



AKRON REGIONAL HOSPITAL ASSOCIATION

ALLIED HEALTH STAFF CREDENTIALING APPLICATION

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>
330-834-4760	Affinity Medical Center	erica.miller@affinitymedicalcenter.com
330-543-8113	Akron Children's Hospital	ssimms@chmca.org
330-543-8024	Akron Children's Hospital	tfrishgesell@chmca.org
330-344-6565	Cleveland Clinic Akron General <i>Akron General Medical Center and Edwin Shaw Rehab, LLC</i>	stephanie.hahn@akrongeneral.org debbie.bunn@akrongeneral.org
330-948-5501	<i>Cleveland Clinic Akron General Lodi Hospital</i>	Rachel.Smith4@akrongeneral.org linda.fitzgerald@akrongeneral.org jbortz@aultman.com
330-363-6255	Aultman Hospital	mfunk@ccf.org
330-721-5182	Cleveland Clinic Medina Hospital	mindy.mcelfresh@Uhhospitals.org
330-297-2460	U.H. Portage Medical Center	michelle.circelli@Uhhospitals.org
330-297-2461	U.H. Portage Medical Center	csvoboda@selectmedicalcorp.com
330-761-7574	Select Specialty Hospital Akron	
330-489-8175	Select Specialty Hospital Canton	
330-375-7100	Summa Health System	draganp@summahealth.org brookshl@summahealth.org dsukie@summahealth.org
330-331-1339	Summa Barberton Hospital	tlenart@summahealth.org
330-331-1339	Summa Health Wadsworth-Rittman Medical Center	

**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:

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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 / / 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 / / 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 ()

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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 Entity¹ 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.

Name of Hospital/Health Care Entity¹ or Organization			
Complete Address	City	State	Zip Code
Fax Number ()	From / / To / /		
Phone Number ()			
Staff Level/Status	Collaborating/Supervising Physician		

Name of Hospital/Health Care Entity¹ or Organization			
Complete Address	City	State	Zip Code
Fax Number ()	From / / To / /		
Phone Number ()			
Staff Level/Status	Collaborating/Supervising Physician		

Name of Hospital/Health Care Entity¹ or Organization			
Complete Address	City	State	Zip Code
Fax Number ()	From / / To / /		
Phone Number ()			
Staff Level/Status	Collaborating/Supervising Physician		

Name of Hospital/Health Care Entity¹ or Organization			
Complete Address	City	State	Zip Code
Fax Number ()	From / / To / /		
Phone Number ()			
Staff Level/Status	Collaborating/Supervising Physician		

¹For 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.

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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? <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

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8. Have you ever been convicted, arrested, or charged with a felony or misdemeanor (other than minor traffic offenses)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you ever been terminated or placed on probation or otherwise limited by an HMO, PPO, or other managed care organization in which you have had a professional staff appointment or privilege?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you ever been suspended or terminated from participating in Medicare/Medicaid; are you currently under investigation by either program or have you ever been named as a defendant in any lawsuit alleging inappropriate conduct in either program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you ever withdrawn an application for medical/allied health staff privileges?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you ever had any action taken against you that has been reported to the NPDB? <i>If yes, attach a copy of the report.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Ability to Perform

1. Are you currently capable, with or without reasonable accommodation, of fully, competently, and safely carrying out the scope of patient care services and allied health responsibilities for which you have applied? <i>If "No", please provide full details on a separate sheet.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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IF YOU ANSWER "YES" TO ANY OF THE QUESTIONS BELOW, PLEASE EXPLAIN ON A SEPARATE SHEET OF PAPER

1. Do you currently use any illegal drugs (or prescriptive drugs for reasons other than treating a medical condition); or do you currently abuse or excessively consume alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you currently under any consent decree or any other type of agreement with any professional licensing board and/or state or local professional association, the terms of which, if violated, would result in the suspension, restriction, or revocation of your professional license/certification to practice?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Health

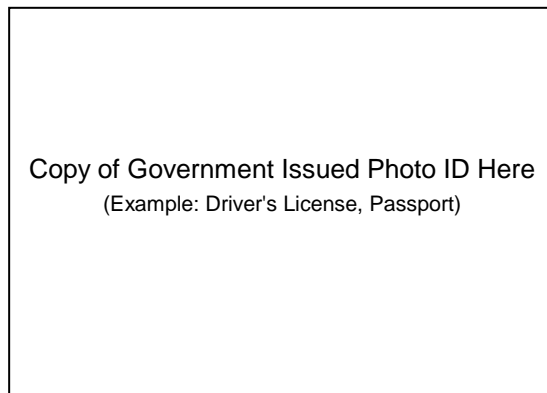
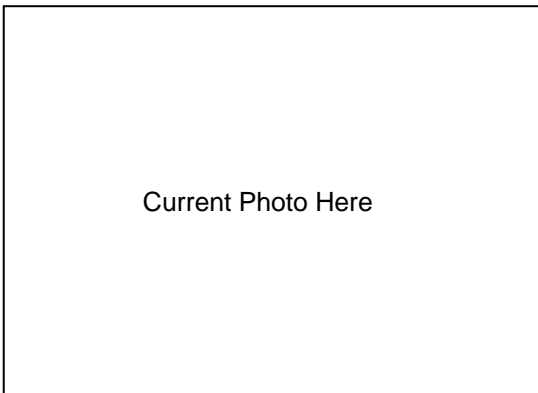
Have you had the Hepatitis B Vaccination?: <input type="checkbox"/> No <input type="checkbox"/> Yes	Date of Vaccination
PPD Date: / /	Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
PPD Not Done (Reason):	
If new positive, date CXR was done: / /	Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative

Continuing Education

Have you maintained continuing education in the amounts expected by your licensing and certifications boards?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you maintained continuing education in your specialty/subspecialty?	<input type="checkbox"/> Yes <input type="checkbox"/> No

NOTE: Proof of attendance and program content must be submitted upon request

Two (2) photos are required as indicated below:



ADDITIONAL INFORMATION/COMMENTS

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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.