ALLIED HEALTH PROFESSIONALS
APPLICATION FOR INITIAL CREDENTIALING

Doctors Hospital, Dublin Methodist Hospital, Grady Memorial Hospital, Grant Medical Center, Hardin Memorial Hospital, Mansfield Hospital, Marion General Hospital, O’Bleness Hospital, Riverside Methodist Hospital, Shelby Hospital

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 3 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 (pending licenses can be verified via their respective websites).
   (c) Return completed one-sided documents to: OhioHealth Group Credentialing Services, 155 East Broad Street, Suite 1700, Columbus, OH 43215. OR
   (d) If not applying to the Health4 and/or HealthReach/Health Reach Preferred, you may email or fax the completed packet to Jessica Bardin at bardin@ohiohealthgroup.com or fax (614)566-0401.

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 apply.
   (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  
   Mansfield Hospital: (419) 526-8581  
   Dublin Methodist Hospital: (614) 544-8040  
   Marion General Hospital: (740) 383-8665  
   Grant Medical Center: (614) 566-9346  
   O’Bleness Hospital: (740) 592-9492  
   Grady Memorial Hospital: (740) 615-1045  
   Riverside Methodist Hospital: (614) 566-4492  
   Hardin Memorial Hospital: (419) 675-8283  
   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.
Participation Selection

Place a checkmark in the box for each entity 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 Health4/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

Application Fee: 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: 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.
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 Number below.
  - 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.
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, lighting should be from studio light or natural
  - Attire should be professional (i.e. suit, sport coat or 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 Jessica Bardin at jbardin@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

Start Date with Practice: _____ / _____ / _____

Practice Name: ________________________________  Tax ID: ______________________

Practice Manager: ____________________________

Credentialing Contact Name: __________________ Phone Number: (_____ ) ____________ ext. _________

Contact Name’s Email Address: ________________________________

Preferred Email address for Credentialing: ________________________________

Preferred Mailing Address for Medical Staff Correspondence: ________________________________

__________________________________________________________________________

Street Address

City    State    Zip Code
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 )

Contact Preference:   1. ___________ 2. ___________ 3. ___________

Please 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

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)

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

______________________________________________________________________________
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 for at least 3 months and within the past 3 years and hold the same license or certification 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.

### OTHER ACCEPTABLE REFERENCES in ADDITION TO REQUIRED REFERENCES

**REFERENCES MUST HAVE OBSERVED YOUR CLINICAL PRACTICE FOR AT LEAST THREE (3) MONTHS WITHIN THE PAST THREE (3) YEARS**

- **Peer** - A provider who works in the same discipline with the same credentials as you, and is knowledgeable about the quality of your performance.
- **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.
### Documentation of Five (5) Professional References

#### Reference #1
- **First Name:** [Field]  
- **Last Name:** [Field]  
- **Degree:** [Field]  
- **Phone:** (   )  
- **Fax:** (   )  
- **Email Address:** [Field]  
- **Name of School/Hospital:** [Field]  
- **Relationship:**  
  - Program Director  
  - Preceptor  
  - Supervising/Collaborating Physician  
  - Peer  

#### Reference #2
- **First Name:** [Field]  
- **Last Name:** [Field]  
- **Degree:** [Field]  
- **Phone:** (   )  
- **Fax:** (   )  
- **Email Address:** [Field]  
- **Name of School/Hospital:** [Field]  
- **Relationship:**  
  - Program Director  
  - Preceptor  
  - Supervising/Collaborating Physician  
  - Peer  

#### Reference #3
- **First Name:** [Field]  
- **Last Name:** [Field]  
- **Degree:** [Field]  
- **Phone:** (   )  
- **Fax:** (   )  
- **Email Address:** [Field]  
- **Name of School/Hospital:** [Field]  
- **Relationship:**  
  - Program Director  
  - Preceptor  
  - Supervising/Collaborating Physician  
  - Peer  

#### Reference #4
- **First Name:** [Field]  
- **Last Name:** [Field]  
- **Degree:** [Field]  
- **Phone:** (   )  
- **Fax:** (   )  
- **Email Address:** [Field]  
- **Name of School/Hospital:** [Field]  
- **Relationship:**  
  - Program Director  
  - Preceptor  
  - Supervising/Collaborating Physician  
  - Peer  

#### Reference #5
- **First Name:** [Field]  
- **Last Name:** [Field]  
- **Degree:** [Field]  
- **Phone:** (   )  
- **Fax:** (   )  
- **Email Address:** [Field]  
- **Name of School/Hospital:** [Field]  
- **Relationship:**  
  - Program Director  
  - Preceptor  
  - Supervising/Collaborating Physician  
  - Peer
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. Applicants will be required to sign a consent form for this process (below). Failure to sign a consent form will terminate the application process.
- Do not schedule an appointment on your own. OHGCS will contact you to schedule an appointment at any of the locations listed below. It is important that you arrive at your designated location at the time scheduled in order to ensure availability of designated OhioHealth personnel and to ensure timely completion of your application. A valid driver’s license is required for this process.
- If you are solely applying to Mansfield Hospital, Shelby Hospital 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.
- Please note that our fingerprint process is separate from the process you completed when obtaining your Ohio Professional License. If you are unable to come to an OhioHealth Hospital to be fingerprinted OHGCS will provide you with other options for fingerprinting.

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

Marion General Hospital
Human Resources Department

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.

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

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 hold said persons and/or organizations blameless and without liability for statements or opinions made regarding my character, experience or qualifications. 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.

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/State

Note: If you are located in MN, OK or CA, check this box if you would like a free copy of your report ☐
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:__________________________________________

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
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 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 as much information as possible below could delay the application process.

<table>
<thead>
<tr>
<th>Employer Name:</th>
<th>Job Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone Number for Verifying Employment:</td>
<td>Fax Number for Verifying Employment:</td>
</tr>
<tr>
<td>Employment Start Date:</td>
<td>Employment End Date:</td>
</tr>
<tr>
<td>Reasoning for Departure (if applicable):</td>
<td></td>
</tr>
<tr>
<td>Malpractice Carrier:</td>
<td>Policy Number:</td>
</tr>
<tr>
<td>Policy Dates:</td>
<td>Retroactive Date:</td>
</tr>
</tbody>
</table>

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<td>Policy Number:</td>
</tr>
<tr>
<td>Policy Dates:</td>
<td>Retroactive Date:</td>
</tr>
</tbody>
</table>

*Make a copy of this form if additional employers need to be listed.*
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 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 on the following page 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>Employer/School Name:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax:</td>
</tr>
<tr>
<td>Policy Number:</td>
<td>Policy Dates:</td>
</tr>
<tr>
<td></td>
<td>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>Employer/School Name:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax:</td>
</tr>
<tr>
<td>Policy Number:</td>
<td>Policy Dates:</td>
</tr>
<tr>
<td></td>
<td>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>Employer/School Name:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax:</td>
</tr>
<tr>
<td>Policy Number:</td>
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<td>Retroactive Date:</td>
</tr>
</tbody>
</table>

<table>
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<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>Employer/School Name:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax:</td>
</tr>
<tr>
<td>Policy Number:</td>
<td>Policy Dates:</td>
</tr>
<tr>
<td></td>
<td>Retroactive Date:</td>
</tr>
</tbody>
</table>

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

Send a signed copy of this form to EACH malpractice carrier (or insurance agent) that you listed on your CAQH application. 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

Carrier Name:  

Policy Number:  Employer/School:  

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

If submitting a separate form, response must be 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
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 five races.

- **I do not wish to provide this information**
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) 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.

7) 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: 5200 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
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.

<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>
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</thead>
<tbody>
<tr>
<td><strong>/</strong>/____</td>
<td>RFA/LFA</td>
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1st step (if required)

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<tr>
<th>Date applied</th>
<th>Site</th>
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<th>Lot #</th>
<th>Exp. Date</th>
<th>Signature</th>
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2nd step

Date applied         Site             Manufacturer              Lot #                 Exp. Date                Signature                 Date read             Induration               Signature

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:

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 ___ (c) INH Therapy?   No___ or Yes ___
(b) Treated by physician?   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>
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<tbody>
<tr>
<td>Abdominal or gastrointestinal problems such as frequent diarrhea, nausea or vomiting.</td>
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<tr>
<td>Unexplained weight loss or excessive fatigue.</td>
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<tr>
<td>Frequent upper respiratory symptoms such as colds, sore throat, productive cough, or pneumonia.</td>
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<tr>
<td>Persistent fever or excessive sweating, especially at night.</td>
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<tr>
<td>Skin problems; such as cold sores, boils, abscesses or other skin lesions of the face and hands.</td>
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<tr>
<td>Communicable disease such as Hepatitis or Tuberculosis.</td>
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<tr>
<td>Compromised immune system or serious illnesses.</td>
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<tr>
<td>Allergies NO ___ Yes ____  (please list):</td>
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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 IMMUNIZATION 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 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.

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

1. Go to the OhioHealth eSource page at ohesource.ohiohealth.com. You will be prompted to sign in with your OPID and password, which will be sent to you by the Medical Staff Office (MSO).

2. Once in eSource, select OhioHealth University in the left-hand side menu.
3. You will be redirected to the OhioHealth University website. You may be asked to login again; please use your OPID and password.

4. Click on All Tasks as illustrated below.

5. 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.

6. 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.
7. Click Catalog in at the top menu and type CX4302 in the search box. (Do not type .D as this will not appropriately)

8. Click on the course name.

9. Click on the enroll button to have the course assigned to your LMS account.
APPLICANT CHECKLIST

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 (**Required**)
  - Your timeline for education and work history must contain both **month/year**

- Copy of Board Certification (**if applicable**)

- W-9 for verification of each tax identification number (TIN) used for the practice that the applicant will be working under

- **OPTIONAL:** Attach a **current** copy of the DEA certification (**if applicable**) and a **current** copy of a professional liability insurance policy face sheet showing expiration date, policy limits and the applicant’s name **ONLY IF** these documents are NOT attached to the CAQH application

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

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

**If applying to OhioHealth Group Clinically Integrated Network**

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

**REQUIRED DOCUMENTS IF APPLYING TO AN OHIOHEALTH HOSPITAL**

- Application Fee (refer to page 2 for details)
- Portrait Quality Professional Photograph (**PASSPORT photo is not acceptable**)  
- Completed Information for Conflict of Interest and Credentialing Contact Information
- Completed Information for OhioHealth Clinical Directory & Radiation Safety Questions
- Documentation of 5 Peer References
- Authorization Form to conduct a Criminal Background and/or Fingerprint Process
- Verification of Practitioner Identification Form
- Verification of Employment History
- 5 year Malpractice Claims History Verification— Listing of Insurance Companies
- 5 year Malpractice Claims History Verification – Release Form  
  - **Response must be made to the attention of OhioHealth Group Credentialing**
- OhioHealth **Voluntary** Self-Disclosure of Race and Ethnicity
- Current TB Skin Test & Health Assessment Form (**Both are required**)  
- Submission of Vaccination Records
- OhioHealth Internet User Agreement / Confidentiality Statement of Understanding
INFORMATIONAL ONLY

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.

PAIN, THE FIFTH VITAL SIGN – INFORMATIONAL ONLY

The Joint Commission’s current standards require that organizations establish policies regarding pain assessment and treatment, and conduct educational efforts to ensure compliance.

- The hospital educates all licensed independent practitioners on assessing and managing pain.
- The hospital respects the patient’s right to pain management.
- The hospital assesses and manages the patient’s pain.

Pain has often been referred to as 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.

   ![Pain Assessment Scales](image)

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 makes 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, search pain management in OhioHealth University on eSource.