The goal of OhioHealth Group Credentialing Services (OHGCS) and the OhioHealth Hospitals is to make the credentialing process as efficient as possible. **There are THREE (3) main parts to the credentialing process. Each part must be completed in its entirety for your application to be deemed complete in order to start the credentialing process. Once our process for initial credentialing begins, it can take up to 60 days to complete. Please note that this timeframe doesn’t include applicable committee dates for approval.**

**PAPERWORK THAT MUST BE COMPLETED FOR CREDENTIALING & PRIVILEGING**

- **OhioHealth Group (OHG) Application**
  - Enclosed

- **CAQH Application**
  - Needs to be completed via the CAQH website
  - [https://proview.caqh.org](https://proview.caqh.org)
  - (Instructions are enclosed)
  - **CAQH ID must be submitted with your paperwork**

- **Hospital specific packet for clinical privileges**
  - You will receive paperwork from each hospital to which you are applying for clinical privileges. The hospital specific paperwork will be sent to you AFTER the OHG and CAQH applications have been submitted and deemed complete.

The enclosed packet outlines the necessary steps needed to complete the OhioHealth Group Application and the CAQH (online) application.

Once OHGCS begins the credentialing process, you will receive a supplemental packet from each hospital to which you are applying. This supplemental packet must be completed and returned to the hospital where you are applying. Failure to return this packet in a timely manner will cause additional delays.

Upon OHGCS completing the credentialing / primary source verification on your application, each hospital will then complete the decision making portion of your application process and notify you of the results. Questions related to privileging/membership should be directed to:

- **Doctors Hospital**: (614) 544-2236
- **Dublin Methodist Hospital**: (614) 544-8055
- **Grant Medical Center**: (614) 566-9346
- **Grady Memorial Hospital**: (740) 615-1046
- **Hardin Memorial Hospital**: (419) 675-8283
- **Mansfield/Shelby Hospitals**: (419) 526-8533
- **Marion General Hospital**: (740) 383-8665
- **O’Bleness Hospital**: (740) 592-9492
- **Riverside Methodist Hospital**: (614) 566-4492
- **The Medical Group of Ohio**: (614) 566-0113
Dear Applicant,

This application, along with the CAQH online application, needs to be completed in its entirety. If either application are incomplete this will delay the start of your process for privileges. The subsequent pages of this application provide detailed instructions for accurate completion. Also included is an applicant checklist to be used for your convenience. Once your application is submitted and OHGCS begins the credentialing process, we may ask for your assistance in obtaining the required verifications pertinent to the credentialing process. It is ultimately the responsibility of the applicant to make sure that all required documents are obtained and verified.

If you already have privileges at an OhioHealth hospital(s) and you’re interested in applying for privileges at an additional hospital, you are still required to complete this application process in its entirety unless you have already completed this application and applied to another Hospital within the last 6 months.

Depending on the group that you will be joining and whether this group participates with the Medical Group of Ohio (MGO) and/or the HealthReach PPO, you may also need to sign the provider agreements associated with these companies. If you have questions on whether or not you need to complete these agreements please let me know.

Do not delay in returning this application if your State of Ohio Medical License, DEA certificate and/or current malpractice insurance for the group that you will be joining are still pending. OHGCS will begin the credentialing process with the understanding that these documents will need to be submitted before your file will be deemed complete. Please email me if you need assistance with these pending items in order to provide a complete CAQH online application.

Please return this packet via the US Mail to:

OhioHealth Group Credentialing Services
155 East Broad Street, Suite 1700
Columbus, OH 43215

Only original copies of this packet are acceptable. Do not staple any documents. The documents need to be returned as single-sided. Please do not copy the packet as a double-sided document.

If you decide at a later date that you would like to apply with additional entities or have questions about the status of your application please don’t hesitate to let me know. My office hours are Monday through Friday from 7:00am to 4:00pm with Lunch typically at 11:00am. My primary method of contact is email at bchapman@ohiohealthgroup.com

Sincerely,
Bonnie J. Chapman, Credentialing Specialist
OhioHealth Group Credentialing Services
155 East Broad Street, Suite 1700
Columbus, OH 43215
Phone: 614-566-0010
Fax: 614-566-0401
E-Mail: bchapman@ohiohealthgroup.com

*Because of the high volume of calls received to this office, voice mail messages are returned within 48 hours.*
Membership Selection and Applicant Fees

Place a checkmark in the box for each entity to which you are requesting membership.

OhioHealth Group Managed Care Products

☐ HealthReach / HealthReach Preferred (a PPO managed care product). Applicant must be on the medical staff of a hospital contracted with HealthReach PPO / HealthReach Preferred. A list of those hospitals is enclosed.

The Medical Group of Ohio

☐ By signing the enclosed MGO Provider Agreement a physician is expressing interest in participating in services offered by this physician organization, including contracting, group purchasing, practice management, quality management, etc.

OhioHealth Hospital - Affiliation & Clinical Privileges (check all that apply)

☐ Doctors Hospital (medical staff membership and clinical privileges)
☐ Dublin Methodist Hospital (medical staff membership and clinical privileges)
☐ Grant Medical Center (medical staff membership and clinical privileges)
☐ Grady Memorial Hospital (medical staff membership and clinical privileges)
☐ Hardin Memorial Hospital (medical staff membership and clinical privileges)
☐ Mansfield/Shelby Hospitals (medical staff membership and clinical privileges)
☐ Marion General Hospital (medical staff membership and clinical privileges)
☐ O’Bleness Hospital (medical staff membership and clinical privileges)
☐ Riverside Methodist Hospital (medical staff membership and clinical privileges)

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

☐ Check for processing fee for one hospital – $390
☐ Check for processing fee for two hospitals – $505
☐ Check for processing fee for three hospitals – $620
☐ Check for processing fee for four hospitals – $735
☐ Check for processing fee for five hospitals – $850
☐ Check for processing fee for six hospitals – $965
☐ Check for processing fee for seven hospitals – $1,080
☐ Check for processing fee for eight hospitals - $1,195
☐ Check for processing fee for all nine hospitals - $1,310

Make checks payable to: OhioHealth Group Credentialing Services

Please note the application fee is a one-time fee and is non-refundable once the primary source verification has been initiated.
Instructions for Completing the CAQH On-Line Application

OhioHealth Group Credentialing Services participates with the Council of Affordable Quality Healthcare (CAQH) Universal Credentialing Database initiative. This 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. This single application will allow for the processing of your application one time even when you are applying to more than one entity.

It is EXTREMELY important to follow the instructions that CAQH outlines in regards to the timeline of clinical practice. For example, please document the practice that you will be joining, start date, malpractice claims history, work history, etc. If the information listed on your CAQH application is submitted and then deemed incomplete, you will be alerted to update your CAQH application which will result in a delay of the credentialing process. Do not print the CAQH application. OhioHealth Group will download your application directly from the website once it is completed.

The CAQH website can be found at https://proview.caqh.org/

My CAQH Provider ID Number is: _____________________

• If you are already a CAQH Provider, list your ID Number above.
• 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.
• First time users should expect to spend at least 2 hours to complete your entire CAQH application.
• You can call the CAQH Help Desk at 888-599-1771 for any issues related to your application. This includes if you have a CAQH ID number but do not remember or know your username and password for the website.

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 YOU’RE JOINING, CURRENT MALPRACTICE CLAIMS, HOSPITAL AFFILIATIONS, ATTESTATION QUESTIONS, ETC...)

Start Date with Practice: ____ / _____ / ______
Practitioner’s Name:__________________________________________ Degree: ____________________
(e.g. MD, DO, DPM, DDS, PhD, PsyD)
Specialist: _______________ PCP: _____________ (choose one)
Contact Name: _____________________________ Contact Phone Number: (____)___________ ext. _______
Contact Name’s Email Address: _______________________________________________________________
Group Name:  ________________________________________________ TAX ID # ______________________
Mailing Address: ___________________________________________________________________________
(Street Address, City, State, Zip)
Frequently Asked Questions when completing the CAQH Application

How do I find out if I already have a CAQH ID?
Call the CAQH Help Desk at 1-888-599-1771 and they will ask you some identifying information to see if they can locate you in the Database. If you don’t have an ID Number you are able to self-register on the CAQH website. Go to https://proview.caqh.org and click to self-register. Please note that whatever email is used during registration is where the CAQH ID Number will be sent. You will need to provide this number to us for credentialing (see page 4).

If I have a CAQH ID Number, how do I get a username and password to log in?
You will need to contact the CAQH Help Desk at 1-888-599-1771 to request a username and password. Please note that your office manager will not be allowed to request this information on your behalf. The Help Desk will only release this information to the practitioner.

What do I do if I don’t yet have the Malpractice Facesheet for the practice that I am joining and this document needs to be faxed into CAQH?
Please contact the OhioHealth Group Credentialing Services office via email at bchapman@ohiohealthgroup.com for assistance.

What if my application for my DEA and/or Ohio medical license is still pending, how do I complete the CAQH application?
Please contact the OhioHealth Group Credentialing Services office via email at bchapman@ohiohealthgroup.com for assistance.

Do I have to update my practice information in CAQH with the new group I’m joining?
Yes. We will need to know what group you are joining and the specifics such as start date, primary and billing addresses. If there are issues with your current group’s knowledge of you leaving please contact the OhioHealth Group Credentialing Services office at 614-566-0010 for assistance.

There are 5 references requested in the OHG application and 3 references requested for CAQH. Can I use the same ones?
Yes. If you are applying for privileges with one or more of the OhioHealth Hospitals, it is required to have 5 references with the application. They will need to have observed you in the past 3 years and be of the same discipline as you.

Do I have to list any pending and/or settled malpractice claims on CAQH?
Yes. All claims against you within the last 10 years, regardless if they are pending or settled, need to be listed on the CAQH Application. To avoid a delay in processing your application make sure you have provided enough information for all of your malpractice claims on the CAQH application.

Who should I list as my Credentialing Contact on CAQH?
This is the designation person responsible for credentialing at the practice you are joining. Please note that any Insurance Company you are credentialed with will contact this person regarding your credentialing process at their entity. If you are in a solo practice and do not have an office manager then enter your information in this section.

What are all the steps in completing my CAQH Application? There are 6 steps to the application process.

1. Enter your information in all the sections of the online application.
2. Once all data entry has been entered, you will need to perform an audit of the data. If there is any information in the required fields those will need fixed before progressing any further.
3. Once the audit is complete you will need to attest the application. It is at this time the data will be “entered” and appear complete.
4. After you complete your application, you will need to upload any required supporting documents directly into the system. This will include your Attestation & Release and any other documents based on your data entry such as your DEA and Malpractice.
5. You can also upload your documents as you are completing your application. To do so, follow these steps:
   a. The “Documents” or “Review” pages will inform you what documents are needed to complete your application.
   b. Upload the supporting documents (e.g., Attestation & Release, DEA certificates, Malpractice, etc.) directly to CAQH ProView by following the instructions.
6. Once your application is complete and your supporting documents are reviewed for accuracy, your information will then become available to the organizations you authorized. You will need to check with each individual organization to determine your credentialing status.
I’m being told my CAQH Application is not complete. What could be wrong?
It could be that you did not attest your application. If you don’t attest to the accuracy of the application, it will show as incomplete. In addition, there could also be that one or more of your supporting documents were rejected by CAQH. You can tell if all your documents were accepted by viewing your Activity Log.

Why is my information not being uploaded into CAQH?
It’s possible the Attestation & Release form wasn’t dated, or a supporting document wasn’t readable. If a document isn’t being approved by CAQH please contact the CAQH Help Desk at 1-888-599-1771 to find out why.

How do I re-attest my CAQH Application?
Every 120 days your CAQH application will need to be re-attested to remain in a current status. If your application doesn’t remain current it will end up in an expired status and an entity you are with will not be able to process your application. To complete your re-attestation follow these steps:

1. If you have updates to make to your data profile, click on “Manage Information” from the top navigation bar and then the applicable section to update any necessary information in your data profile.
2. If you need to upload any updated supporting documentation, click on “Documents” from the top navigation bar to upload your documentation.
3. Once you have updated any applicable information or supporting documentation, click on “Attest” from the top navigation bar to begin the re-attestation process.

I am coming from out of state, how do I change my primary practice state to Ohio?
In the very beginning part of your application process you will see a section for the provider type and primary practice state. Make sure this is listed in Ohio. Some states have a state mandated application and in that instance we can’t credential your application until it’s an Ohio application. Please note you will be required to also sign/date and fax an updated Attestation & Release form if you are coming from out of state. Failure to do this will delay your credentialing process.

How if the information that I populate in Areas of Interest (Section 3 of the CAQH application) being utilized? We want to encourage you to provide us with any information related to your areas of professional interest, activities, procedures and diagnosis. This information is currently being tracked in our database and may be used to better serve patients looking for specific areas of practice which is currently not recognized as a board certification (i.e. breast surgery, holistic healing, bariatric surgery, Parkinson’s disease, etc...)

OhioHealth Group Credentialing Services - 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 peer review statutes.
- 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.
APPLICANT CHECKLIST

Your application must be deemed complete before OHGCS will start the credentialing process. Please complete the following checklist **before** submitting your application to OHGCS. An incomplete application will NOT be processed until all required documents are received.

**Required documents for all entities:**

- Copy of a **current** Curriculum Vitae / Resume
  - Your timeline needs to contain both month/year for education and work history
- Copy of Board Certification **(if applicable)**
- Copy of DEA Registration **(if applicable)**. If pending, please submit a copy to us when received. If you are relocating from another state you will be required to update your address information on your DEA registration to reflect your practice location associated with this application.
  - Due to the poor quality that could appear on CAQH when downloading scanned documents, we ask that you include a copy of your DEA certificate EVEN IF provided to CAQH.
- Copy of current professional liability insurance policy face sheet, showing expiration dates, limits, and applicant’s name (if pending, please submit a copy to us when received)
  - Due to the poor quality that could appear on CAQH when downloading scanned documents, we ask that you include a copy of your insurance policy face sheet EVEN IF provided to CAQH.
- Copy of all out of state license(s)
- Copy of ECFMG Certificate **(if applicable)**
- W-9 for verification of each tax identification number used for the practice that the applicant will be working under.

**If applying to OhioHealth Group Managed Care Products:**  (HealthReach / HealthReach Preferred)

- Signed Provider Agreements **(if applicable)**

**If applying to The Medical Group of Ohio (MGO)**

- Signed Provider Agreements **(if applicable)**
  By signing the enclosed MGO Provider Agreement a practitioner is expressing interest in participating in services offered by this physician organization, including contracting, group purchasing, practice management, quality management, etc.
In order for your application to be released to the Hospital(s) for processing, ALL of the required documents listed below must accompany your application.

- Hospital Application Fee**
  - Check for processing fee for one hospital – $390
  - Check for processing fee for two hospitals – $505
  - Check for processing fee for three hospitals – $620
  - Check for processing fee for four hospitals – $735
  - Check for processing fee for five hospitals – $850
  - Check for processing fee for six hospitals – $965
  - Check for processing fee for seven hospitals – $1,080
  - Check for processing fee for eight hospitals - $1,195
  - Check for processing fee for all nine hospitals - $1,310

- OhioHealth Medical Staff Office Addendum *

- Authorization Form to conduct a Criminal Background and/or Fingerprint Process *

- Legible Notarized copy of applicant’s driver’s license or other government issued photo ID *

- Medicare/TriCare/KePRO Patient Penalty Statement Form *

- 5 year Malpractice Claims History Request Information Page *

- 5 year Malpractice Claims History Verification *
  - Response must be made to the attention of OhioHealth Group Credentialing

- Current TB Skin Test & Health Assessment Form* (Both are required)

- OhioHealth Internet User Agreement / Confidentiality Statement of Understanding *

- Portrait Quality Professional Photograph** (NO PASSPORT)

* Included in this application packet that must be completed and returned.

** Required documents that must be returned along with this packet.
MEDICAL STAFF OFFICE ADDENDUM

Applicant Full Name (Print): _______________________________________________  Degree________________

Marital Status (Optional): ____ Single     ____ Married            ____ Widow
____ Divorced   ____ Partner

Spouse or Partner’s Name: ___________________________________________________ (For Hospital Events)

Pager Number:__________________________      *Cellular Number: ______________________________
(*Required in order to obtain remote access to OhioHealth computer systems. This number will not be released, and will only be used for OhioHealth purposes).

Applicant email address: ___________________________________________________________________

Your email address will be used to communicate pertinent Medical Staff correspondence

Preferred mailing address for the OhioHealth Medical Staff Offices:
This address will be used for all business correspondence sent by the Medical Staff Offices

Street Address_____________________________________________
City______________________________________________________
State_________________________          Zip_____________________

1) For Riverside, Grant, Dublin and Doctors applicants only: Do you hold a direct or indirect ownership interest in an inpatient hospital located in Franklin County, Ohio or any contiguous county? (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) For Riverside, Grant, Dublin and Doctors applicants only: 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 in Franklin County, Ohio or any contiguous county?

Yes ☐  No ☐

If yes please explain:
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

Initial Application Packet as of 01/01/16
DOCUMENTATION OF 5 PEER REFERENCES

- If you have completed a training program within the past 12 months, you must list the name of your Program Director as one of your 5 peer references. If you’ve been out of training for more than 12 months, one of your 5 references listed must be the Department Chair at your current Primary Hospital. **This is a required reference regardless if you personally know him/her.**
- An acceptable peer must have observed your clinical practice for at least 3 months and within the past 3 years.
- The CAQH Online Application requires 3 references. You may include these same 3 references along with 2 additional names below as long as the references meet the above requirements.
- In order to expedite the process **fax numbers must be documented**. **It is also beneficial to contact your references to let them know that a request will be sent to them via fax.**

Reference 1 – Program Director if graduated in the past 12 months **(OR)** Department Chair of your current Primary Hospital if you’ve been out of Residency for longer than 12 months.

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Reference 3 - Peer

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Reference 5 - Peer

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CRIMINAL BACKGROUND INVESTIGATION

- All new applicants applying for membership at an OhioHealth hospital are required to provide fingerprints to the OhioHealth Protective Services or Human Resources Department. The fingerprinting will be conducted only at initial application. Applicants will be required to sign a consent form for this process (refer to page 12 of this application). Failure to sign a consent form will terminate the application process.

- If you are solely applying to Mansfield/Shelby Hospitals and/or O’Bleness Hospital, you are not required to be fingerprinted at this time. A criminal background check will be performed in lieu of fingerprinting.

- Our fingerprint process is separate from the process completed when obtaining your Ohio Professional License.

- Practitioners who choose to get fingerprinted at an OhioHealth Hospital are required to have an appointment scheduled through our office. Do not schedule an appointment on your own. OhioHealth Group Credentialing Services will contact you to schedule an appointment at any of the below locations to conduct the fingerprinting process. It is important that you arrive at your designated location on time in order to ensure availability of designated OhioHealth personnel and to ensure timely completion of your initial application.

Below are the designated sites to have your fingerprinting performed. A valid driver’s license is required for this process.

- **Riverside Methodist Hospital**
  Protective Services / ID Badge Center or
  the Human Resources Department

- **Grant Medical Center**
  Human Resources Department

- **Doctors Hospital**
  Human Resources Department

- **Dublin Methodist Hospital**
  Human Resources Department

- **Grady Memorial Hospital**
  Human Resources Department

- **Marion General Hospital**
  Human Resources Department

Note: OHGCS will be notified if you are unable to come to an OhioHealth Hospital (i.e. if you currently reside out of state) when they contact you to schedule your appointment. You will then be informed on what needs to be done in lieu of coming to Ohio for fingerprinting.
AUTHORIZATION FORM TO CONDUCT A CRIMINAL BACKGROUND CHECK

NOTICE TO APPLICANTS
An investigative report including fingerprinting and/or a criminal background check, information concerning your character, employment history, general reputation, personal characteristics, police record, education, qualifications and motor vehicle record will be obtained 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 OHGCS to obtain investigative reports as described.

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 hereby authorize any present or former employers, educational institutions, criminal justice agencies, departments of motor vehicles or public agency, to submit information or opinions about me including data received from other sources in order that my qualifications can be evaluated. I hereby release and hold harmless OHGCS, its predecessors, successors, assignees, trustees, directors, officers, administrators, employees and agents from any and all liability and responsibility, damages and claims of any kind whatsoever arising from this investigation of my background.

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

Print Name (First, MI, Last, Degree) ___________________________________________  Date _______________________________
Signature ____________________________________________________________________________________________________

The following information is required by law enforcement agencies for positive identification purposes when checking public records. It is confidential and will not be used for any other purpose.

(Date of Birth) (Social Security Number) (Maiden or other name(s) used)  Driver’s License Number and State

Home Address City State Zip

DISCLOSURE QUESTION: Failure to disclose will add processing time to your application.

Have you ever pled guilty to or been found guilty of a violation of any law, other than a minor traffic violation (Note: a DUI or DUI reduced to reckless operation is not considered a minor traffic violation). This background check will identify information greater than 10 years old.

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

________________________________________________________________________________________________________
_______________________________________________________________________________________________________
________________________________________________________________________________________________________

Note: If you are located in MN, OK or CA, check this box if you would like a free copy of your report  ☐
NOTARIZED COPY OF DRIVER’S LICENSE OR PASSPORT

If you are applying for clinical privileges at an OhioHealth Hospital you are required to submit a notarized copy of your driver’s license or passport that is clear and legible. This form must be completed as requested. **A separate form will not be accepted.**

*Please note that the notary is attesting to the applicant’s signature below and not the actual driver’s license.*

**APPLICANT’S DRIVER’S LICENSE OR PASSPORT**

(The copy must be clear and legible, including the photo. Failure to provide a legible copy will cause this form to be refused and a new form will be required)

COPY OF DRIVER’S LICENSE OR PASSPORT (front side only) HERE

I certify the below signature to be a true copy of the original document.

_________________________________________________________________________  ______________________
Applicant’s Signature           Date

STATE OF ____________________________:  COUNTY Of_______________________________:

Acknowledged and signed in my presence by: _______________________________________

this _______ of __________________, ________

__________________________________________ _________________________________________
Notary Public                               My Commission Expires:

Notary: You must include your notary seal on this form and you must sign/date this form at the same time as the applicant.
The Medicare / TRICARE/KePRO health insurance program reimburses the hospital on a DRG basis. According to Medicare / TRICARE/KePRO regulations, the hospital is required to have on file a signature of each physician that confirms receipt of the Medicare / TRICARE /KePRO penalty statement. This form needs to be signed as part of the application process.

Please note that stamped signatures on this acknowledgement are not acceptable under the regulations.

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

NOTICE TO PHYSICIANS

“Medicare /TRICARE /KePRO payment to hospitals is based in part on each patient’s principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient’s attending physician by virtue of his/her signature in the medical record. Anyone who misrepresents falsifies or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal law.”

This notice also applies to Ohio Medicaid payment to hospitals.

My signature below acknowledges that I have received and read the above “Notice to Physicians”.

______________________________________________  ________ ________________
Signature of Physician              Date

______________________________________________
Printed Physician Name, Degree
STEP 1 OUT OF 2 – VERIFICATION OF MALPRACTICE CLAIMS HISTORY

**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 Residency and/or Fellowship Training if it was within the past 5 years.** Do not bypass this portion of the application by including copies of past malpractice face sheets. Copies of past face sheets will NOT be accepted. The form below 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. Sign the release form (refer to page 16) and send it to the Legal Department/Risk Management department so they can provide us with the claims history verification.
- 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.

<table>
<thead>
<tr>
<th>Malpractice Carrier 1</th>
<th>check which applies for the carrier: Employer ☐ Residency/Fellowship ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier Name:</td>
<td>Policy Number:</td>
</tr>
<tr>
<td>Contact Name (<em>if known</em>):</td>
<td>From Date: Expiration:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax: Retroactive Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Malpractice Carrier 2</th>
<th>check which applies for the carrier: Employer ☐ Residency/Fellowship ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier Name:</td>
<td>Policy Number:</td>
</tr>
<tr>
<td>Contact Name (<em>if known</em>):</td>
<td>From Date: Expiration:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax: Retroactive Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Malpractice Carrier 3</th>
<th>check which applies for the carrier: Employer ☐ Residency/Fellowship ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier Name:</td>
<td>Policy Number:</td>
</tr>
<tr>
<td>Contact Name (<em>if known</em>):</td>
<td>From Date: Expiration:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax: Retroactive Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Malpractice Carrier 4</th>
<th>check which applies for the carrier: Employer ☐ Residency/Fellowship ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier Name:</td>
<td>Policy Number:</td>
</tr>
<tr>
<td>Contact Name (<em>if known</em>):</td>
<td>From Date: Expiration:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax: Retroactive Date:</td>
</tr>
</tbody>
</table>

*Make a copy of this form if additional carriers need to be listed.*
STEP 2 OUT OF 2 – VERIFICATION OF MALPRACTICE CLAIMS HISTORY

Please send a signed copy of this page to EACH malpractice carrier (or insurance agent) that you have listed on the previous page. PLEASE COMPLETE THE TOP PORTION OF THE FORM BELOW. 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 hospitals: Grant Medical Center, Doctors Hospital, Dublin Methodist Hospital, Riverside Methodist Hospital in Columbus, Ohio, and/or Grady Memorial Hospital in Delaware, Ohio, and/or Hardin Memorial Hospital in Kenton, Ohio, and/or Mansfield/Shelby Hospitals in Mansfield, Ohio, and/or Marion General Hospital in Marion, Ohio, and/or O’Bleness Hospital in Athens, Ohio. 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.

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 __________

Carrier Name: __________________________________________________________________________

Policy Number: ___________________________ Employer/School: ______________________________________

*****The following information needs to be completed by the malpractice insurance company******

If submitting a separate form, the document MUST BE addressed to the attention of OhioHealth Group Credentialing Services

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

Policy Amount: __________ Effective Dates / From: __________ Expired Date: __________

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 __________________________
Carefully read the instructions below while referring to the form on page 19.

1. At this stage in the process, you do not need to have a health assessment completed by your physician. We simply need you to complete the questions on Section Two and provide a current TB Test for Section One.
2. The TB Test must have been placed within 12 months. Depending on when your last TB Test was performed, you may need to get it placed again while in the credentialing process.
3. Proof of having a TB Skin Test placed and read at another institution is acceptable. However, you still need to complete the questions under Section Two.
4. 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.
     - It is not necessary that the positive result and chest x-ray to have been within the past 12 months.
5. 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.
6. If there is another shortage on supplies to perform the TB Test. This is still a requirement for the application process and must be submitted. If your institution will not perform a TB Test you are able to go to the OhioHealth’s Associate Health & Wellness to have them complete this for your application process. Let them know you are applying for hospital privileges.
7. If you have this test performed at an OhioHealth Associate Health & Wellness location, you must request a copy of the completed results to submit with your application.
8. If you are going to an OhioHealth location to receive a TB Test/Blood Test, refer to clinical locations and times on Page 18. Please inform them you are getting this test as part of the application process for hospital privileges.

Please note: Once the applicant receives their clinical privileges, annual Health Evaluations/TB Tests must be sent directly to the Medical Staff Office the applicant holds their privileges. We only receive this at initial appointment only. Thank You!
Associate Health and Wellness
Clinic Locations and Walk-In Hours

**Doctors Hospital**
5200 W. Broad St.    Columbus, OH 43228    Ground Floor
614-544-1008

Monday, Wednesday and Friday: 7:00am to 12noon, 1:00pm to 4:00pm
Tuesday: 7:00am to 12noon
Thursday: 1:00pm to 4:00pm

**Dublin Methodist Hospital**
7500 Hospital Drive    Dublin, OH 43016    Outside Lab
614-544-8044

Monday and Wednesday: 7:00am to 12noon, 1:00pm to 4:00pm

**Grady Memorial Hospital**
561 W. Central Ave.    Delaware, OH 43015    1st Floor Near Pediatrics
740-615-1134

Tuesday and Friday 7:00am to 12noon, 1:00pm to 4:00pm

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

Monday, Tuesday, Wednesday, and Friday: 7:00am to 12noon, 1:00pm to 4:00pm
Thursday: 7:00am to 12noon

**Marion General Hospital**
1000 McKinley Park Dr.    Marion, OH 43302    Basement near HR
740-383-8959

Monday, Tuesday, Wednesday, and Friday: 7:00am to 12noon, 1:00pm to 4:00pm
Thursday: 7:00am to 12noon

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

Monday, Tuesday, Wednesday, and Friday: 7:00am to 12noon, 1:00pm to 4:00pm
Thursday: 7:00am to 12noon
**OhioHealth Group Credentialing Services (OHGCS)**

155 E. Broad Street, Suite 1700, Columbus, OH 43215  Phone: 614.566.0010  800.635.7207  Fax: 614.566.0401

**OHIOSHEALTH HEALTH EVALUATION FOR COMMUNICABLE DISEASE**

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

<table>
<thead>
<tr>
<th>Name (please print full name)</th>
<th>SS#</th>
<th>Date of Birth</th>
<th>Phone (work)</th>
</tr>
</thead>
</table>

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

**Section One: TB Documentation**

☐ Refer to Attached Documentation

Please complete this section of the form or provide 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.

<table>
<thead>
<tr>
<th>Date applied</th>
<th>Site</th>
<th>Manufacturer</th>
<th>Lot #</th>
<th>Exp. Date</th>
<th>Signature</th>
<th>Date read</th>
<th>Induration</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>__<strong><strong>/</strong></strong></td>
<td>RFA/LFA</td>
<td>___________</td>
<td><strong><strong>/</strong></strong></td>
<td><strong><strong>/</strong></strong></td>
<td><strong><strong>/</strong></strong></td>
<td><strong><strong>/</strong></strong></td>
<td><strong><strong>/</strong></strong></td>
<td><strong><strong>/</strong></strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2nd step (if required)</th>
<th>Site</th>
<th>Manufacturer</th>
<th>Lot #</th>
<th>Exp. Date</th>
<th>Signature</th>
<th>Date read</th>
<th>Induration</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>__<strong><strong>/</strong></strong></td>
<td>RFA/LFA</td>
<td>___________</td>
<td><strong><strong>/</strong></strong></td>
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<td><strong><strong>/</strong></strong></td>
<td><strong><strong>/</strong></strong></td>
<td><strong><strong>/</strong></strong></td>
</tr>
</tbody>
</table>

**Section Two: Health History**

Please answer the questions in this section

<table>
<thead>
<tr>
<th>History of POSITIVE TB test?</th>
<th>No</th>
<th>Yes</th>
<th>If you answer No, go to question #1.</th>
<th>If you answer Yes, answer the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of positive test</td>
<td>________</td>
<td>Date of last chest x-ray</td>
<td>________</td>
<td>X-ray result</td>
</tr>
</tbody>
</table>

(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)*

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
<th>Resolved</th>
<th>If not resolved, please comment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Abdominal or gastrointestinal problems such as frequent diarrhea, nausea or vomiting.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Unexplained weight loss or excessive fatigue.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Frequent upper respiratory symptoms such as colds, sore throat, productive cough, or pneumonia.</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>4. Persistent fever or excessive sweating, especially at night.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Skin problems; such as cold sores, boils, abscesses or other skin lesions of the face and hands.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Communicable disease such as Hepatitis or Tuberculosis.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Compromised immune system or serious illnesses.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Allergies NO ___ Yes ___(please list):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature: ____________________________  Date: __________________

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

<table>
<thead>
<tr>
<th>Full Name (Print First Name MI, Last Name)</th>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

5065580v2

Initial Application Packet as of 01/01/16
SUBMISSION OF PROFESSIONAL PHOTOGRAPH

A professional photograph of the applicant, IN COLOR, is a requirement.

Your photograph will be used for the following purposes:

1. Verification of identity when practicing in the hospital(s). Your photograph will appear for the clinical staff to view when verifying your clinical privileges.


3. The photograph must meet the following requirements to be considered acceptable.
   a. Must be in color
   b. Must be a recent photograph
   c. Passport photos or photos that are of size and appearance of a passport are NOT acceptable.
   d. Plain or studio backdrop
   e. Attire should be professional (i.e. suit, sport coat or lab coat)
   f. Body should be at a slight angle with head turned to lens
   g. Lighting should be from studio light or natural
   h. The photograph needs to be of a professional manner and friendly in appearance
   i. Wallet size or larger
   j. Save as a .jpg and email to Bonnie Chapman at bchapman@ohiohealthgroup.com
      ○ If you can’t email the photo you may use one of the following formats:
         a. On CD as a .jpg format – Include the CD with your completed application
         b. As an original photo printed on photo paper (regular paper is not acceptable due to the poor quality of scanning) – Include with your completed application

A tip for taking a photo: You don’t need to have a professional photo taken to have it appear professional. You can stand in front of a blank wall and have someone take your picture as described above. Please note that self-portraits taken with a cellphone do not turn out professional.

The OhioHealth Group application will NOT be deemed complete without submission of an acceptable professional photo. Failure to submit a professional photo will DELAY the credentialing process.
PAIN, THE FIFTH VITAL SIGN – INFORMATIONAL ONLY

Pain is often called the Fifth Vital Sign. It 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.

To achieve adequate pain control it is necessary to understand how to assess pain. The following questions and assessment scales will help you evaluate your patient’s pain.

1. **Where is your pain?** Pain can be in more than one place. Pointing to the place where it hurts is sometimes the best way to explain where it is.
2. **When did the pain start?**
3. **How bad does it hurt?** To help measure pain, there are different scales that sometimes help. The most common is a number scale with 0 meaning no pain and 10 meaning the worst pain. Below are some examples of scales. Use the scale that works best for you.

![Image of pain assessment scales]

4. **What does it feel like?** Does it burn? Tingle? Ache? Is it dull or sharp?
5. **Is it worse at any time of the day more than another?** Morning? Evening?
6. **What make the pain feel better?** What makes the pain feel worse? Does medicine make it feel better? Heat? Cold? Lying in a certain position? Does it hurt more when you’re active or when you’re lying still?
7. **Has the pain affected any other parts of your life?** For example, does it make it hard to sleep, eat or care for yourself or others? Has it affected your emotions? Your relationships?

**WHEN PAIN EXISTS, TREATMENT IS POSSIBLE**

For further education on this topic, refer to OhioHealth University through ORB.