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:

Phone	Hospital	Email
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	
	Akron General Medical Center and	stephanie.hahn@akrongeneral.org
	Edwin Shaw Rehab, LLC	debbie.bunn@akrongeneral.org
330-948-5501	*Cleveland Clinic Akron General Lodi Hospital*	Rachel.Smith4@akrongeneral.org
		linda.fitzgerald@akrongeneral.org
330-363-6255	Aultman Hospital	jbortz@aultman.com
330-721-5182	Cleveland Clinic Medina Hospital	mfunk@ccf.org
330-297-2460	U.H. Portage Medical Center	mindy.mcelfresh@Uhhospitals.org
330-297-2461	U.H. Portage Medical Center	michelle.circelli@Uhhospitals.org
330-761-7574	Select Specialty Hospital Akron	csvoboda@selectmedicalcorp.com
330-489-8175	Select Specialty Hospital Canton	
330-375-7100	Summa Health System	draganp@summahealth.org
		brookshl@summahealth.org
330-331-1339	Summa Barberton Hospital	dsukie@summahealth.org
330-331-1339	Summa Health Wadsworth-Rittman Medical Center	tlenart@summahealth.org

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):			
☐ Male ☐ 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: ☐ Single ☐ Married ☐ Divorced ☐ 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:

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: ☐ Yes ☐ 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: ☐ Yes ☐ 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 ( )

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[1] 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 Entity[1] or Organization			
Complete Address	City	State	Zip Code
Fax Number ( )			
Phone Number ( )		From / /	To / /
Staff Level/Status		Collaborating/Supervising Physican	

Name of Hospital/Health Care Entity[1] or Organization			
Complete Address	City	State	Zip Code
Fax Number ( )			
Phone Number ( )		From / /	To / /
Staff Level/Status		Collaborating/Supervising Physician	

Name of Hospital/Health Care Entity[1] or Organization			
Complete Address	City	State	Zip Code
Fax Number ( )			
Phone Number ( )		From / /	To / /
Staff Level/Status		Collaborating/Supervising Physician	

Name of Hospital/Health Care Entity[1] or Organization			
Complete Address	City	State	Zip Code
Fax Number ( )			
Phone Number ( )		From / /	To / /
Staff Level/Status		Collaborating/Supervising Physician	

[1]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.

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? *If yes to above, please complete the enclosed Malpractice Claims/Suit history sheet.*	☐ Yes ☐ No
2. Have you ever been denied malpractice liability insurance or has any malpractice liability insurance ever been canceled?	☐ Yes ☐ No
3. Has your present professional liability insurance carrier placed any limitations/exclusions on your coverage?	☐ Yes ☐ 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?	☐ Yes ☐ 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?	☐ Yes ☐ 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?	☐ Yes ☐ 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?	☐ Yes ☐ No

8. Have you ever been convicted, arrested, or charged with a felony or misdemeanor (other than minor traffic offenses)?	☐ Yes ☐ 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?	☐ Yes ☐ 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?	☐ Yes ☐ No
11. Have you ever withdrawn an application for medical/allied health staff privileges?	☐ Yes ☐ No
12. Have you ever had any action taken against you that has been reported to the NPDB? *If yes, attach a copy of the report.*	☐ Yes ☐ 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? *If "No", please provide full details on a separate sheet.*	☐ Yes ☐ No

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?	☐ Yes ☐ 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?	☐ Yes ☐ No

Health

Have you had the Hepatitis B Vaccination?: ☐ No ☐ Yes	Date of Vaccination
PPD Date: / /	Results: ☐ Positive ☐ Negative
PPD Not Done (Reason):	
If new positive, date CXR was done: / /	Results: ☐ Positive ☐ Negative

Continuing Education

Have you maintained continuing education in the amounts expected by your licensing and certifications boards?	☐ Yes ☐ No
Have you maintained continuing education in your specialty/subspecialty?	☐ Yes ☐ No

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

Two (2) photos are required as indicated below:

Current Photo Here

Copy of Government Issued Photo ID Here
(Example: Driver's License, Passport)

ADDITIONAL INFORMATION/COMMENTS

_____

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: _____

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