



## AKRON REGIONAL HOSPITAL ASSOCIATION

### ALLIED HEALTH STAFF CREDENTIALING APPLICATION

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This application may be used at the hospitals listed below. The Medical Staff office phone numbers of the participating hospitals are as follows:

| <u>Phone</u>        | <u>Hospital</u>                   | <u>Email</u>                                                                                                                                                                                                           |
|---------------------|-----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 330-837-7499        | Affinity Medical Center           | <a href="mailto:leah.hoskins@affinitymedicalcenter.com">leah.hoskins@affinitymedicalcenter.com</a>                                                                                                                     |
| 330-543-8113        | Akron Children's Hospital         | <a href="mailto:ssimms@chmca.org">ssimms@chmca.org</a>                                                                                                                                                                 |
| 330-363-6255        | Aultman Hospital                  | <a href="mailto:jbortz@aultman.com">jbortz@aultman.com</a>                                                                                                                                                             |
| 330-784-1271 x 5203 | Edwin Shaw Rehab                  | <a href="mailto:dbunn@agmc.org">dbunn@agmc.org</a> or <a href="mailto:ngroves@agmc.org">ngroves@agmc.org</a>                                                                                                           |
| 330-948-5501        | Lodi Community Hospital           | <a href="mailto:kflegel@lodihospital.com">kflegel@lodihospital.com</a>                                                                                                                                                 |
| 330-721-5182        | Medina Hospital                   | <a href="mailto:mfunk@ccf.org">mfunk@ccf.org</a>                                                                                                                                                                       |
| 330-861-2086        | Regency Hospital of Akron/Ravenna | <a href="mailto:ksanders@regencyhospital.com">ksanders@regencyhospital.com</a>                                                                                                                                         |
| 330-297-2460        | Robinson Memorial Hospital        | <a href="mailto:mmcelfresh@rmh2.org">mmcelfresh@rmh2.org</a>                                                                                                                                                           |
| 330-761-7574        | Select Specialty Hospital - Akron | <a href="mailto:csvoboda@selectmedicalcorp.com">csvoboda@selectmedicalcorp.com</a>                                                                                                                                     |
| 330-489-8175        | Select Specialty Hospital-Canton  |                                                                                                                                                                                                                        |
| 330-375-7100        | Summa Health System               | <a href="mailto:draganp@summahealth.org">draganp@summahealth.org</a><br><a href="mailto:conlinm@summahealth.org">conlinm@summahealth.org</a><br><a href="mailto:brookshl@summahealth.org">brookshl@summahealth.org</a> |
| 330-615-3109        | Summa Barberton Hospital          | <a href="mailto:dsukie@barbhosp.com">dsukie@barbhosp.com</a>                                                                                                                                                           |
| 330-335-6940        | Summa Wadsworth Rittman Hospital  | <a href="mailto:StephS@wrhhs.org">StephS@wrhhs.org</a>                                                                                                                                                                 |

**IF YOU ARE APPLYING TO MORE THAN ONE OF THE HOSPITALS LISTED ABOVE,  
PLEASE CONTACT EACH HOSPITAL TO OBTAIN THE APPROPRIATE HOSPITAL  
SPECIFIC FORMS PRIOR TO SUBMITTING YOUR APPLICATION.**

**Akron Regional Hospital Association  
Allied Health Credentialing Application**

**ALL BLANK SPACES MUST BE FILLED IN  
INCOMPLETE INFORMATION WILL RESULT IN THIS APPLICATION BEING RETURNED**

APPLICATION FOR ALLIED HEALTH STAFF

**ALL INFORMATION MUST BE PRINTED OR TYPED: DO NO USE WHITE OUT OR CORRECTION FLUID**

**General Information**

|                                                                                                                                                     |                                 |                           |                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------|------------------------|
| Last Name                                                                                                                                           | First Name                      | Middle Name               | Title                  |
| Indicate any other name(s) you have practiced under (First Name, Last Name):                                                                        |                                 |                           |                        |
| <input type="checkbox"/> Male                                                                                                                       | <input type="checkbox"/> Female | Maiden Name               | Social Security Number |
| Practicing with whom and nature of affiliation (collaborating or supervising physician):                                                            |                                 |                           |                        |
| Business Mailing Address                                                                                                                            | City                            | State                     | Zip Code               |
| Phone Number ( )                                                                                                                                    | Fax Number ( )                  |                           |                        |
| Additional Business Mailing Address                                                                                                                 | City                            | State                     | Zip Code               |
| Phone Number ( )                                                                                                                                    | Fax Number ( )                  |                           |                        |
| Residence Mailing Address                                                                                                                           | City                            | State                     | Zip Code               |
| Phone Number ( )                                                                                                                                    | Fax Number ( )                  |                           |                        |
| Date of Birth                                                                                                                                       | City/State of Birth             | Citizenship               | Visa Status            |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed |                                 |                           |                        |
| Name of Significant Other:                                                                                                                          |                                 |                           |                        |
| Beeper/Pager Number                                                                                                                                 | Business Email Address          | Answering Service Number  | NPI Number             |
| Emergency Contact Name/Relationship                                                                                                                 |                                 | Emergency Contact Phone # | Medicaid Number        |

**In the following sections you must provide a complete chronology of your training and practice history.**

⇒ ⇒      **Any dates not accounted for on the application must be explained on an attached CV.**      ⇐ ⇐

**Undergraduate Education**

|                               |              |
|-------------------------------|--------------|
| Name of College or University |              |
| Complete Address              | Fax Number   |
|                               | Phone Number |
| Date of Graduation:           | Degree:      |

Each page **MUST** be dated & initialed  
**EACH TIME** you submit this form to a hospital

\_\_\_\_\_ Date \_\_\_\_\_ Initials

**ARHA APPLICATION FOR ALLIED HEALTH STAFF**

**Professional Education**

|                               |              |
|-------------------------------|--------------|
| Name of College or University |              |
| Complete Address              | Fax Number   |
|                               | Phone Number |
| Date of Graduation:           | Degree:      |

|                               |              |
|-------------------------------|--------------|
| Name of College or University |              |
| Complete Address              | Fax Number   |
|                               | Phone Number |
| Date of Graduation:           | Degree:      |

**Post Graduate Education**

|                                     |                                                                                                |
|-------------------------------------|------------------------------------------------------------------------------------------------|
| Name of Hospital/Health Care Entity | From / / To / /<br>Program Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Complete Address                    | City State Zip Code                                                                            |
| Phone Number ( )                    | Fax Number ( )                                                                                 |
| Type                                | Current Program Director                                                                       |

|                                     |                                                                                                |
|-------------------------------------|------------------------------------------------------------------------------------------------|
| Name of Hospital/Health Care Entity | From / / To / /<br>Program Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Complete Address                    | City State Zip Code                                                                            |
| Phone Number ( )                    | Fax Number ( )                                                                                 |
| Type                                | Current Program Director                                                                       |

**Professional PEER References (three [3] are required):**

- Licensed practitioners in your specialty (other than your training directors) or referring practitioners who have observed your practice
- Only one reference can be a current partner or associate. Do not include relatives.      ← ← ← ←
- The references listed should be professionals with whom you have had contact within the last **THREE** years

|                  |                     |
|------------------|---------------------|
| Name             | Title               |
| Complete Address | City State Zip Code |
| Phone Number ( ) | Fax Number ( )      |

|                  |                     |
|------------------|---------------------|
| Name             | Title               |
| Complete Address | City State Zip Code |
| Phone Number ( ) | Fax Number ( )      |

**ARHA APPLICATION FOR ALLIED HEALTH STAFF**

**Professional References Continued**

|                  |                |       |          |
|------------------|----------------|-------|----------|
| Name             |                | Title |          |
| Complete Address | City           | State | Zip Code |
| Phone Number ( ) | Fax Number ( ) |       |          |

|                  |                |       |          |
|------------------|----------------|-------|----------|
| (Optional) Name  |                | Title |          |
| Complete Address | City           | State | Zip Code |
| Phone Number ( ) | Fax Number ( ) |       |          |

**Hospital/Health Care Entity<sup>1</sup> Appointments and/or Professional Employment: List all current, past, or pending Hospital/Health Care Entity affiliations and/or professional employment. Use an additional sheet, if necessary. List primary first.**

|                                                                        |                                     |       |          |
|------------------------------------------------------------------------|-------------------------------------|-------|----------|
| <b>Name of Hospital/Health Care Entity<sup>1</sup> or Organization</b> |                                     |       |          |
| Complete Address                                                       | City                                | State | Zip Code |
| Fax Number ( )                                                         | From / / To / /                     |       |          |
| Phone Number ( )                                                       |                                     |       |          |
| Staff Level/Status                                                     | Collaborating/Supervising Physician |       |          |

|                                                                        |                                     |       |          |
|------------------------------------------------------------------------|-------------------------------------|-------|----------|
| <b>Name of Hospital/Health Care Entity<sup>1</sup> or Organization</b> |                                     |       |          |
| Complete Address                                                       | City                                | State | Zip Code |
| Fax Number ( )                                                         | From / / To / /                     |       |          |
| Phone Number ( )                                                       |                                     |       |          |
| Staff Level/Status                                                     | Collaborating/Supervising Physician |       |          |

|                                                                        |                                     |       |          |
|------------------------------------------------------------------------|-------------------------------------|-------|----------|
| <b>Name of Hospital/Health Care Entity<sup>1</sup> or Organization</b> |                                     |       |          |
| Complete Address                                                       | City                                | State | Zip Code |
| Fax Number ( )                                                         | From / / To / /                     |       |          |
| Phone Number ( )                                                       |                                     |       |          |
| Staff Level/Status                                                     | Collaborating/Supervising Physician |       |          |

|                                                                        |                                     |       |          |
|------------------------------------------------------------------------|-------------------------------------|-------|----------|
| <b>Name of Hospital/Health Care Entity<sup>1</sup> or Organization</b> |                                     |       |          |
| Complete Address                                                       | City                                | State | Zip Code |
| Fax Number ( )                                                         | From / / To / /                     |       |          |
| Phone Number ( )                                                       |                                     |       |          |
| Staff Level/Status                                                     | Collaborating/Supervising Physician |       |          |

<sup>1</sup>For the purpose of this application, a health care entity that provides or arranges for the provision of health care services including, but not limited to hospitals, managed care organizations, HMOs, nursing homes, free-standing ambulatory care clinics, physician practices, etc. \_\_\_\_\_ Date \_\_\_\_\_ Initials

**ARHA APPLICATION FOR ALLIED HEALTH STAFF**

**Certifications: Please attach a copy of each certificate**

| Certifying Agency | Number | Date Certified | Last Date Re-Certified | Certification Expires |
|-------------------|--------|----------------|------------------------|-----------------------|
|                   |        | / /            | / /                    | / /                   |
|                   |        | / /            | / /                    | / /                   |
|                   |        | / /            | / /                    | / /                   |
|                   |        | / /            | / /                    | / /                   |

**Licensing: List all current & past**

| Professional License Number | State | Date Issued | Expiration Date |
|-----------------------------|-------|-------------|-----------------|
|                             |       | / /         | / /             |
|                             |       | / /         | / /             |
|                             |       | / /         | / /             |

**Professional Liability Insurance (for the past five years):  
Include a copy of your recent certificate of insurance (Use Additional Information Sheet if necessary)**

**Name of Present Carrier:**

|                        |                            |
|------------------------|----------------------------|
| Complete Address:      | Policy Number              |
| Amount of Coverage: \$ | Coverage Period / / to / / |

**Name of Prior Carrier:**

|                        |                            |
|------------------------|----------------------------|
| Complete Address:      | Policy Number              |
| Amount of Coverage: \$ | Coverage Period / / to / / |

**Name of Prior Carrier:**

|                        |                            |
|------------------------|----------------------------|
| Complete Address:      | Policy Number              |
| Amount of Coverage: \$ | Coverage Period / / to / / |

**Disclosure Information**

**IF YOU ANSWER "YES" TO ANY OF THE QUESTIONS BELOW, PLEASE EXPLAIN ON A SEPARATE SHEET OF PAPER**

|                                                                                                                                                                                                                                                                                                                       |                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 1. In the last five (5) years have there been or are there currently pending any malpractice settlements, claims, suits, judgements, or arbitrations as a defendant or plaintiff involving your professional practice?<br><i>If yes to above, please complete the enclosed Malpractice Claims/Suit history sheet.</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have you ever been denied malpractice liability insurance or has any malpractice liability insurance ever been canceled?                                                                                                                                                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Has your present professional liability insurance carrier placed any limitations/exclusions on your coverage?                                                                                                                                                                                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Have you ever been denied membership on any Hospital/Health Care Entity medical/allied health staff or has such a denial ever been recommended?                                                                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Has your medical/allied health membership for staff status at any Hospital/Health care entity ever been limited, placed on probation, suspended, revoked, or not renewed either voluntarily or involuntarily?                                                                                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Has your request for any specific medical/allied health staff status ever been denied or granted with stated limitations (aside from ordinary and initial requirements of proctorship) or has such a denial or limitation ever been recommended?                                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Has your license, or application for license or certification, to practice your profession in any jurisdiction ever been suspended, revoked, denied or subject to probationary conditions, voluntarily or involuntarily relinquished, or have proceedings toward any of these events ever been instituted?         | <input type="checkbox"/> Yes <input type="checkbox"/> No |



**ADDITIONAL INFORMATION/COMMENTS**

\_\_\_\_\_ Date \_\_\_\_\_ Initials

APPLICATION FOR ALLIED HEALTH STAFF

Provider Name (Please Print)

PROFESSIONAL LIABILITY CLAIM FORM

(Important: Each claim reported must be on a separate form. Photo copy as needed.)

Please supply adequate responses in sufficient clinical detail to allow proper review and evaluation by the Credentials Committee of your application.

Please report all claims, pending, settled, and dismissed.

Patient Name: Age: Sex:

Incident date:

Describe any alleged injury and clinical outcome:

Patient's condition and diagnosis at time of incident:

Alleged basis for claim, if known:

County where filed:

Names of additional defendants, if known:

Claim disposition: Pending Closed with no payment Closed with payment, by verdict or settlement

If closed, please give date:

If closed with payment, please indicate the amount paid on your behalf:

Other actions in which the applicant has been a plaintiff or defendant: Explain

I UNDERSTAND THAT ALL INFORMATION SUBMITTED HEREIN BECOMES PART OF MY APPLICATION, AS SUBMITTED

Provider Signature: Date:

1Claim is defined as being named as defendant in a malpractice suit.

Date Initials