrated Network (previously Health[4]/The Medical Group of Ohio):** By signing the enclosed OHG CIN Advanced Practice Provider and/or Clinical Counselor Participation Addendum you are confirming that you are employed by a physician/group that participates in the CIN.

OhioHealth Hospitals (Membership and/or Clinical Privileges) *(check all that apply)*

- ❑ Doctors Hospital
- ❑ Dublin Methodist Hospital
- ❑ Grant Medical Center
- ❑ Grady Memorial Hospital
- ❑ Hardin Memorial Hospital
- ❑ Mansfield Hospital
- ❑ Marion General Hospital
- ❑ O'Bleness Hospital
- ❑ Riverside Methodist Hospital
- ❑ Shelby Hospital

<u>Application Fee:</u> Application fee **MUST** be received in order for your application to be processed for any of the above hospitals.

- ❑ Fee for 1 entity – $405
- ❑ Fee for 2 entities – $520
- ❑ Fee for 3 entities – $635
- ❑ Fee for 4 entities – $750
- ❑ Fee for 5 entities – $865
- ❑ Fee for 6 entities – $980
- ❑ Fee for 7 entities – $1,095
- ❑ Fee for 8 entities - $1,210
- ❑ Fee for 9 entities - $1,325
- ❑ Fee for 10 entities - $1,440

Make checks payable to: *<u>OhioHealth Group Credentialing Services.</u>* ***Please note the application fee is a one-time fee and is non-refundable once the primary source verification has been initiated.***

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COMPLETING THE CAQH APPLICATION

The CAQH application is an online service where practitioners can provide standardized credentialing information to multiple organizations without filling out multiple forms. By signing the CAQH Standard Authorization, Attestation and Release form you understand the term "Entity" applies to any of the entities that OHGCS provides credentialing services on your behalf.

If you have any questions regarding your CAQH ID number, username, password, an incomplete application, unapproved document, etc., please refer to the CAQH website at https://proview.caqh.org or call the CAQH Help Desk at 1-888-599-1771. New users can also register on the CAQH website by clicking on "Self-Register." The CAQH ID Number will be sent to the email address provided during registration.

- If you are already a CAQH Provider, list your ID. **My CAQH Provider ID Number is: _____**
- If you do NOT have a CAQH ID number, you are able to self-register on the CAQH website. The Provider Registration Email with the ID Number will be sent to the primary method of contact email address set up at time of registering. Make sure to list your ID Number above.

THE CAQH ONLINE APPLICATION MUST BE COMPLETED IN ITS ENTIRETY OR THE APPLICATION WILL BE DEEMED INCOMPLETE BY OHIOHEALTH GROUP CREDENTIALING SERVICES. PLEASE MAKE SURE THAT THE CAQH APPLICATION IS REFLECTIVE OF ANY NEW ACTIVITY (PRACTICE LOCATION, CURRENT MALPRACTICE CLAIMS, HOSPITAL AFFILIATIONS, ETC.)

GENERAL STEPS TO COMPLETE THE CAQH APPLICATION

1. **General Info:** Enter identification information in every section of the online application.
2. **Credentialing Contact:** This is the person responsible for credentialing at the practice the applicant is joining (if a solo practice, please enter the applicant's information).
3. **Practice Info:** We need to know what group (Tax ID) the applicant is joining – specifically – start date, group name, Tax ID, and primary and billing addresses. If there are issues with the current practice's knowledge of the applicant leaving, please contact the OhioHealth Group Credentialing Services office at 614-566-0010 for assistance.
4. **Malpractice Claims:** List any pending and/or settled malpractice claims. All claims against the applicant within the last 10 years, regardless if they are pending or settled, must be listed on the CAQH Application.
5. **Review:** Once all data entry is complete, the data needs to be audited. If any required fields are missing information, these need to be completed before progressing.
6. **Attest:** Once the audit is complete, the applicant needs to attest the application. Then, the data will be "entered" and appear complete.
7. **Supporting Documents:** After completion, the applicant needs to upload any required supporting documents directly into the system. This includes the Attestation & Release and any other documents based on the data entry such as DEA and Malpractice.
8. **Activity Log:** Documents can also be uploaded as the application is being completed. To do so, follow these steps:
    a. The "Documents" or "Review" pages will inform the applicant what documents are needed to complete the application.
    b. Upload the supporting documents (ex. Attestation & Release, DEA certificates, Malpractice) directly to CAQH ProView by following the instructions.
9. **Completion:** Once the application is complete and the supporting documents are reviewed for accuracy, the applicant's information will become available to the organizations that were authorized. The applicant needs to check with each individual organization to determine his/her credentialing status. If a document is not approved, an email will be sent to the user, indicating that the application is incomplete.
10. **Re-Attesting:** The CAQH application needs to be **re-attested every 120 days** to retain a "current" status. If the application does not remain current, it will change to an "expired" status and any entity the applicant participates with will be unable to process the application. The profile can be updated by clicking on "Manage Information," upload new documents by clicking on "Documents," and finish by clicking on "Attest."

If the applicant is coming from out of state, he/she must also change the primary practice state to Ohio.
In the beginning of the application process, there is a section for the provider type and primary practice state. Please list Ohio. Some states have a state mandated application and in that instance we cannot credential the applicant until an Ohio application is accessible. Please note the applicant will be required to also sign/date and fax an updated Attestation & Release form if coming from out of state.
Failure to do this will delay the credentialing process.

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SUBMISSION OF A PROFESSIONAL PHOTOGRAPH

A professional photograph of the applicant is required.

- The photograph must meet the following requirements to be considered acceptable.
  - Must be in color *and* be a recent photograph; plain or studio backdrop, natural lighting or from studio lighting
  - Attire should be professional (i.e. suit, lab coat); body should be at a slight angle with head turned to lens
  - Wallet size or larger (Passport photos are NOT acceptable)
- Save as a .jpg and email to at the credentialing department at OhioHealthCredentialing@ohiohealthgroup.com

CONFLICT OF INTEREST

The following two questions must be answered by all applicants:

1) Do you hold a direct or indirect ownership interest in an inpatient hospital located within the state of Ohio? (For purposes of this question, "indirect ownership" means that another person or entity may own the interest but you will receive a benefit from it, e.g., ownership by a spouse, employer, pension program or beneficial trust).

Yes ❑ No ❑

If yes please explain:_____

2) **If the answer to question 1 is "no":** are you in a profit-sharing arrangement with a person or entity that holds a direct or indirect ownership interest in an inpatient hospital located within the state of Ohio?

Yes ❑ No ❑

If yes please explain:_____

PROVIDER INFORMATION SPECIFIC TO CREDENTIALING

Fields that are highlighted must be completed in its entirety.

Applicant Name_____

Name of Your Current Primary Hospital _____

Will your primary hospital named above change once you are credentialed with this group? _____NO _____YES

*If yes, name of upcoming Primary Hospital_____

Practice Name: _____ Tax ID:_____

Practice Manager: _____

Credentialing Contact: _____Phone Number: (____) _____ext. _____

Credentialing Contact's Email Address: _____

Preferred Mailing Address for Medical Staff Correspondence:

_____

Street Address City State Zip Code

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PROVIDER INFORMATION for the OHIOHEALTH CLINICAL DIRECTORY

The information requested below will be used to populate the OhioHealth Clinical Directory and to provide contact information for patient care purposes at OhioHealth Hospitals.

Provider Name: _____
Last First MI Degree

Provider Email Address: _____ Specialty: _____ ❒ Specialist ❒ PCP

Office #:_(___)_____ Fax #: (___)_____ Pager #: (___)_____
Preferred fax # for patient matters

Pager Type (circle one): Numeric or Alpha Name of Pager Vendor (i.e. USA Mobility): _____

*Cell Phone #: (___)_____
*(*Required in order to obtain remote access to OhioHealth computer systems)*

Please indicate the order in which you prefer to be contacted by hospital staff for patient care purposes: (Ex: *1. Cell 2.Office 3.Pager*)

Contact Preference: 1._____ 2._____ 3. _____

Indicate below any contact numbers that are considered private. These numbers will only be accessed by the hospital operators, and will NOT be viewable by the clinical staff. ***Please note that you CANNOT list a private number as a contact preference.***

_____

Other Special Instructions/Miscellaneous Contact Information that is essential for contacting you:

_____

RADIATION SAFETY

1. Will you be present, on a routine basis, in an area where fluoroscopy is used? ❒ Yes ❒No
   (e.g. surgery, cath lab, endoscopy, electrophysiology lab, radiology)

2. Do you plan to personally perform fluoroscopic evaluations? ❒Yes ❒ No
   If yes, check all that apply: ❒ Mini C-Arm ❒ C-Arm ❒ O-Arm ❒ Angiographic fluoro ❒ Other fluoro

If "yes", please note that you will be mandated, per the Ohio Department of Health, to fulfill education requirements regarding radiation safety before you are approved to work. Your office manager will be contacted to arrange radiation safety training and equipment competency.

PRINTED NAME **SIGNATURE** **DATE**

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INSTRUCTIONS FOR SUBMITTING FIVE (5) PROFESSIONAL REFERENCES

You are required to submit the names of 5 professional references. The specific references that are required for credentialing is dependent upon your training pathway. Please adhere to the following criteria when submitting the names of your professional references.

- An **acceptable reference** must have **observed your clinical practice and be able to attest to your current clinical competence.** An acceptable reference must also hold the same license (ex. Certified Nurse Practitioner for Certified Nurse Practitioner, Physician Assistant for a Physician Assistant, etc.) with similar clinical privileges.
- A registered nurse (RN) is not an acceptable peer.
- Physicians are considered to be appropriate references.
- Please note, friends and/or relatives are not an acceptable reference.
- If you are an advanced practice nurse who is currently working at a Hospital where you previously functioned as a RN, your references must have observed your clinical practice as an advanced practice nurse and not as a registered nurse.

REQUIRED REFERENCES

- **Program Director** – This is a required reference if you completed classroom or online training within the past twelve (12) months *OR* if you have not previously held clinical privileges in the past three (3) years.
- **Preceptor** – This is a required reference if you graduated from an online training program within the past twelve (12) months.
- **Supervising/Collaborating Physician** – This is a required reference if you have ever had either a Standard Care Arrangement or Supervision Agreement with a physician as an Advanced Practice Provider. You are required to submit the name of a current/most recent supervising or collaborating physician. If you have changed practices or employers within the past three years, one (1) reference must be from a supervising/collaborating physician from each of your previous practices or employers.

OTHER ACCEPTABLE REFERENCES in ADDITION TO REQUIRED REFERENCES

REFERENCES MUST HAVE OBSERVED YOUR CLINICAL PRACTICE AND BE ABLE TO ATTEST TO YOUR CURRENT CLINICAL COMPETENCY.

- **Peer** - A provider who works in the same discipline and holds the same license as you, and is knowledgeable about the quality of your performance.
- **Current Supervising/Collaborating Physician**
- **Preceptor**

In order to expedite the process, fax numbers and email addresses must be documented on the following page. It is also beneficial to contact your references to let them know that a request will be sent to them.

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DOCUMENTATION OF FIVE (5) PROFESSIONAL REFERENCES

PLEASE WRITE LEGIBLY. IF THIS INFORMATION IS NOT LEGIBLE, THE APPLICATION WILL BE DEEMED INCOMPLETE.

Fields that are highlighted must be completed in its entirety. The information must be completed on this form. A separate page will not be accepted. An email address is strongly recommended since the form is sent electronically. If the reference does not have an email address, a fax number will suffice in its place.

Reference #1

First Name:	Last Name:	Degree :
Phone:		
Email Address		
Name of School/Hospital:		
Relationship: ☐ Program Director ☐ Supervising/Collaborating Physician	☐ Preceptor ☐ Peer with the same licensure & similar clinical privileges	

Reference #2

First Name:	Last Name:	Degree :
Phone:		
Email Address		
Name of School/Hospital:		
Relationship: ☐ Program Director ☐ Supervising/Collaborating Physician	☐ Preceptor ☐ Peer with the same licensure & similar clinical privileges	

Reference #3

First Name:	Last Name:	Degree :
Phone:		
Email Address		
Name of School/Hospital:		
Relationship: ☐ Program Director ☐ Supervising/Collaborating Physician	☐ Preceptor ☐ Peer with the same licensure & similar clinical privileges	

Reference #4

First Name:	Last Name:	Degree :
Phone:		
Email Address		
Name of School/Hospital:		
Relationship: ☐ Program Director ☐ Supervising/Collaborating Physician	☐ Preceptor ☐ Peer with the same licensure & similar clinical privileges	

Reference #5

First Name:	Last Name:	Degree :
Phone:		
Email Address		
Name of School/Hospital:		
Relationship: ☐ Program Director ☐ Supervising/Collaborating Physician	☐ Preceptor ☐ Peer with the same licensure & similar clinical privileges	

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CRIMINAL BACKGROUND INVESTIGATION

- All new applicants applying for membership or privileges at an OhioHealth hospital are required to provide fingerprints to a designated OhioHealth location. Applicants will be required to sign a consent form for this process (below). **Failure to sign the below consent form will terminate the application process.**
- Do not schedule an appointment on your own. OhioHealth Group Credentialing Services (OHGCS) will contact you regarding this requirement. A valid driver's license is required for this process.
- If you are solely applying to Mansfield Hospital, Shelby Hospital and/or Hardin Hospital, you are not required to be fingerprinted at this time. A criminal background check will be performed in lieu of fingerprinting.
- Please note that OhioHealth's fingerprint process is separate from the process you completed when obtaining your Ohio Professional License.

DISCLOSURE QUESTION

Failure to disclose will add processing time to your application. Have you ever been convicted of, plead guilty, no contest or nolo contendere to a misdemeanor or felony, other than a minor traffic violation? (*Note*: a DUI or DUI reduced to reckless operation is not considered a minor traffic violation.) Do not report any conviction that has been sealed, expunged, statutorily eradicated, annulled, impounded, erased, dismissed, dismissed under a first offender's law, pardoned by the Governor or which state law allows you to lawfully deny. This background check will identify information greater than 10 years.

☐ No ☐ Yes If yes, please explain below and include a separate sheet if necessary.

_____

_____

AUTHORIZATION FORM TO CONDUCT A CRIMINAL BACKGROUND CHECK AND TO GATHER INFORMATION AS IT PERTAINS TO THE CREDENTIALING PROCESS

NOTICE TO APPLICANTS

OhioHealth or affiliate including OHGCS (collectively, "OhioHealth") may obtain information about you from a consumer reporting agency made in connection with your application for membership and/or privileges at an OhioHealth facility. 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 including, but not limited to: verification of identification, and/or Social Security number; checks of criminal history; verification of employment; verification of education; credentials and/or licensures; sanctions/exclusions from Medicare/Medicaid and/or other information on your background or history in connection with your application for membership and privileges at an OhioHealth facility. Upon a written request made to OHGCS, and within 5 days of the request, the name, address and phone number of the reporting agency and the nature and scope of the report will be disclosed to you.

Before any adverse action is taken, based in whole or in part on the information contained in the report, you will be provided a copy of the report, the name, address and telephone number of the reporting agency, a summary of your rights under the Fair Credit Reporting Act, as well as additional information on your rights under the law.

CONSENT TO OBTAINING REPORTS

I have read the above "Notice to Applicants" and hereby authorize OhioHealth to obtain consumer reports and/or investigative reports as described at any time after receipt of this authorization and throughout my period of membership and/or privileges at an OhioHealth facility. I consent to and authorize OhioHealth throughout the tenure of my membership and/or privileges to share any consumer report or investigative report received with a related entity if I apply for or maintain privileges or membership at that OhioHealth facility. 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 OhioHealth or another outside organization acting on behalf of OhioHealth. I understand that I have the right to make a written request within a reasonable amount of time to receive additional, detailed information about the nature and scope of any investigative report including the name, address and telephone number of the reporting agency.

I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original. I understand, to the extent permitted by law, this authorization will remain in effect throughout my membership or privileges at an OhioHealth facility.

By my signature below I acknowledge that I have read and understand all of the above statements.

Note: If you are located in a state that allows you to obtain a free report, check this box if you would like a free copy of your report.

_____

Signature **Date**

OhioHealth Office of the General Counsel 248864v1

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VERIFICATION OF PRACTITIONER IDENTITY

The Joint Commission requires that the hospital verifies the practitioner requesting membership and/or privileges is the same practitioner identified in the credentialing documents. We therefore require that you provide a **clear and legible** copy of your government issued driver's license or passport. This notary form must be completed as requested. A separate notary form will not be accepted.

APPLICANT'S DRIVER'S LICENSE OR PASSPORT

(The copy must be clear and legible, including the photo.

Failure to provide a legible copy will result in refusal of this form and a new form will be required.

DRIVER'S LICENSE OR PASSPORT HERE
(front side only)

By signing and dating this document in the presence of a notary I attest that the image above, or on an attached page represents a true copy of my original government issued identification document.

Applicant's Signature _____ Date _____

STATE OF: _____ COUNTY OF: _____

Acknowledged and signed in my presence by: _____
(Applicant's Name)

the _____ of _____, _____

Notary Public _____ My Commission Expires _____

Please note that the notary is attesting to the applicant's signature on this form and not the actual driver's license.

Notary: You must include your notary seal on this form

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VERIFICATION OF EMPLOYMENT HISTORY

Have you ever been subject to any disciplinary action by an employer including but not limited to termination or non-renewal of a contract for cause?

❑ NO ❑ YES

If yes, please provide specific details:

_____

_____

_____

Please make sure that your resume and/or CAQH application document a comprehensive listing of every employer that you have worked for and/or are currently working for since your graduation from professional school or from the past 10 years, whichever is less. Please note that you only need to provide employment information for jobs in which you functioned in a clinical capacity. Please note that failure to provide a complete timeline of your employment history, as well as hospital affiliations, will delay the credentialing process.

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VERIFICATION OF MALPRACTICE CLAIMS HISTORY - LISTING OF INSURANCE COMPANY

PLEASE READ CAREFULLY

There are two (2) separate steps that need to be completed in order to verify your malpractice claims history from the past 5 years.

Please document a comprehensive listing of all the malpractice carrier(s) that have insured you in the past 5 years. This includes your training if it was within the past 5 years. Copies of past/current insurance face sheets will suffice in lieu of completing this form **if** the face sheets account for a comprehensive list of the past 5 years.
Fields that are highlighted must be completed in its entirety.

Take note of the following:

- If you were/ are insured by a self- indemnification fund at a Hospital/University, please document the necessary information about your employer/schooling below.
- Regardless of where you have worked/trained, all practitioners are required to have Malpractice coverage.
- If you have worked for the Federal Government, document below along with the start/end dates of your affiliation. No other information is needed.

Malpractice Carrier 1 **check which applies for the carrier: Employer ❑ Training Program ❑**

Carrier Name:	Employer/School Name:	
Phone:	Fax	
Contact Name ***(if known)***:	Email Address	
Policy Number:	Policy Dates:	Retroactive Date:

Malpractice Carrier 2 **check which applies for the carrier: Employer ❑ Training Program ❑**

Carrier Name:	Employer/School Name:	
Phone:	Fax:	d
Contact Name (***if known***):	Email Address	
Policy Number:	Policy Dates:	Retroactive Date:

Malpractice Carrier 3 **check which applies for the carrier: Employer ❑ Training Program ❑**

Carrier Name:	Employer/School Name:	
Phone:	Fax:	
Contact Name (***if known***):	Email Address	
Policy Number:	Policy Dates:	Retroactive Date:

***Make a copy of this form if additional carriers need to be listed.**

OhioHealthGroup

VERIFICATION OF MALPRACTICE CLAIMS HISTORY – RELEASE FORM

PLEASE COMPLETE THE TOP PORTION OF THIS FORM. THE BOTTOM PORTION OF THE FORM NEEDS TO BE COMPLETED BY YOUR INSURANCE AGENT/CARRIER. ***PLEASE INCLUDE A SIGNED COPY of this form when returning your application.***

I have applied for clinical privileges at one or more of the following OhioHealth Hospitals: Grant Medical Center, Doctors Hospital, Dublin Methodist Hospital, Riverside Methodist Hospital, Grady Memorial Hospital, Hardin Memorial Hospital, Mansfield Hospital, Shelby Hospital, Marion General Hospital, and/or O'Bleness Hospital. Please provide my claims history information for the past five (5) years to OhioHealth Group Credentialing Services by completing this form and faxing it to **614-566-0401 or emailing to claimshistory@ohiohealthgroup.com.** *By signing this form below, I authorize release of this information.*

Printed Name of Practitioner (must be legible) _____ Type of Degree (eg: MD, DO, DPM, DDS, PhD, PsyD) _____

Practitioner Signature (must be legible) _____ Date _____ Last 4 digits of SSN _____ Date of Birth _____

******The malpractice insurance company must complete this section*******

If submitting a separate form, response must be to the attention of OhioHealth Group Credentialing Services

Carrier Name: _____

Policy Number: _____ Employer/School: _____

Type: ☐occurrence ☐claims-made ☐other Retroactive Date: _____

Policy Amount: _____ Effective Dates/From: _____ Expired Dates/To: _____

Have any specific procedures been excluded from his/her coverage? YES____ NO____

Has your company defended this applicant in any liability suits in the past? YES____ NO____

Has your company paid any judgments or settlements on behalf of the applicant for any professional liability suits in the last 5 years? YES____ NO____

Does the applicant currently have any pending lawsuits? YES____ NO____

If the answer to any of these questions is YES please provide a full explanation of details and attach your response.

Printed name of insurance representative _____ Title _____ Phone _____

Signature of insurance representative _____ Date _____

OhioHealth Group

VOLUNTARY SELF-DISCLOSURE OF RACE AND ETHNICITY

To assess the diversity of its provider workforce (independent and employed) OhioHealth requests each applicant to self-disclose his/her race and ethnicity. Self-disclosure, while important, is not required for credentialing.

Refusal to complete this information will NOT subject you to adverse treatment. The information you provide is confidential and will be kept separate from your other credentialing information. This information will not be considered in making any decisions regarding your credentialing.

Race & Ethnic Identification

☐ **Hispanic or Latino**
A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture origin, regardless of race.

☐ **White (Not Hispanic or Latino)**
A person having origins in any of the original peoples of Europe, the Middle East or Asia.

☐ **Black or African American (Not Hispanic or Latino)**
A person having origins in any of the Black racial groups of Africa.

☐ **Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)**
A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **Asian (Not Hispanic or Latino)**
A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **American Indian or Alaska Native (Not Hispanic or Latino)**
A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

☐ **Two or More Races (Not Hispanic or Latino)**
All persons who identify with more than one of the above six races.

☐ **I do not wish to provide this information**

OhioHealthGroup

OHIOHEALTH HEALTH EVALUATION FOR COMMUNICABLE DISEASE

INSTRUCTIONS – READ CAREFULLY

1) On the following page, complete the questions in Section Two and provide a current TB Test Result for Section One.
2) The date of your last TB Test must be within the past 12 months of submitting this application.
3) If you have a history of a positive TB Test and/or your most recent test comes back positive, you must have a TB blood test (IGRA testing) performed (i.e., TSpot or Quantiferon-Gold) and submit those results with your application.
   - If you have a positive TSpot or Quantiferon-Gold test on file, you will need to submit a record of the positive result, a copy of your chest x-ray, and complete the questions under Section Two.
     - The positive result and chest x-ray do not have to be within the past 12 months.
4) If you are allergic to the TB Test process and are advised not to have this done yearly, you must have a TB blood test (IGRA testing) performed (i.e., TSpot or Quantiferon-Gold) and submit those results with your application.
5) Proof of a TB test performed and read at another facility is acceptable, **however, you still need to complete the questions under Section Two.**
6) **The TB testing itself can be completed on any form. The additional questions on the OhioHealth form is a broader screening for communicable diseases. These questions must be completed on the OhioHealth form even if the TB test is completed on another form.**
7) If you are unable to attain a TB Test at your current institution, you may have it performed at one of OhioHealth's Associate Health & Wellness departments. **You must request a copy of the completed results with your application.**
8) If you are going to an OhioHealth location to receive a TB Test/Blood Test, refer to clinical locations listed below. Please call the applicable number to find out hours of operation. Please inform them you are getting this test as part of the application process for hospital privileges.

OhioHealth Associate Health and Wellness Clinic Locations

Doctors Hospital: 5100 W. Broad St. Columbus, OH 43228 614-544-1008

Dublin Methodist Hospital: 7500 Hospital Dr. Dublin, OH 43016 614-544-8044

Grady Memorial Hospital: 561 W. Central Ave. Delaware, OH 43015 740-615-1134

Grant Medical Center: 393 E. Town St. Suite 202 Columbus, OH 43215 614-566-9515

Marion General Hospital: 1000 McKinley Park Dr. Marion, OH 43302 740-383-8959

Riverside Methodist Hospital: 3545 Olentangy River Rd. Suite 411 Columbus, OH 43214 614-566-5514

OhioHealthGroup

OHIOHEALTH HEALTH EVALUATION FOR COMMUNICABLE DISEASE

Once privileged, annual forms will go directly to the Medical Staff Office not OHGCS*

Name (please print full name)	SS#	Date of Birth	Phone (work)

***Both* sections of this form *must be* completed**

Section One: TB Documentation ☐ Refer to the Attached Documentation

Please complete this section of the form *or* provide a chest x-ray if skin test is positive *or* provide TB documentation. If you had a PPD test in the past 12 months you may submit a copy of the results in lieu of having another test.

Date of last TB skin test _____. Tests must be read in 48-72 hours. Test read greater than 72 hours will need to be repeated.

Date applied	Site	Manufacturer	Lot #	Exp. Date	Signature	Date read	Induration	Signature
1st step								
___/___/___	RFA/LFA	_____	_____	___/___/___	_____	___/___/___	_____	_____
2nd step (if required)								
___/___/___	RFA/LFA	_____	_____	___/___/___	_____	___/___/___	_____	_____

Section Two: Health History

Please answer the questions in this section

History of POSITIVE TB test? **No** _____ **If you answer No**, go to question #1.
Yes _____ **If you answer Yes, answer the following:**

Date of positive test _____ Date of last chest x-ray _____ X-ray result _____

(a) BCG vaccine? No___ *or* Yes ___
(b) Treated by physician? No___ *or* Yes ___
(c) INH Therapy? No___ *or* Yes ___
(d) Traveled outside the USA? No___ *or* Yes ___
If so when? _____

During the last year, have you experienced any of the following conditions over a prolonged period of time? **(more than 2 weeks duration)**	**No**	**Yes**	**Resolved**	**If not resolved, please comment.**
1. Abdominal or gastrointestinal problems such as frequent diarrhea, nausea or vomiting.				
2. Unexplained weight loss or excessive fatigue.				
3. Frequent upper respiratory symptoms such as colds, sore throat, productive cough, or pneumonia.				
4. Persistent fever or excessive sweating, especially at night.				
5. Skin problems; such as cold sores, boils, abscesses or other skin lesions of the face and hands.				
6. Communicable disease such as Hepatitis or Tuberculosis.				
7. Compromised immune system or serious illnesses.				
8. Allergies NO ___ Yes ___(please list):				

Signature:_____ Date: _____

(Your signature authorizes release of TB testing information to be sent to the Medical Staff office.)

OhioHealthGroup

SUBMISSION OF VACCINATION RECORDS

BACKGROUND

Exposure to vaccine-preventable diseases continues to be a risk at OhioHealth. In the past few years in central Ohio, there have been several exposures to vaccine-preventable diseases, some including physicians. These incidents resulted in hundreds of associates and patients being potentially exposed.

As a result, we offer a voluntary Physician Immunization Program for all medical staff members at OhioHealth, similar to requirements of all OhioHealth associates, to evaluate immunity status for measles/mumps/rubella (MMR), hepatitis B, varicella, pertussis and influenza in order to ensure protection for all of our physicians, associates and patients.

Immunization records will be documented in a confidential database by Associate Health and Wellness where they can be easily and quickly accessed in the event of an exposure. By doing this, we can minimize the possibility of delays or stopping of work for our associates and/or physicians, which can occur during an exposure when immunization records are not readily available.

HOW DOES THE PROGRAM WORK?

OhioHealth offers the program through Associate Health and Wellness with the following objectives:

- To determine immunity status for all current medical staff members at OhioHealth through the review of vaccination records submitted by medical staff members.
- To provide necessary titers and/or immunizations and boosters to those physicians who need them.
- Associate Health and Wellness will document, track and update all physician immunization records for future reference.

This program is provided at no cost to all medical staff members as long as they have their titer drawn at one of OhioHealth's lab locations and are given any necessary vaccinations by Associate Health and Wellness.

3 WAYS TO SUBMIT YOUR IMMUIZATION RECORDS:

1. Fax your immunization records to OhioHealth Associate Health and Wellness at **(614) 533.1080**.
2. Scanned copies can be emailed to **AH_Immunization_Review@ohiohealth.com**.
3. You may include copies of your immunization records when submitting your credentialing application.

Once your records are received, a nurse will review them to confirm your immunity status. The nurse will notify you if any additional follow-up is needed.

REQUESTED VACCINE RECORDS:

- MMR – (Measles, Mumps, Rubella)
- Varicella –(Chicken Pox)
- Hepatitis B
- Pertussis

Submission of vaccine records is voluntary and is not considered to be a required component of the credentialing application. Submitting vaccine records will NOT subject you to adverse treatment. The information you provide is confidential and will be kept separate from your other credentialing information. This information will not be considered in making any decisions regarding your credentialing.

OhioHealth Group

OhioHealth Confidentiality Statement of Understanding and Internet Use Agreement

This statement summarizes the responsibilities and obligations of all persons who use, create or receive confidential information through any affiliation with OhioHealth, as set out in OhioHealth's Privacy Policy. This statement further serves to inform workforce members of the expectations and responsibilities regarding appropriate internet use when representing OhioHealth or utilizing OhioHealth resources. The scope of this statement covers all OhioHealth "workforce members" defined to include (but not limited to): employees, volunteers, trainees, contractors, employed physicians (including residents), non-employed physicians, and associated staff that may access OhioHealth confidential information for patient care or healthcare operations, and other persons whose conduct, in the performance of work for OhioHealth, is under the direct control of OhioHealth, whether or not the person is paid by OhioHealth.

I understand and acknowledge that:

- It is my legal and ethical responsibility to protect the privacy, confidentiality, and security of all confidential or sensitive information including, but not limited to, Protected Health Information (patient-identifiable information) and Health Care Business Information such as proprietary business, associate, or provider information.
- I will not, at any time during or after my employment or affiliation with OhioHealth, improperly use, disclose to any person, or store any confidential information, nor will I permit any unauthorized person to examine or make copies of any reports, documents, or on-line information that comes into my possession. Confidential information is made available on a need to know basis and is limited to the minimum necessary requirement, and thus, I will not access confidential information without authorization, and I will do so only when I am required to do so for specific business purposes.
- Unauthorized disclosure of confidential information is totally prohibited.
- Disclosure of or sharing of passwords, access codes, and hardware token devices assigned to me (my "Access Credentials") is prohibited. I am accountable for my Access Credentials and for any improper access to information gained through use of my Access Credentials. My Access Credentials are the equivalent of my legal signature, and I shall take all reasonable and necessary steps to protect my Access Credentials. I am responsible for all actions taken using my Access Credentials. If I have reason to believe that the confidentiality of my Access Credentials or the confidentiality of my staff's credentials has been broken, I shall immediately notify the OhioHealth Director of Information Security.
- If I utilize a personal electronic device to access confidential information, I will ensure that all confidential information accessed through the device will be afforded the protections required by federal, state, and local laws and regulations. It is my responsibility to apply the required and indicated technical, physical, and administrative safeguards to such devices. Such safeguards include but are not limited to: encryption, password protection, anti-virus software, not leaving my devices unattended, and locking and logging off the device after my use. Further guidance on such safeguards can be found in OhioHealth Policies and Procedures.
- OhioHealth assumes no responsibility for the use, maintenance, support, or potential damages that may be incurred with any personal devices used to access OhioHealth confidential information.
- If a personal device used to access Protected Health Information is lost or stolen, I will immediately report such incident to the OhioHealth Privacy Officer at 866-411-6181 or via mycompliancereport.com (Access ID: OHH).
- Internet access and use on an OhioHealth network should be limited to business purposes, and personal use should be minimized. Inappropriate activity includes but is not limited to: utilizing an OhioHealth internet connection for activities that are not directly related to a business purpose of OhioHealth; activities that are illegal or intended to circumvent applicable laws and regulations; activities that could lead to accusations of unethical behavior or damage OhioHealth's professional reputation.
- I will immediately report any suspicious activity (e.g. unexplained appearances of new files, corrupted files, access by unauthorized staff, access to inappropriate websites) or any computers that are suspected of being compromised by malicious attack to the OhioHealth Director of Information Security.
- I will not divulge confidential information to unknown sources without proper identification, authorization, and confirmation of identity.
- I understand that I may use "cloud" applications and servers (such as Evernote and Dropbox) only for educational purposes and presentations I am giving. In conjunction with my use of cloud applications, I may not use, upload, or share (i) any Protected Health Information or (ii) any confidential and proprietary business information of or from OhioHealth; and that I will not, at any time, identify OhioHealth Corporation as the source of such information.
- If I violate any of the above statements, I may lose my access privileges immediately and may be subject to corrective actions up to and including termination.

By signing below, I acknowledge I have read and understand the foregoing information, and I agree to comply with the above terms.

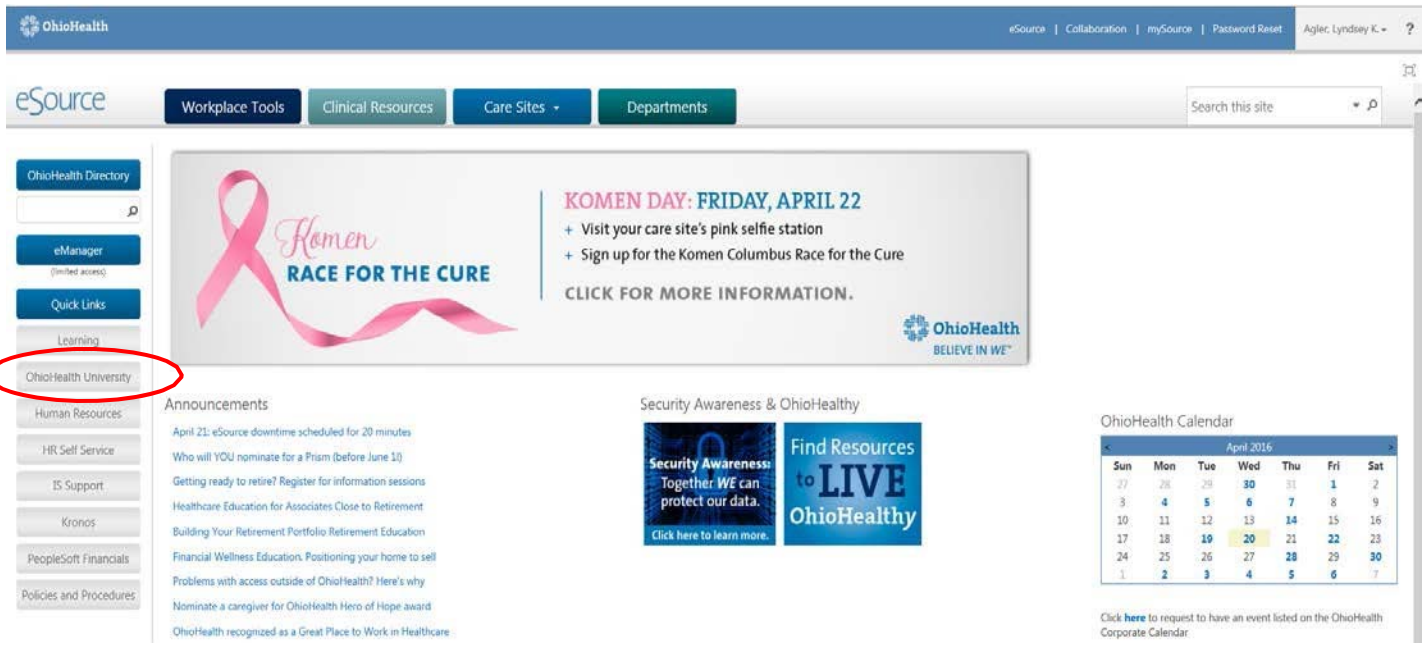
Full Name (Print First Name MI, Last Name)	**Signature:**	**Date:**

OhioHealth Group

Patient Safety Evaluation Instructions

1. If you are signing in to OhioHealth University outside of the OhioHealth network please use this website address - http://ohu.ohiohealth.com/
2. If you are signing in to OhioHealth University from the OhioHealth network, please go to the OhioHealth eSource page at ohesource.ohiohealth.com.

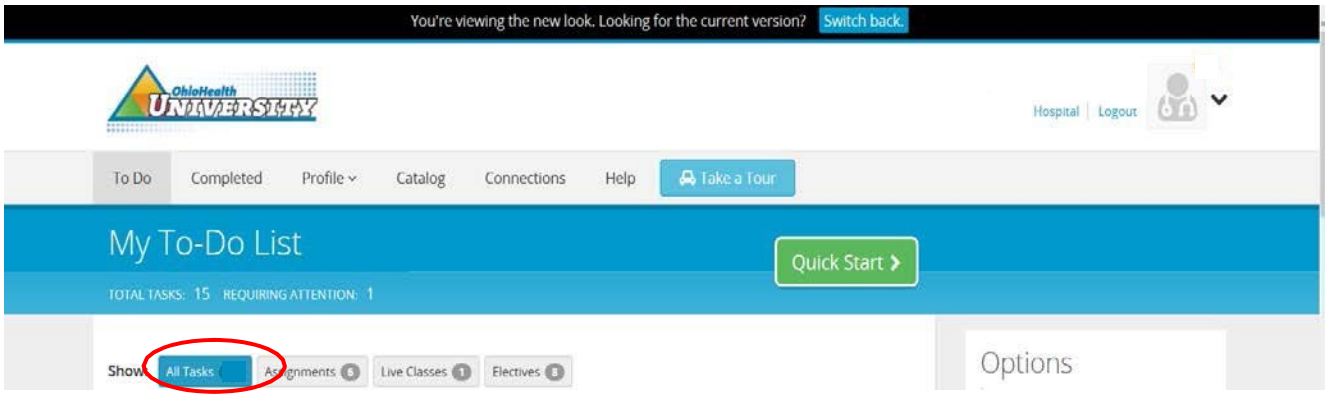
3. Once in eSource, select OhioHealth University in the left-hand side menu.



4. You will be redirected to the OhioHealth University website. You may be asked to login again; please use your OPID and password.

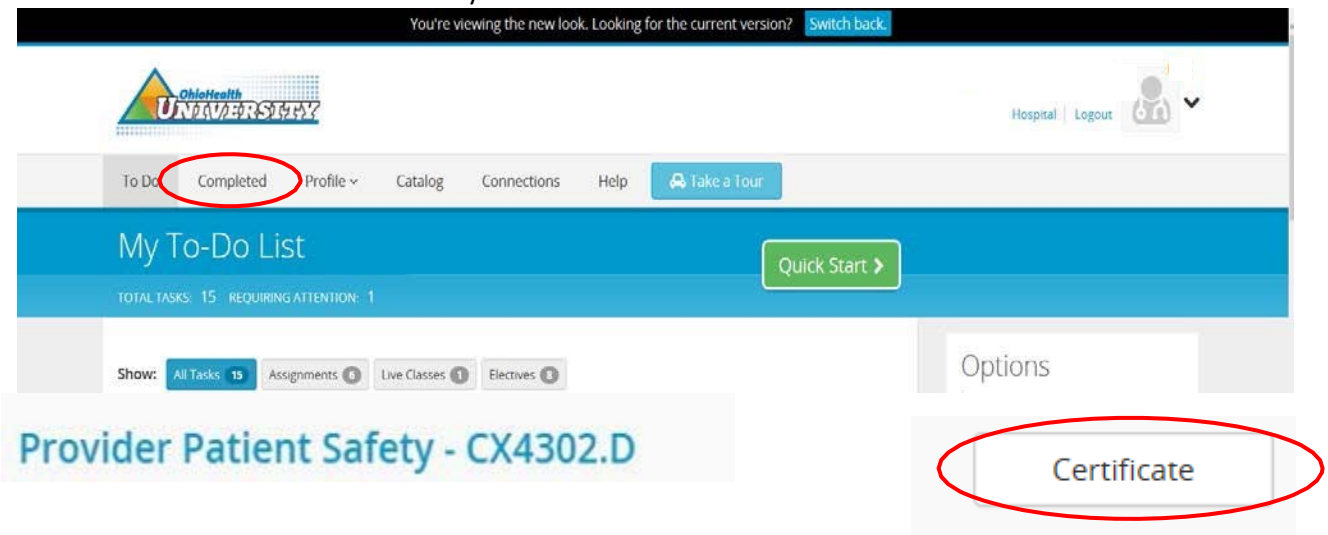
5. You will be prompted to sign in with your OPID and password, which will be sent to you by the Medical Staff Office (MSO).

6. Click on All Tasks as illustrated below.



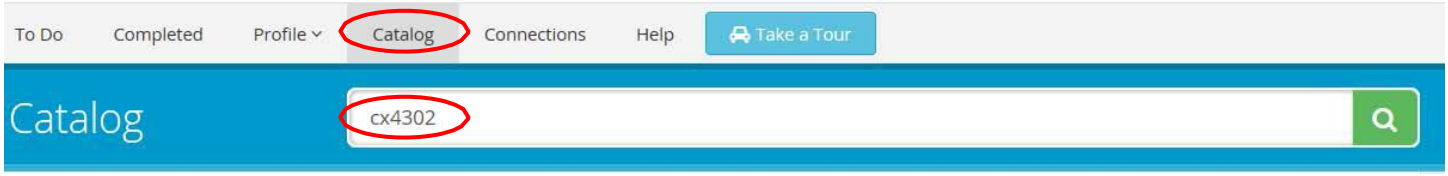
7. Click on the Provider Patient Safety – CX4302.D to complete the course. The course will consist of the study content and a post-assessment quiz with eight multiple choice questions. Your results will be displayed upon completion.

8. To view your score and print a certificate of completion, click the Completed tab, then click the Certificate button next to Provider Patient Safety – CX4302.D.



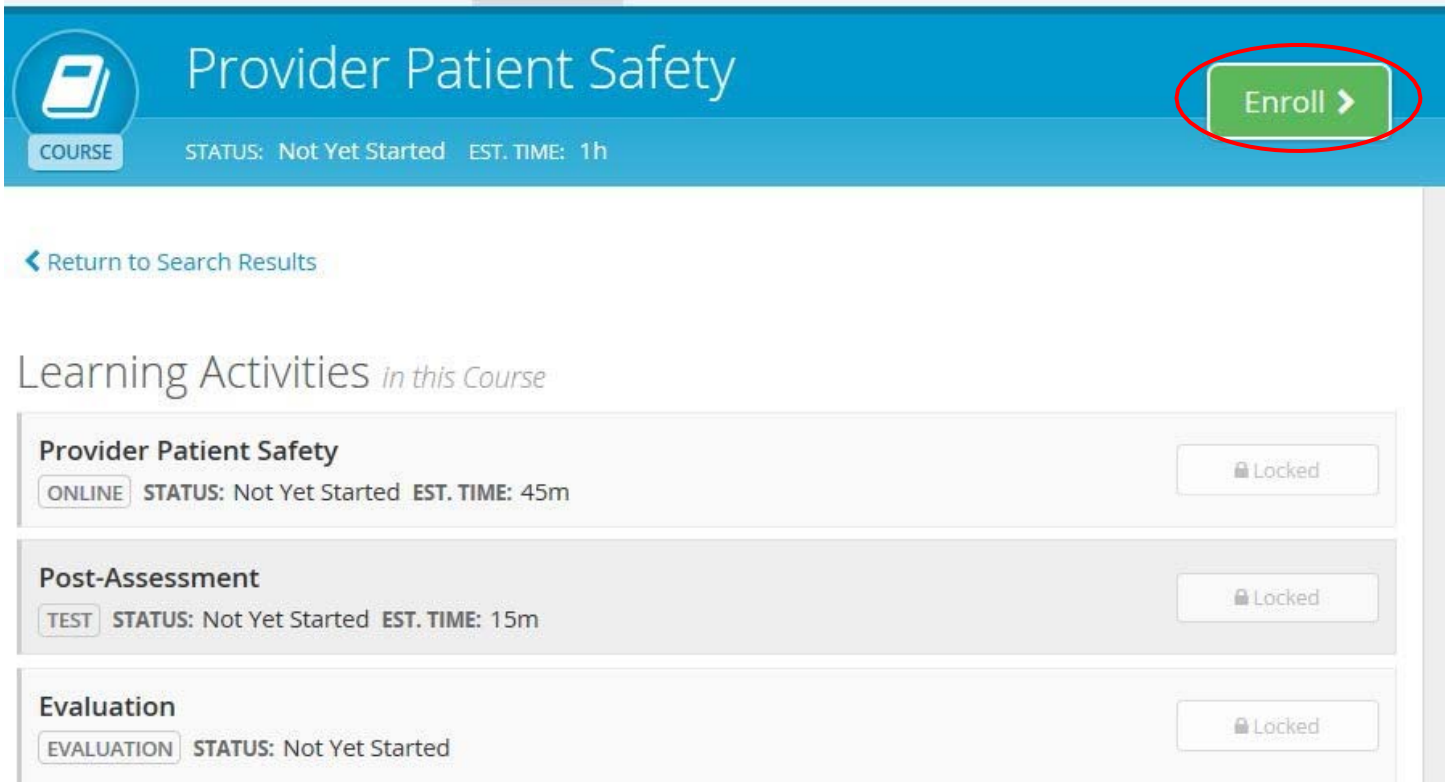
PLEASE NOTE: If for any reason the course is not assigned to your LMS account, you can search and enroll in the test.

9. Click Catalog in at the top menu and type CX4302 in the search box. (Do not type .D as this will not appropriately)



10. Click on the course name.

11. Click on the enroll button to have the course assigned to your LMS account.



OhioHealthGroup

INFORMATIONAL ONLY

NOTIFICATION OF PRACTITIONER RIGHTS

- Practitioners have the right to be informed of the status of their credentialing or reappointment application upon request.
- Practitioners have the right to review information obtained and used for purposes of credentials evaluation with the exception of professional references.
- Practitioners have the right to correct information collected from outside sources that is erroneous. Corrections to erroneous information must be made in writing and sent to OHGCS within fifteen days of notification that erroneous information has been received.
- Practitioners have the right to copy only documents in their file which they have submitted with regard to their application.
- Practitioners have the right to be credentialed in a non-discriminatory manner based upon race, gender, nationality, origin, or religion.

COMPREHENSIVE PAIN MANAGEMENT

The Joint Commission's current standards require that organizations establish policies and procedures that address comprehensive clinical assessment of pain; treatment or referral for treatment; and reassessment for patients as it designates, based on patient population and scope of services provided. They required that an organization:

- Establish a clinical leadership team
- Actively engage medical staff and hospital leadership in improving pain assessment and management, including strategies to decrease opioid use and minimize risks associated with opioid use
- Provide at least one non-pharmacological pain treatment modality
- Facilitate access to prescription drug monitoring programs
- Improve pain assessment by concentrating more on how pain is affecting patients' physical function
- Engage patients in treatment decisions about their pain management
- Address patient education and engagement, including storage and disposal of opioids to prevent these medications from being stolen or misused by others
- Facilitate referral of patients addicted to opioids to treatment programs

Pain can reveal a tremendous amount about the health status of your patient. Pain can affect the quality of life through its effect on such things as mood, activity, appetite and the ability to focus and concentrate. OhioHealth recognizes the priority of pain management in the overall wellbeing of the patient and that pain relief is important in the overall management of patient care. Pain should be managed to a level that is both safe and acceptable to the patient's clinical situation. If pain is identified, perform a pain assessment which may include but is not limited to the following components as warranted by the patient's condition and clinical setting:

- Location
- Pain Intensity Rating
- Description of pain (e.g., burning, dull, ache, etc.)
- Onset, duration, and pattern (e.g., constant, intermittent, radiating)
- Aggravating factors
- Alleviating factors
- Current pain management interventions
- Effects on function and quality of daily life
- Establish Comfort Goal with patient
- Screen for risk factors associated with opioid induced over sedation and respiratory depression
- Assess history of analgesic use or abuse, duration and possible side effects to identify potential opioid
- Tolerance or intolerance

- Reconcile pain medications with patient including last dose taken
- Assess patient for presence of patch (e.g., Fentanyl or Lidocaine patch), implanted drug delivery or system or infusion pump prior to administration of new opioid

The standard pain rating tool for adults and appropriate pediatric patients is the 0-10 Numeric Pain Intensity scale with 0=no pain and 10=the worst pain possible. If the patient is unable to speak English, the 0-10 Numeric Pain Intensity scale is available in 19 different languages. If the patient is unable to use the 0-10 Numeric Pain Intensity scale, use alternative scales such as the Simple Descriptive Pain Intensity Scale; Visual Analogue Scale (VAS); Wong-Baker Faces Pain Rating Scale. Infants/Children: Wong-Baker Faces Scale for children, FLACC Face/ Legs/Activity/Cry/Consolability for children ages 2 months – 7 yrs of age, NIPS Neonatal Infant Pain Scale. For patients unable to provide self-reports of pain (e.g., confused, decreased level of consciousness) use the Critical-Care Pain Observation Tool (CPOT) to assess for pain.

Safety considerations should be made for patients receiving opioids and could include assessing risk factors such as age, obesity, renal/hepatic impairment, known or suspected sleep apnea, multiple coexisting conditions, concurrent central nervous system depressants, opiate nativity, smoking status, and post-operative/post-anesthesia complications.

For examples of the tools used in pain assessment, refer to Policy P-100.010 Pain Management on Compliance 360.