AUTHORIZATION FOR THE RELEASE OF INFORMATION AND LIABILITY

I hereby authorize and expressly consent that Kettering Medical Center, the members of the Medical Staff, and the agents and representative thereof to consult with Administrators and members of the Medical Staff and credentialing institutions, other hospitals, healthcare institutions, and healthcare providers with whom I have been associated and/or previously applied for privileges from the Medical Staff, and with others, including past and present malpractice carriers, licensing agencies, peers, educational institutions and government programs, and credentialing reporting agencies which may have information bearing on my professional activities, competence, character, and ethical qualifications.

I acknowledge that the Medical Staff at Kettering Medical Center is comprised of licensed physicians, podiatrists and dentists who practice their respective specialty in and around Dayton, Ohio and who have been granted privileges with Kettering Medical Center. The members of the Medical Staff at Kettering Medical Center are not, for purposes of the credentialing and peer review processes and functions, employees of the Hospital, but rather, are licensed independent practitioners participating in the credentialing and peer review processes.

I consent to the inspection by Kettering Medical Center, the members of the Medical Staff, and its agents and representatives of all documents, including but not necessarily limited to peer review evaluation records, educational records, clinical competency evaluations, and credentialing files maintained by other hospitals or other healthcare institutions, that may be material to an evaluation of my personal and professional activities, professional qualifications and competence to perform and carry out the clinical privileges as requested, as well as my moral and ethical qualifications for privileges and/or scope of service to be granted by the Medical Staff.

I hereby release from liability all agents and representatives of Kettering Medical Center and the members of the Medical Staff for its acts performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications. I further release from any liability any individuals or organizations who provide information to Kettering Medical Center and the members of the Medical Staff, in good faith and without malice concerning my past personal and professional activities, professional competence, ethics, character, and other qualifications for appointment and/or granting of clinical privileges and/or scope of service.

I am willing to appear, if requested, for interviews in reference to my application.

I understand and acknowledge that Kettering Medical Center, the members of the Medical Staff, and the agents and representatives thereof may be required to report to licensing agencies, State Medical Licensing Board, the National Practitioners' Data Bank, and other credentialing and accrediting agencies or government entities information regarding my appointment, clinical privileges and/or scope of service, disciplinary action (if any) and professional conduct which may otherwise be protected from disclosure as confidential peer review information. I hereby release from and agree to hold Kettering Medical Center, the members of the Medical Staff, and the agents and representatives thereof harmless for any liability for the release of such information when Kettering Medical Center and/or the members of the Medical Staff, by and through their/its respective agents and representatives, discloses such information in good faith in compliance with such laws, regulations and applicable governing requirements.

I further understand that, pursuant to written authorization by me or a duly entered court order, Kettering Medical Center, the members of the Medical Staff, and the agents and representatives thereof may provide to other hospitals, organization, insurers, healthcare providers, reporting and accrediting agencies and other persons information concerning my professional competence, character, ethics, credentials and credential status, clinical privileges and/or scope of service status, appointment and other peer review information. I hereby releases from and agree to hold Kettering Medical Center, the members of the Medical Staff and the agents and representatives thereof harmless for any liability for release of such information, pursuant to my written authorization or a duly entered court order, when made in good faith.

A copy of this authorization shall have the same effect as the original.

____ ____________________
Applicant's Signature Date

Kettering Medical Center
REQUEST FOR CHANGE IN STATUS/ADDITIONAL PRIVILEGES

Applicant Name: ____________________________ Date Requested: ____________________

Clinical Services Department: ____________________________ Specialty: ____________________

☐ Change in staff category ____________________ to ____________________

☐ Resignation from staff effective ____

☐ Additional privilege(s) requested:

____

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I am requesting only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform. I attest by signature that I have and will continue to meet the minimum criteria of procedures/diagnoses management.

For those applicants requesting additional privileges, the following must be completed:

Since your appointment/reappointment or within the last two years:

1. Have any disciplinary actions been initiated or are any pending against you by any state licensure board? ☐ Yes ☐ No
2. Has your license to practice in any state been (voluntarily or involuntarily) denied, limited, suspended, reprimanded, revoked, relinquished, or is your license to practice in any state under current challenge? ☐ Yes ☐ No
3. Have you been suspended, sanctioned, or otherwise restricted from participating in any private, federal or state health insurance program? (for example Medicare or Medicaid) ☐ Yes ☐ No
4. Have you been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program? ☐ Yes ☐ No
5. Has your narcotics registration certificate and/or DEA been (voluntarily or involuntarily) limited, suspended, revoked, relinquished, or is it currently being challenged or reviewed? ☐ Yes ☐ No
6. Has your employment, staff appointment, clinical privileges and/or scope of practice ever been (voluntarily or involuntarily) suspended, limited, revoked, not renewed, or refused at any hospital or other healthcare facility? ☐ Yes ☐ No
7. Have you ever withdrawn your application for appointment, reappointment, clinical privileges and/or scope of practice, or resigned before a decision by a hospital's or healthcare facility's governing body was rendered? ☐ Yes ☐ No
8. Have you been the subject of disciplinary proceedings or investigation at any hospital or healthcare facility? ☐ Yes ☐ No

9. Are your staff appointment or clinical privileges and/or scope of practice at any hospital or other healthcare facility currently under investigation? ☐ Yes ☐ No

10. Have you been denied membership or renewal thereof, or been subject to disciplinary proceedings in any professional organization? ☐ Yes ☐ No

11. Have you entered into any agreement (voluntarily or involuntarily) with any licensing organization or accrediting board to limit your medical practice as a result of any condition, mental or physical, which you suffer, including but not limited to alcoholism or substance abuse? ☐ Yes ☐ No

12. Have you been charged or convicted of a felony or a misdemeanor other than a minor traffic violation? ☐ Yes ☐ No

13. Has your professional liability insurance coverage been terminated by action of the insurance company? ☐ Yes ☐ No

14. Have you been denied professional liability insurance coverage? ☐ Yes ☐ No

15. Has any professional liability insurance carrier excluded any specific procedures from your coverage? ☐ Yes ☐ No

16. Have you practiced medicine without professional liability insurance? ☐ Yes ☐ No

17. Have any professional liability suits been filed against you or have you received written notice of intent to file such a suit? ☐ Yes ☐ No

18. Have any professional liability suits been filed against you, which are presently pending? ☐ Yes ☐ No

19. Have any judgments been made against you or settlements rendered on your behalf in any professional liability cases? ☐ Yes ☐ No

20. Do you have any physical or mental conditions, which could affect your ability to exercise the clinical privileges requested or would require an accommodation in order for you to exercise the privileges requested safely and competently? To answer this question appropriately, please report any condition, which is infectious, which affects motor skills, cognitive ability or judgment, or which may adversely affect your ability to care for patients or to interact with other caregivers? ☐ Yes ☐ No

21. Do you know of any reason that would prevent you from performing all the essential functions required by the privileges you requested without posing a substantial risk of serious harm to yourself, your patients, or others? ☐ Yes ☐ No

For responses marked "YES", please provide a letter of explanation.

Complete <u>applicable</u> sections below; documenting your current competence and ability to perform the requested procedure/privilege(s):

EXPERIENCE	
	Number of cases/procedures you performed during the past two (2) years.
	Approximate date you last performed this procedure.
	Name, address, and contact number of hospital/facility where you last performed this procedure. ***(If applicable, please enclose verification from the Medical Staff Dept. that you currently hold and utilize the requested privilege at a hospital other than Kettering Medical Center.)***
Describe any complications you encountered while performing this procedure:	

FORMAL TRAINING / EDUCATION	
	Name the residency/fellowship (hospital), address, and contact number where you received your training in this procedure. **(Attach case log and/or applicable operative notes)**
	Name and date of educational seminar, approved by an accredited CME provider, you attended to receive your primary education in this procedure. **(Attach certificate of completion.)**
	Title and date of any relevant CME activities you have completed recently.
	Name, address, and contact number of the qualified Preceptor who provided you with training. **(Attach any relevant documentation of training.)**
	Date you completed applicable training.

_______________________________ _______________________

Applicant's Signature Date

____

Printed Name