*Please read this letter before completing the attached paperwork*

TO: New Applicant

RE: Initial Credentialing with one or more of the following: Riverside, Grant, Doctors, Dublin, Grady and Marion Hospitals

Thank you for your interest in applying for privileges with our OhioHealth Hospitals. I would like to bring to your attention some advice that I hope will help make your credentialing process go more smoothly.

- Consider this application process as a job application. Take time and effort in completing this process.
- We won’t accept faxed copies of this packet. We also request that you do not use staples or double-side the packet.
- If you already have active/courtesy privileges at any of the above hospitals and you’re interested in applying for privileges with an additional hospital listed above, you are still required to complete this application process in its entirety unless you have already completed this application and applied within the last 6 months.
  - Each hospital has a separate Medical Staff Office and by-laws that must be followed.
- I will need this application packet to be returned to me completed in its entirety, in addition to the completed CAQH Online Application,* before I can release your application for processing.
  - The hospital initial credentialing process can take 90 to 120 days to complete.
  - Don’t delay in returning this paperwork if the following are still in a pending status:
    - Ohio State License, DEA Certificate and/or current Malpractice Insurance for the group you will be joining.
    - Contact me for tips on completing your CAQH Online Application,* if these are pending.
    - While we are able to begin the credentialing process without these items, they will be required before your file will go through the decision making process at the hospital(s).
  - Once you begin the credentialing process, we may ask for your assistance in order to obtain required primary source verification(s) on your application.
- In this packet we request 5 references of practitioners that are of the same discipline as you and have observed you in the past 3 years.
  - The CAQH Online Application* requires 3 references. You may include these 3 along with 2 additional names on the Medical Staff Office Addendum as long as they meet the requirements for our references.
  - If you’re completing Residency training, one of your 5 references listed must be your Program Director.
  - If you’ve been out of training for more than 3 years, one of your 5 references listed must be the Department Chair at your current Primary Hospital. This is required regardless if you know him/her.
  - In order to expedite the process fax numbers are required of all 5 references.
  - To expedite the process, contact your references and let them know a request will be sent to them so they can complete the form and return it in a timely manner.
- You will be required to complete the fingerprinting process prior to obtaining hospital privileges.
  - Do not do this on your own, as practitioners are required to have an appointment scheduled through our office to have this done at an OhioHealth Hospital.
  - We strongly suggest that you are scheduled for the fingerprinting process through our office. However, if you aren’t able to come to one of our hospitals listed please contact me for instructions on completing this process through WebCheck at your own cost and with the understanding this may delay your privileging.
  - Our fingerprint process is separate from the process completed when obtaining your Ohio Professional License.
  - You won’t need to complete the fingerprinting process if you’re presently on staff with one of our above hospitals or are graduating from Residency at OhioHealth within 3 months of applying.
• The driver’s license notary form must be completed as requested. A separate form won’t be accepted.
• We require claims history from all Malpractice Carrier(s) you have had in the past 5 years, including your Residency Program. Please sign the form in this packet and forward accordingly.
  o This must be received in our office before hospital privileges / membership can be obtained.
  o If you’re in Residency, please sign this form and send to the Risk Management department of your Residency so they can complete and return to us during your credentialing process.
  o Regardless of where you have worked, all practitioners are required to have Malpractice coverage.
  o If you worked for the Federal Government, they don’t provide a claims history.
  o It’s your responsibility to make sure that all required claims histories are received in our office.
• Both sections on the Health Assessment must be completed even if you submit a separate form for your TB Test.
  o The TB Test must be within 12 Months from the time you receive hospital privileges. Depending when your last TB Test was done, you may need to get it done again before you’re approved at the hospital(s).
  o If you had a Chest X-Ray instead of a standard TB Test, you must include a copy of the results that were completed within the past 10 years.
  o At this stage in the process we don’t require a full health assessment from your physician. We just need you to answer the questions in Section 2.
  o If you are allergic to the TB Test process and are advised not to have this done yearly, you must complete a T-Spot and submit those results with your application.
• A color professional photograph of yourself is required, as mentioned in the packet check list.
  o The photograph must meet the requirements listed on the check list to be considered acceptable.
  o The photograph needs to be of a professional manner and friendly in appearance.
  o You may send the photo to me in one of the following formats:
    ▪ To my email address listed below
    ▪ On CD along with your original application packet
    ▪ As an original photo printed on photo paper
      We will not accept passport photos or photos that are of size and appearance of a passport.
• Once we receive and begin 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 in receiving hospital privileges / membership.

Depending on the group you will be joining, and whether they participate 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 you need to complete these agreements please let me know.

*In addition to the paperwork in this packet we also require a completed CAQH Online Application. I have attached a New Applicant Notification Form if you need to have an ID Number created. Please fax this form to me at 614-566-0401. If you already have a CAQH ID Number, please contact the CAQH Help Desk at 888-599-1771 to obtain a personal username and password so you may log into your application. The CAQH website can be found at https://upd.caqh.org/oas/. Once you obtain this information, please log on and make sure to update your application with all current information; such as the practice that you will be joining, all malpractice claims, work history, etc... Do not print the application and send to me as I will be able download directly from the website.

If you have any questions during the credentialing process, please don’t hesitate to let me know. I work Monday through Friday from 7:00am to 4:00pm EST with Lunch around 11:00am.

Thank You,
Bonnie J. Chapman, Administrative Assistant
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

Note: Due to the high volume of phone calls in this office voicemails are returned within 48 hours.
New Initial Applicant CAQH Notification Form

DATE: ________________       SPECIALIST: _______   PCP: ________

New Practitioner’s First Name:________________ M.I.:____  Last Name:________________  Degree: ______

CAQH Practitioner’s 8-Digit Identification Number (if applicable):____________________________________

If No CAQH ID is available do you need one created? YES ____  NO ___ (in process w/another insurance agency)
(The Practitioner must be credentialed by us for the ID to be created by us)

Practitioner’s Social Security #: __________________  Practitioner’s Date of Birth (mm/dd/yy): __________

Contact Name: ____________________________ Contact Phone Number: (____)___________ ext. _______

Contact Name’s Email Address: ______________________________________________________________
(Additional information related to below may need sent to you, such as an application packet or provider agreements)

Group Name:  ______________________________________________ TAX ID #: _____________________

Provider Address: _________________________________________________________________________

City: ____________________________________ State: ________________  Zip: ______________________

Please check what entity/entities you are interested in having the practitioner join:

*Need to apply for Hospital Privileges? YES ____ NO ____ If yes, please check one or more of the following:
*There is an application packet required for hospital privileges in addition to a completed CAQH.

Riverside Methodist Hospital: ______  Grant Medical Center: _______  Doctors Hospital: ______

Grady Memorial Hospital: _______ Dublin Methodist Hospital: _______  Marion General Hospital_____

*Need to join Insurance Plans? YES ____ NO ____ If yes, please check one or more of the following:
*There are provider agreements required depending on which insurance plan and/or group the practitioner will be joining.

Medical Group of Ohio (MGO): ____________  OhioHealth Group / HealthReach PPO: ____________

Please return this form along with the Practitioner’s CV / Resume via fax to:
Attention Bonnie Chapman --- Fax 614-566-0401 --- Phone 614-566-0010 Option 2

OHGCS provides high quality credentialing services on behalf of the following:
Doctors Hospital ● Dublin Methodist Hospital ● Grady Memorial Hospital ● Grant Medical Center
Marion General Hospital ● The Medical Group of Ohio ● OhioHealth Group (HealthReach & HealthReach Preferred)
OhioHealth Physician Group, Inc. (GRMCFI) ● Riverside Methodist Hospital
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. Simply enter your information into the database and authorize users to access it.

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.

Completion of this application DOES NOT guarantee acceptance by any of the entities. Each participating entity to which you are applying will be given a copy of your application. The entity will give OhioHealth Group Credentialing Services the approval to go forward with processing your application if you meet their membership and credentialing criteria. Upon the approval to process you will be sent additional hospital(s) specific paperwork for you to complete and return to each Medical Staff Office(s).

Upon completion of the credentialing / primary source verification process, the entity will then complete the decision making portion of the application process and notify you of the results.

If you decide you would like to apply with additional entities or have questions about the status of your application, please call OhioHealth Group Credentialing Services at (614) 566-0010.

Questions related to privileging should be directed to the individual hospital(s)

- **Riverside Methodist Hospital**: (614) 566-5751
- **Grant Medical Center**: (614) 566-8268
- **Doctors Hospital**: (614) 544-2236
- **Dublin Methodist Hospital**: (614) 544-8373
- **Grady Memorial Hospital**: (740) 615-1025
- **Marion General Hospital**: (740) 383-8665
- **The Medical Group of Ohio**: (614) 566-0113

For your convenience we have included in this packet a Frequently Asked Questions document concerning CAQH and the Universal Credentialing Datasource.

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If you are already a CAQH Provider, indicate your ID number below. Make sure to complete the CAQH online application in its entirety with current information and authorize OhioHealth Group Credentialing Services to retain your credentialing information, and complete the enclosed.

**My CAQH Provider ID Number is: __________________**

If you do not have an established CAQH Identifications number, please contact our office at 614-566-0010 opt 2. Our representative will establish a CAQH number for you to submit your credentialing information on line.
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.

Please note for the following: Family Practice, General Practice, Internal Medicine, Pediatrics, Allergy/Immunology, Dermatology, Physical Medicine, Preventative Medicine, Psychology, Psychiatry, Oral Maxillofacial, Ophthalmology and Urgent Care, are not required to have admitting privileges to a hospital. However, if the PCP/specialist(s) does have admitting privileges at a hospital they must be at a contracted OHG panel hospital from the enclosed list.

As stated in the OhioHealth Participating Provider Agreement, page 3, section II, number 4 “As applicable, practitioner shall designate one or more participating hospitals to admit beneficiaries under his or her care unless otherwise approved by OhioHealth Group or its designee. Practitioner shall admit beneficiaries only to participating hospitals (enclosed list) except in the case of an emergency medical condition or as otherwise described in applicable program requirement or as otherwise required by law.”

OhioHealth Hospital Medical Staffs

- **Riverside Methodist Hospital** (medical staff membership and clinical privileges).
- **Grant Medical Center** (medical staff membership and clinical privileges).
- **Doctors Hospital** (medical staff membership and clinical privileges).
- **Dublin Methodist Hospital** (medical staff membership and clinical privileges).
- **Grady Memorial Hospital** (medical staff membership and clinical privileges).
- **Marion General Hospital** (medical staff membership and clinical privileges).

Separate membership/privilege criteria apply to all the above

- Check box for processing fee for one hospital is enclosed. – $390
- Check box for processing fee for two hospitals is enclosed – $505
- Check box for processing fee for three hospitals is enclosed – $620
- Check box for processing fee for four hospitals is enclosed. – $735
- Check for processing fee for five hospitals enclosed – $850
- Check for processing fee for all six hospitals enclosed – $965

*Application fee MUST be received in order for application to be processed for any of the above hospitals. Please note the application fee is a one time fee and is non-refundable once the primary source verification is completed on your application.

Make checks payable to: OhioHealth Group Credentialing Services

The Medical Group of Ohio

- (By signing the enclosed MGO Provider agreements a physician is expressing interest in participating in services offered by this physician organization, including contracting, group purchasing, practice management, quality management, etc.)
Frequently Asked Questions

I don’t know if I have a CAQH ID, how do I find out?

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 the Help Desk will not create one for you. You will be asked to contact an Insurance Company to create an ID Number. In this instance call the OhioHealth Group Credentialing Services office at 614-566-0010 to obtain an ID Number. We will need your birthday, social security number, and your primary practice address and phone number.

I have a CAQH ID Number but 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.

I don’t have the Malpractice Facesheet for the Practice I’m joining and this needs faxed into CAQH. What do I do?

Please contact the OhioHealth Group Credentialing Services office at 614-566-0010 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 the 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 this application and 3 references listed on 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. It would also be helpful to include fax numbers or email addresses of the references otherwise there will be a delay if we need to mail the request. Please also contact your references and let them know they will be getting a request and to respond as soon as possible. Failure to do these things will cause a delay with your application process.

I have settled claims, does this need to be listed 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 on all of your malpractice claims on the CAQH application.

Who is my Credentialing Contact on CAQH?

This is the office manager 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 4 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. Once you attest the application you will be asked to fax supporting documents into CAQH. Follow all the steps provided by CAQH.
   a. Print the Attestation & Release Form. Sign and Date the form.
   b. Print your Fax Cover Sheet
   c. Gather up your supporting documents, including the Attestation & Release form and your DEA and Malpractice Facesheet.
   d. Complete the Fax Cover Sheet following the guidelines listed.
   e. Fax your supporting documents into CAQH.

It will take at least 24 to 48 hours for CAQH to show receipt of your documents. When logged into your CAQH application you can click on the Activity Log to find out if all documents were received by CAQH.

I’m being told my CAQH Application is not complete, but I’ve done everything. What’s wrong?

It could be that you did not attest your application. If you don’t attest the application it will not show complete. It could also be that one or more of your supporting documents were rejected by CAQH. Looking at your Activity Log will show if all documents were accepted.

Why is my fax I sent for supporting documents being rejected by CAQH?

It’s possible the Attestation & Release form wasn’t dated, or a supporting document wasn’t readable. If a document was rejected 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. When you log into your CAQH you will see a bubble to re-attest the application. Click on this bubble and follow the steps that are prompted.

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.

The Checklist in this packet says I need to include a Professional Photograph. Is this really needed?

Yes, if you are initially applying to any of the 6 OhioHealth hospitals and do not have a professional photo on file with OhioHealth Media Services you are required to submit a professional photograph of yourself from the shoulders up. Please contact the OhioHealth Group Credentialing Services at 614-566-0010 for the options available but this must be included with your packet. Failure to do this will delay your credentialing process.

This application packet includes a Claims History release form that needs sent to my carriers. Do I need to send this?

Yes. Verification of your malpractice claims history from the carrier is a requirement of the credentialing process when you are initially applying to any of the 6 OhioHealth hospitals. Please send this release form to all of your carriers you have had in the past 5 years including your Residency and Fellowship programs. Failure to do this will delay your credentialing process.

Areas of Interest – Section 3 of the CAQH application: 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...).
• 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.
There are a number of required documents that must accompany your application when you submit it to OHGCS.

Failure to submit the required documentation will deem the application “incomplete” and your application will **NOT** be processed until all required documents are received.

**Checklist of “Required” documents for all Entities:**

- Copy of Curricula Vita / Resume
- Copy of DEA Registration (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
- 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)
- Copy of all out of state license(s)
- Copy of ECFMG Certificate if applicable
- Copy of Board Certification if applicable
- W-9 for verification of each tax identification number used

**OhioHealth Group Managed Care Products (OHG)**

- Signed Provider Agreements

**The Medical Group of Ohio (MGO)**

- Provider Agreements:  *(By signing the MGO Provider Agreements enclosed a physician 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.

- **Application fee**
  - Check for processing fee for one hospital enclosed – $390
  - Check for processing fee for two hospitals enclosed – $505
  - Check for processing fee for three hospitals enclosed – $620
  - Check for processing fee for four hospitals enclosed – $735
  - Check for processing fee for five hospitals enclosed – $850
  - Check for processing fee for all six hospitals enclosed – $965

- **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**

- **Health Assessment** (the Medical Staff Office(s) will accept a Health Assessment that was performed by another organization within the last 12 months)

- **ORB Registration / Connectivity Agreement / OhioHealth Internet User Agreement / Confidentiality Statement of Understanding**

- **Recent Portrait Quality Photograph of yourself** that meets the following requirements: **
  - Plain or studio backdrop
  - Attire should be suit, sport coat or lab coat
  - Body should be at a slight angle with head turned to lens
  - Lighting should be from studio light or natural
  - Save at a resolution of 300 pixels as a .jpg
  - If scanning, save at 150 dpi or higher

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

** Required documents that must be returned along with this packet.
Applicant Name (Print): ____________________________________________________________

Marital Status (Optional): ___Single ___Married

If married, spouse’s name: __________________________________________________________

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: __________________________________________________________

Preferred mailing address: _________________________________________________________
(This will be used for all business correspondence sent by OhioHealth entities)

1) - For RMH, GMC, 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 o No o

If yes please explain:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

2) - For RMH, GMC, 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 o No o

If yes please explain:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Q:\Credentialing\Packet Contents\2013 Packet Contents\2013 inc Marion General\5 MSO Addendum 3-21-2013.doc  Revised 7/13/09
Please provide all of the information below for 5 references. These references should include the Department Chair from Primary Hospital or Program Director (if training completed in the past 12 months) and 4 other peers that have observed your clinical practice within the past 3 years.

### Reference 1 – Department Chair from Primary Hospital or Program Director (if training completed in the past 12 months)

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### Reference 2 - Peer

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### Reference 3 - Peer

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### Reference 4 - Peer

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### Reference 5 - Peer

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<td>Relationship/Title:</td>
<td>Hospital/Practice:</td>
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TO: New Applicants applying to the following:
- Riverside Methodist Hospital
- Grant Medical Center
- Doctors Hospital
- Dublin Methodist Hospital
- Grady Memorial Hospital
- Marion General Hospital

To improve the safety and screening process not only for our new associates but also for new physicians the following is set forth.

All new applicants applying for membership at an OhioHealth hospital listed above 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. Failure to sign a consent form will terminate the application process.

Physicians who are currently in an internship/residency training program at Riverside, Grant or Doctors and are applying for membership on an OhioHealth Medical Staff immediately following their training program will not be required to submit fingerprints provided that fingerprints were obtained at some point during their training program.

Physicians who have completed a training program at Riverside, Grant or Doctors and have relocated or did not apply for membership to an OhioHealth Medical Staff within 3 months of completing the training will be considered new applicants for the purposes of the fingerprinting policy.

OhioHealth currently participates with National WebCheck as the vendor to electronically submit fingerprints to the BCII. This submission allows for a criminal records check to be completed by both BCII and the FBI. OhioHealth will accept an original background check that is performed by another National WebCheck vendor. If you utilize the services of another National Webcheck vendor other than OhioHealth you will be required to pay the vendor’s fee at the time the service is performed. Reports that are completed by another National WebCheck vendor other than OhioHealth are required to have both the BCII and FBI record check completed. Results of the reports are to be submitted to:

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

OhioHealth currently provides the following designated sites to have your fingerprinting performed.

A valid driver’s license is required for this process

| Riverside Methodist Hospital Protective Services / ID Badge Ctr. | Dublin Methodist Hospital Human Resources Department |
| Grant Medical Center Human Resources Department | Grady Memorial Hospital Human Resources Department |
| Doctors Hospital Human Resources Department | Marion General Hospital Human Resources Department |

OhioHealth Group Credentialing Services will contact you to schedule an appointment at any of the above 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.
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.

____________________________________  ___________________
Signature                       Date

CONSENT TO OBTAINING REPORTS

Read carefully before signing

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.

Print Name___________________________________________ 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 DWI 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 or your applicants are located in MN, OK, or CA you should always include the following in your authorization and disclosure:
“☐ If you would like to receive a free copy of your report, please check this box.”
TO: Applicants applying to the following:

- Riverside Methodist Hospital
- Grant Medical Center
- Doctors Hospital
- Dublin Methodist Hospital
- Grady Memorial Hospital
- Marion General Hospital

SUBJECT: Notarized copy of driver’s license or passport

If you are applying for membership on the medical staff of any OhioHealth hospital listed above you are required to submit a notarized copy of your driver’s license or passport that is clear and legible.

COPY APPLICANT’S DRIVER’S LICENSE OR PASSPORT HERE
(The copy must be clear and legible)

I certify the attached photo identification 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:
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
TO: Applicants of the following:
- Riverside Methodist Hospital
- Grant Medical Center
- Doctors Hospital
- Dublin Methodist Hospital
- Grady Memorial Hospital
- Marion General Hospital

FROM: Credentialing Services Department

SUBJECT: Malpractice Claims History

Please send a copy of the attached form to each malpractice carrier (or insurance agent) that you have had during the past 5 years including the carrier or self-indemnification fund that covered you during your residency training if applicable.

**DO NOT COMPLETE THE FORM YOURSELF. THE FORM NEEDS TO BE COMPLETED BY YOUR AGENT/CARRIER.**

Sign the top part of the form before forwarding it to the agent/carrier. After completing the form your agent/carrier should fax it directly to our attention at 614-566-0401. It would be wise to impress upon them that failure to provide this information will result in delays in processing your application for membership and privileges at one or all of the Hospitals listed above.
Verification of Malpractice Claims History is a requirement for hospital privileges/membership. We may be contacting you if we haven’t received a response from the malpractice carrier(s) you list below.

Provide below a comprehensive listing of your malpractice carrier(s) that you have had during the past 5 years – this includes if you graduated from your residency or fellowship during this time. NOTE: This also includes all malpractice carriers that covered you for any Locum work during the past 5 years.

Do not put “see attached” and include facesheets. This form must be completed. Sign the attached release form and forward to each malpractice carrier(s) you list below.

*PLEASE PRINT CLEARLY* *(If you worked for the Government, note it here but we understand they may not respond.)*

<table>
<thead>
<tr>
<th><strong>Malpractice Carrier 1</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier Name:</td>
<td>Policy Number:</td>
</tr>
<tr>
<td>Contact Name <em>(if known)</em>:</td>
<td>Effective Dates:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax:</td>
</tr>
<tr>
<td></td>
<td>Retroactive Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Malpractice Carrier 2</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier Name:</td>
<td>Policy Number:</td>
</tr>
<tr>
<td>Contact Name <em>(if known)</em>:</td>
<td>Effective Dates:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax:</td>
</tr>
<tr>
<td></td>
<td>Retroactive Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Malpractice Carrier 3</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier Name:</td>
<td>Policy Number:</td>
</tr>
<tr>
<td>Contact Name <em>(if known)</em>:</td>
<td>Effective Dates:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax:</td>
</tr>
<tr>
<td></td>
<td>Retroactive Date:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Malpractice Carrier 4</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier Name:</td>
<td>Policy Number:</td>
</tr>
<tr>
<td>Contact Name <em>(if known)</em>:</td>
<td>Effective Dates:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax:</td>
</tr>
<tr>
<td></td>
<td>Retroactive Date:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Malpractice Carrier 5</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier Name:</td>
<td>Policy Number:</td>
</tr>
<tr>
<td>Contact Name <em>(if known)</em>:</td>
<td>Effective Dates:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Fax:</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.
MALPRACTICE CLAIMS HISTORY VERIFICATION

1. **Please sign ONLY the top portion of this form.** This will authorize the insurance company to release your malpractice claims history to OhioHealth Group.

2. **Forward the signed release form to your insurance carrier** for them to complete.

   I have applied for membership for one or more of the following: Grant Medical Center, Doctors Hospital, Dublin Methodist Hospital, Riverside Methodist Hospital in Columbus, Ohio, and/or Grady Memorial Hospital in Delaware, Ohio and/or Marion General Hospital in Marion, Ohio. Please provide my claims history information for the past five (5) years to the OhioHealth Group Credentialing Services Department by completing this form and faxing it to **614-566-0401**

   *By signing this form I authorize release of this information.*

<table>
<thead>
<tr>
<th>Printed Name of Practitioner</th>
<th>Type of Degree (eg: MD, DO, DPM, DDS, PA, CNP, CNM, CNS, CRNA)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Practitioner Signature</th>
<th>Date</th>
<th>Last 4 digits of SSN</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Carrier:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Policy Number:</th>
</tr>
</thead>
</table>

   *****The following information needs to be completed by your insurance company****

   Type: occurrence claims-made other

<table>
<thead>
<tr>
<th>Policy Amount:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Effective Dates:</th>
<th>Retroactive Dates:</th>
</tr>
</thead>
</table>

   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.*

<table>
<thead>
<tr>
<th>Printed name of insurance representative</th>
<th>Title</th>
<th>Phone</th>
</tr>
</thead>
</table>

   Signature of insurance representative Date
HEALTH EVALUATION FOR COMMUNICABLE DISEASE

Please note: Both sections of this form must be completed

Section One: TB 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 placed.

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>1st step</td>
<td>RFA/LFA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd step (if required)</td>
<td>RFA/LFA</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Section Two: Health History
Please answer the questions in this section

History of POSITIVE TB test? No ____ Yes ____

If you answer No, go to question #1.

If you answer Yes, answer the following:

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

(a) BCG vaccine? No ___ or Yes ___
(b) Treated by physician? No ___ or Yes ___
(c) INH Therapy? No ___ or Yes ___
(d) Traveled outside the USA? No ___ or Yes ___

If so when? ______________________________________

During the last year, have you experienced any of the following conditions over a prolonged period of time? (more than 2 weeks duration)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</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>
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<tr>
<td>3. Frequent upper respiratory symptoms such as colds, sore throat, productive cough, or pneumonia.</td>
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<td></td>
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<tr>
<td>4. Persistent fever or excessive sweating, especially at night.</td>
<td></td>
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<td></td>
<td></td>
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<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</td>
<td>No ___</td>
<td>Yes ___</td>
<td>(please list):</td>
<td></td>
</tr>
</tbody>
</table>

Signature: ____________________________ Date: ______________

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

Print: (First Name, MI, Last Name)  Signature / Date

5065580v2
EXECUTIVE SUMMARY - OhioHealth

STANDARD POLICY & PROCEDURE - SECURITY & CONFIDENTIALITY POLICY

It is the policy of OhioHealth to maintain procedures that address granting access to electronic information assets, coordinating statements of confidentiality used throughout the institution, and developing security access and audit control procedures and standards. This policy and the associated procedures are designed with the primary intent: to protect the security and confidentiality of OhioHealth’s patients personal health information. Based on the need-to-know premise both caregivers and non-caregivers at OhioHealth have access to a variety of patient and/or hospital data. For the caregiver, access to patient data is essential for delivering care to the patient. For the non-caregiver, access is specified based on the roles and responsibilities described in the job description.

PHYSICIAN’S RESPONSIBILITIES

- Coordinate access requests with OhioHealth Information Services division and Medical Staff Offices.
- Access to OhioHealth information systems is granted only upon request to medical staff members and their nursing and office staff.
- Submit a Confidentiality Statement of Understanding signed by the physician in order to obtain access.
- Contact the hospital to terminate access for themselves or staff who have left office employment.
- Assure that any resident or allied health practitioner with ability to access and change the data on the physician's behalf signs a confidentiality agreement and adheres to its terms.
- Utilize OhioHealth systems (e.g., email or Internet access) for business purposes only.
- Submit to and participate in periodic random audits as conducted by OhioHealth.

OHIOHEALTH’S GUIDING PRINCIPLES FOR MANAGEMENT OF INFORMATION

GOVERNANCE OVER DATA

- Patient information belongs to the patient, not the hospital.
- The hospital designates what non-patient information is proprietary and confidential.
- The hospital owns the storage devices (electronic or paper) which store hospital and patient information and serves a custodial role in protecting the security and confidentiality of the information stored within its systems.
- Data and information are managed as a hospital-wide resource for use in achieving hospital goals and objectives.

CONTROLLING ACCESS TO DATA

- Every medical staff member is responsible for protecting the confidentiality of information and reporting situations that pose a potential breach of confidentiality or security.
- The patient has the right to authorize or refuse the release of his/her patient identifiable information except in circumstances specified in state or federal law.
- Patients have access to their medical information in accordance with state and federal laws.
- Access to data is granted based on an appropriate need-to-know basis.
- Access to data is controlled through hardware and software security features and management authorization policies and procedures designed with the primary intent to protect the security and confidentiality of information.
- Access to aggregate data does not provide access to the individual data from which the aggregate data was derived.

REDISCLOSURE

- As a general rule, releasing patient data to any party other than the patient will require that no redisclosure of the data be permitted and that the data be handled in a manner such that its security and confidentiality is upheld.
- Redisclosure of data must be specifically requested and approved on a case by case basis.
- Data is to be used only for the purpose for which it was requested.
- The release of proprietary data will require that no redisclosure of such data occurs without consent of the hospital.

COMPLIANCE WITH FEDERAL AND STATE STATUTES

- Data specifically addressed through federal or state statutes of regulations will be identified by the hospital and proper security and confidentiality procedures implemented.

DESIGNATION OF CONFIDENTIAL DATA

- The hospital exercises its right to designate data and records as confidential if the data is not already governed under state or federal law.

EDUCATION

- Educational programs are integral to the management of data and information within the hospital. Medical staff will be informed and educated on their roles and responsibilities in protecting the confidentiality and security of information.
What is ORB (OhioHealth Results Browser)?
ORB is a user-friendly, web-based program offered by OhioHealth, designed to give you and members of your staff access to valuable patient information as well as important business resources via a secure Internet connection.

Why do I need ORB access in my office?
- Access patient information as soon as it's available – No more waiting!
- Physicians can receive message alerts when new patient information is available
- Fax/Print results directly from ORB
- Ensure the continuous delivery of high-quality care
- Save valuable time and money

What is available in ORB?
ORB combines data from all inpatient and outpatient encounters from Riverside Methodist Hospital, Grant Medical Center, Doctors Hospital, Grady Memorial Hospital, Dublin Methodist Hospital and OhioHealth Neighborhood Care sites. ORB also offers reference information and OhioHealth contact information important to your office. You can view:
- Census/Rounding Lists
- Laboratory Results
- Cardiology
- Active Orders
- Clinical Reference Tools
- ePrescribing
- Demographic/Face Sheets
- Radiology (Reports/Images)
- Transcriptions
- Inpatient Medications
- OhioHealth Information

How do I access ORB?
You can access ORB from home, your office, or anywhere there is an Internet connection. You need:
- Internet Service Provider (ISP) (we highly recommend a high-speed ISP)
- Internet Explorer 7.0 or greater
- Adobe Acrobat 7.0 or greater

How do I get access to ORB?
Physicians with privileges at an OhioHealth facility can get access for themselves and their staff by completing an application. Physicians who do not have privileges at an OhioHealth facility can gain access to ORB with limited search capabilities (i.e. Medical Record Number or Social Security Number). To obtain an application or request training:
- Visit https://orb.ohiohealth.com select Request an ORB ID on the Home Page under Need Assistance.
- Call 566-eDoc (3362) to request an application and/or training.
ORB also offers great business tools for you and your practice

Clinical References:
- Electronic PDR
- MDConsult
- MedlinePlus
- OVID
- PubMed
- Up To Date
- Variety of Micromedex products including Drug-Reax, Poisondex, Conversion Calculators

Important Physician Information
- Find A Doctor – search by name or specialty
- Medical Staff and CME information for Doctors Hospital, Grady Memorial Hospital, Grant Medical Center, Riverside Methodist Hospital and Dublin Methodist Hospital
- OhioHealth Unapproved Abbreviations

OhioHealth Information
- Maps and Directions to Central Ohio OhioHealth facilities (Doctors Hospital, Grady Memorial Hospital, Grant Medical Center, Riverside Methodist Hospital, Dublin Methodist Hospital and OhioHealth Neighborhood Care)
- OhioHealth Programs and Services including contact phone and fax numbers
- Insurance plans accepted by OhioHealth
- Printable hospital forms

Patient Education
- CareNotes™ – Disease and Medication Specific printable patient education available in English and Spanish
- Printable OhioHealth teaching sheets on a variety of topics for your patients
PAIN, THE FIFTH VITAL SIGN

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 affect 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.

![0-10 Numeric Pain Distress Scale](image)

![Visual Analog Scale (VAS)](image)

![Modified Faces Pain Rating Scale](image)

![Simple Descriptive Pain Intensity Scale](image)

4. **What does it feel like?** Does it burn? Tingle? Ache? Is it dull or sharp?

5. **Is it worse at anytime 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.
Ohio Physicians Health Program
130 E. Chestnut Street, Suite 400, Columbus, Ohio 43215
(614) 841-9690 - www.ophp.org – info@ophp.org

A Confidential Resource for Physicians and Other Healthcare Professionals in Ohio.

OPHP OVERVIEW

The Ohio Physicians Health Program (OPHP) is a 501(c)3 not-for-profit organization that assists physicians and other healthcare professionals who may be affected by substance use disorders or other issues impacting their health and well-being. OPHP provides evaluation and treatment referral, recovery documentation, education, support, and advocacy.

OPHP services can benefit Ohio’s hospitals, associations, and healthcare professionals by:

• Providing confidential assistance to those seeking help for issues impacting their lives, including: drug and alcohol addiction, disruptive behavior, sexual boundary issues, physical or psychiatric illnesses, mental or behavioral disorders, burnout, stress, and others.
• Assisting with interventions and presenting assessment and treatment referral options.
• Providing monitoring and recovery documentation including toxicology testing, support, and advocacy for healthcare professionals
• Ensuring the adherence of the rules and guidelines set forth by the State Medical Board of Ohio.
• Presenting educational lectures all across Ohio on substance use disorders, physician health, Ohio’s “One-Bite” Rule, and services available through OPHP.

CLIENT COMMENTS

“I want to thank you and let you know that the advice and counseling you gave me has changed my life. I followed through with all of your suggestions and referrals. I have my license back and have decided to continue to practice medicine. I’m a new person. Thank you again!”

• • • • •

“Several years ago I became addicted to opiates that had been prescribed for an orthopedic condition. After completing treatment I signed a contract with the Ohio Physicians Health Program. OPHP has been very helpful and supportive in its advocacy role and I have always felt comfortable calling for advice on a variety of issues. I am deeply indebted to OPHP and…. in that it has been invaluable.”

• • • • •

“At a difficult time in my life, the Ohio Physicians Health Program was there for me, both as an active partner in my recovery and an advocate for my professional practice of medicine. The staff has spent time with me personally, even visiting me at my office. Their knowledge and experience with the disease of chemical dependency and their belief in recovery has been invaluable to me and the medical community in Ohio.”

CONFIDENTIALITY

OPHP is not a licensing or disciplinary authority. It accepts referrals from many sources including individuals themselves, professional colleagues, hospitals, medical staffs, office staffs, regulatory agencies, attorneys, treatment centers, family, and friends. OPHP protects the confidentiality and anonymity of program participants and referral sources to the fullest extent allowed by law.

Visit www.ophp.org to make a donation.
Risk Factors

An addictive Risk Factor is anything that might increase the likelihood of becoming involved with an addictive substance or behavior. People of any age, sex or economic status can become addicted to drugs or alcohol. Risk factors do not predict outcomes and alternatively, lack of risk factors does not prevent disease. The environmental and personal risk factors listed below can affect the likelihood of developing an addiction.

ENVIRONMENTAL RISK FACTORS

Cultural Factors: The glamorous way that drinking is sometimes portrayed in the media may send the message that it’s okay to drink excessively. In American culture, alcohol is often used as a social lubricant and a means of reducing tension.

Social Factors: One of the biggest contributing factors to drug and alcohol abuse risk is having friends who engage in the problem behavior. Having a spouse who drinks or abuses drugs also increases your risk.

Family: Conflicts at home and family management problems are contributing factors to drug and alcohol abuse. Risk also increases with lack of family involvement and support.

Trauma: Transitions and life-changing events can increase the risk of drug and alcohol abuse. These events include divorce, litigation, changing jobs, moving, illness, or death of a loved one.

PERSONAL RISK FACTORS

Gender: Men are more likely to become dependent on alcohol than women and are twice as likely to have problems with drugs.

Family History: If you have a blood relative such as a parent or sibling with alcohol or drug problems, you’re at greater risk for developing alcoholism or drug addiction.

Steady Drinking: Drinking too much on a regular basis for an extended period can produce a physical dependence on alcohol. Trying a highly addictive drug such as heroin and cocaine can cause addiction faster.

Age: People who begin drinking or abusing drugs at an early age are at a higher risk of alcohol dependence or drug abuse.

Psychiatric Disorders: Higher rates of alcohol and drug abuse are present among people with anxiety disorders, depression, attention deficit hyperactivity disorders, and post-traumatic stress disorders.

Emotions: Using drugs or “self-medicating” can become a way of coping with feelings of loneliness, sadness, anger or boredom.

Chronic Pain: A medical condition, such as pain that requires narcotics, can result into addiction.

OPHP OVERVIEW

It is possible to develop an alcohol or drug abuse disorder without the presence of the provided risk factors. However, the more risk factors present, the greater the likelihood of the development of alcohol or drug addiction. If you have concerns regarding your risk factors or those of a friend or colleague, please contact:

Ohio Physicians Health Program
(614) 841-9690
info@ophp.org

The Ohio Physicians Health Program (OPHP) is a confidential resource for those who have concerns about a physician or other healthcare professional’s health and well being such as:

- Substance Use Disorders
- Behavior Health
- Mental Health
- Stress/Burnout

OPHP provides assistance through evaluation and treatment referral, recovery documentation, education, support, and advocacy for healthcare professionals. As a consultation resource, OPHP aims to provide information to physicians and healthcare professionals in Ohio regarding the guidelines set forth by the State Medical Board of Ohio’s “One-Bite Rule”.
Form W-9

Request for Taxpayer Identification Number and Certification

**Give form to the requester. Do not send to the IRS.**

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 2.

**Note:** If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.

#### Social security number

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or

**Employer identification number**

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### Part II For U.S. Payees Exempt From Backup Withholding

(See the instructions on page 2.)

### Part III Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am not subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

#### Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

**Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:**

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

**If you are a foreign person, use the appropriate Form W-8. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Corporations.**

**Note:** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester’s form if it is substantially similar to this Form W-9.

**What is backup withholding?** Persons making certain payments to you must withhold and pay to the IRS 31% of such payments under certain conditions. This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. Payments you receive will be subject to backup withholding if:

- You do not furnish your TIN to the requester, or
- You do not certify your TIN when required (see the Part III instructions on page 2 for details), or
- The IRS tells the requester that you furnished an incorrect TIN, or
- The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
- You use TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the Part II instructions and the separate Instructions for the Requester of Form W-9.

**Penalties**

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.
Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the “Name” line. You may enter your business, trade, or other business (as “DBA”) name on the “Business name” line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner’s name on the “Name” line. Enter the LLC’s name on the “Business name” line.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Other entities. Enter your business name as shown on required Federal tax documents on the “Name” line. This name should match the name shown on your social security card or other legal document creating the entity. You may enter any business, trade, or DBA name on the “Business name” line.

Part I—Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box.

If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see How to get a TIN below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are an LLC that is disregarded as an entity separate from its owner (see Limited liability company (LLC) above), and are owned by an individual, enter your SSN (or “pre-LLC” EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner’s EIN.

Note: See the chart on this page for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office. Get Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS’s Internet Web Site at www.irs.gov.

If you do not have a TIN, write “Applied For” in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradeable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Writing “Applied For” means that you have already applied for a TIN or that you intend to apply for one soon.

Part II—For U.S. Payees Exempt From Backup Withholding

Individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the separate Instructions for the Requester of Form W-9.

If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write “Exempt” in Part II, and sign and date the form.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

Part III—Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required).

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. “Other payments” include payments made in the course of the requester’s trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified state tuition program payments, IRA or MSA contributions or rollovers, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for criminal and civil litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 31% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:

Give name and SSN of:

1. Individual
2. Tax-exempt organization
3. Custodian account of a minor (Uniform Gift to Minors Act)
4. a. The usual revocable savings trust (grantor is also trustee)
b. So-called trust account that is not a legal or valid trust under state law
5. Sole proprietorship

Give name and EIN of:

1. Sole proprietorship
2. A broker or registered nominee
3. Partnership
4. The corporation
5. The partnership
6. The public entity

1 List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person’s number must be furnished.

2 Circle the minor’s name and furnish the minor’s SSN.

3 You must show your individual name, but you may also enter your business or “DBA” name. You may use either your SSN or EIN (if you have one).

4 List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.