3535 Southern Blvd., Kettering, OH 45429

Dear Doctor:

Thank you for your interest in joining the Medical and Dental Staff of Kettering Medical Center. As recommended by the Ohio Department of Insurance, Kettering Medical Center utilizes the Standard Credentialing Form. Information on how to access the application is attached, along with instructions on completing the form. Please take time to thoroughly review your application, making sure to complete all relevant information fields, including dates, names, complete mailing addresses and telephone/fax numbers. This will help to ensure that your application is processed in a timely manner.

Please note that your references should have recent experience in observing and working with you and should be able to provide adequate information pertaining to your present professional competence and character. The Medical Staff Office personnel will forward a “Confidential Practitioner Evaluation Form” to each of your references, as well as to the appropriate program directors, department chiefs, medical directors and other associates with whom you may have practiced.

A checklist of required enclosures is attached to this letter.

Once your application is received by the Medical Staff Office it will be reviewed for completeness. Should your application be deemed incomplete (unanswered questions or omissions, including signatures, on the application or if any of the required documentation is not submitted) the medical staff office personnel will notify you in writing of an incomplete application which will include a listing of all outstanding information.

The Joint Commission on Accreditation of Healthcare Organizations (TJC) requires that we verify certain data with the primary source. This is accomplished by requesting verification directly from the individual or institution and requiring that their response be returned directly to our office. Information requiring primary source verification includes, but is not limited to, professional school graduation, postgraduate training, professional references, hospital affiliations, malpractice history and professional licenses. In addition, we query the National Practitioner Data Bank and the Office of Inspector General’s List of Excluded Individuals prior to consideration of any applicant. In order for your application to be considered complete, all information must be verified. Please remember that it is the applicant's ultimate responsibility to ensure that all information has been received.

Your application will be deemed incomplete if the need arises for new, additional, or clarifying information anytime during the application process.

Your completed application will be reviewed by the appropriate Clinical Service Chief. Your application will then be reviewed by the Credentials Committee and the Medical Executive Committee. These committees make their recommendations to the Hospital Board of Directors, which takes final action regarding your application. You will be notified of their decision. We anticipate that this complete process will take approximately 60 to 90 days.

Expedited Process - KMC is pleased to offer an expedited credentialing process. The fee for this process is an additional **$200.00** to the current application fee. Upon receipt of your completed application (which includes, names, address, phone and fax), the verification process will implemented within 1 business day (24 hours). Your involvement in this process is imperative as it is the applicant’s ultimate responsibility to ensure that all information has been received. We anticipate that this process will take approximately 14 to 30 days.

If you have any additional questions, please contact your assigned Credentialing Specialist at 937-395-8324.

Sincerely,

Melissa

Melissa Walters, MHA, CPMSM, CPCS
Manager, Medical Staff Office

State of OHIO Standardized Credentialing Form
EFFECTIVE September 25, 2008
Utilization of the CAQH Application

Instructions

1. ACCESS:

- The State of Ohio Credentialing Form may be accessed via the Internet. Click on http://www.caqh.org . This will take you to the CAQH website to complete the provider application as required for the insurance payers. Then click on "Universal Provider DataSource". Then click on "CAQH Provider Credentialing Application". Download application from here. Type or print legibly in blue or black ink. Once the application is complete, you may photocopy and submit with a signed Affirmation of Information to each entity to which you wish to apply.

2. COMPLETE:

- Complete each section thoroughly and truthfully, and complete all fields. If an item is not applicable, indicate N/A.
- You are responsible for providing current information at all times and to update substantial changes throughout the credentialing period. Please remember that you must sign and date a new Affirmation of Information page each time your form is submitted.
- Modification to the wording and format of the form will invalidate the application.
- Attach additional sheets where necessary. *(Indicate clearly your name on each attachment.)*
- Complete KMC Addendum – Hospital Required Information; sign and date.

3. SUBMIT:

- Submit the following to Kettering Medical Center:
  1. CAQH Credentialing Form
  2. KMC Addendum – Hospital Required Information
  3. Additional required documents and/or items listed as required by KMC Addendum
  4. Delineation of Privileges – designated specialty and/or subspecialty

KETTERING MEDICAL CENTER
KETTERING HEALTH NETWORK℠

APPLICANT CHECKLIST

In addition to those items required with the CAQH Application, please enclose the following:

- ☐ Application fee (non-refundable) in the amount of **$200.00** (Active) and **$250.00** (Courtesy/Affiliate).
- ☐ If requesting the expedited process, please include an additional **$200.00** (non-refundable).
- ☐ Recent professional photo (passport size - driver's license NOT acceptable – proof of identification is required either upon attending orientation or obtaining KMC identification badge)
- ☐ If not U.S. citizen, provide documentation of VISA Staus and/or Employment Authorization
- ☐ Copies of all Medical Licenses (Active and Inactive)
- ☐ Verification of professional liability insurance in at least the amounts specified in the Medical Staff Bylaws (minimum of $1 million/$1 million). Certificate of Insurance and Declaration Page required.
- ☐ Complete clinical privileges profile
- ☐ If requesting fluroscopic procedures, please contact the medical staff office to obtain the appropriate attestation.
- ☐ If requesting moderate sedation (conscious sedation), please contact the medical staff to obtain a copy of the competency test and provide a current copy of your ACLS, ATLS, PhyAmerica, documentation of approval for procedural sedation privileges from a local GDAHA hospital, or Airway Management course provided by Kettering Medical Center.
- ☐ Curriculum Vitae
- ☐ Documentation of your current clinical competence for those procedures requested (50 **DE-IDENTIFIED** operative reports and/or a comprehensive case log are required for invasive procedures, including pump perfusionist, surgical, endoscopy, cardiac cath, and/or angioplasty procedures. If you are requesting laser privileges, please indicate which types and documentation of training for each – does **NOT** apply to Affiliate – membership only category).
- ☐ Written plan of utilization of Kettering Medical Center, which includes Sycamore Medical Center and Kettering Behavioral Medicine Center.

Also, be sure to submit the following documents provided to you with your application:

- ☐ Medicare/Champus Attestation Form
- ☐ Medical Malpractice Insurance Agreement Form
- ☐ Emergency Deaprtment Preference Form
- ☐ Statement of Authorization and Release from Liability

KETTERING MEDICAL CENTER
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KMC ADDENDUM
HOSPITAL REQUIRED INFORMATION

A. PERSONAL INFORMATION

Applicant Name :	Applicant's Personal Email :
Marital Status :	Spouse's Name :

In addition to the three (3) Professional Peer References, please provide one additional reference, preferably within your clinical specialty. This reference MAY NOT be your residency director, fellowship director, current clinical department chairperson, current partners or associates in practice.

Name :____ Specialty :_____________________________

Address :____ Phone : _______________________________

City, State, Zip : ______________________________________ Fax : _________________________________

B. DISCLOSURE INFORMATION

1. Have you ever withdrawn your application for appointment, reappointment, clinical privileges and/or scope of service, or resigned before a decision by a hospital's or healthcare facilities governing body was rendered? ☐ Yes ☐ No

2. Have you ever been the subject of disciplinary proceeding or investigation at any hospital or healthcare facility? ☐ Yes ☐ No

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

If the answer to questions above is YES, please complete the Professional Sanctions Reporting Form (Form A) included with this packet.

4. Has any (current or past) professional liability insurance carrier excluded any specific procedures from your coverage? ☐ Yes ☐ No

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

If the answer to the questions above is YES, provide a full explanation on a separate sheet, including the name of the carrier, the date and specific information concerning limitation or termination.

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

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

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

If the answer to the questions above is YES, please complete Malpractice Claims Assessment Form. Even if this information is available from the National Practitioner Data Bank, you must provide it in order to complete your application.

9. If you are granted clinical privileges and/or scope of service, do you agree to notify the Hospital of any change to the foregoing answers upon the occurrence of any event, which would or does render any of the foregoing answer(s) incorrect or incomplete? This includes answers provided under Section X of the Ohio Department of Insurance Standardized Credentialing Form. ☐ Yes ☐ No

10. Do you understand and acknowledge that it is an express condition to ongoing clinical privileges and/or scope of service to notify the Hospital of any occurrence/event which renders the foregoing answers incorrect or incomplete when notice of the same is received by you? This includes answers provided under Section X of the Ohio Department of Insurance Standardized Credentialing Form. ☐ Yes ☐ No

Provide information for all time frames of one (1) month or more that are not covered in Education, Hospital

Affiliations or Practice History sections such as extended travel, maternity leave, relocation, etc. If necessary, Please attach an additional sheet.

Dates	From	To	Explanation:

C. MISCELLANEOUS

1. To which staff category do you wish to apply? ☐ Active ☐ Affiliate/membership only ☐ Affilliate/clinical privileges only ☐ Courtesy

2. Clinical Service to which you are applying : (check only one)

☐ Anesthesia	☐ Medical Imaging	☐ Orthopedics	☐ Surgery
☐ Emergency Medicine	☐ Internal Medicine	☐ Pathology	
☐ Family Practice	☐ Ob/Gyn	☐ Pediatrics	

Clinical Specialty/Subspecialty : ____

D. APPLICANT'S ATTESTATION

In making this application, I hereby signify my willingness to appear for interviews in regard to my application. I acknowledge that I have received and read the Medical Staff Bylaws and associated manuals of the Hospital. I agree to be bound by the terms of said Bylaws and associated manuals as may from time to time be enacted if I am granted membership or clinical privileges and/or scope of service and in all matters relating to the consideration of my application for appointment to the medical staff and clinical privileges.

I also acknowledge my obligation as a licensed health care processional to engage in my profession in a manner which is consistent with and in compliance with all applicable federal and state laws. This includes, but is not necessarily limited to, all federal and state laws addressing the obligation to comply with conditions of participation through government sponsored health care entitlement programs. Consistent therewith, I have read the information provided in the HIPAA Review for Physicians and I agree to abide with the principles of this document. I further expressly agree to abide by the policies and procedures of Kettering Medical Center as applicable to my professional practice and will also abide by those requirements of third party accreditation entities, including but not limited to JCAHO.

I agree to submit my clinical performance to, and faithfully participate in the hospital's performance improvement program and I agree to hold members of the medical staff and other authorized representatives of the Hospital engaged in these quality activities free from all liability for their actions performed in good faith/connection herewith. I hereby consent that the Hospital shall notify the Montgomery County Medical Society, other hospitals, licensing board, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the Hospital may have concerning me as well as releasing the Hospital representative from liability for so doing. I further specifically acknowledge that the provisions of said bylaws relating to confidentiality and release from civil liability are express conditions to my application for, and acceptance of medical staff membership and the continuation of such membership and to exercise of my clinical privileges. I pledge to provide for continuous care for my patients.

I understand and agree that I, as an applicant for Medical Staff membership and/or clinical privileges, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualification for membership and clinical privileges as well as resolving any doubts about such qualifications. I further understand that any significant misstatements in or omissions from this application constitute cause for denial of appointment or cause for dismissal from the Medical Staff. If appointment is granted, I understand that my initial staff appointment will be provisional for a period of one year and if necessary, may be extended another year. I agree to accept the clinical privileges appointed by the Medical Executive Committee and the Board of Trustees.

ALL INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE BY MY BEST KNOWLEDGE AND BELIEF.

Signature of Applicant____ Date__________________

Print Name: ____

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

____
Print Name

MALPRACTICE CLAIMS ASSESSMENT FORM

Name:			Date
Patient Name:			DOB:
Civil Action #:			Date of Incident:
Date filed:	Date Settled/Closed:	Professional Involvement: Attending/Resident/Other	
Diagnosis:			
Allegations:			
Case Summary:			
CASE RESOLUTION			
Dismissed:	Settled out-of-court:	Litigated:	
Venue:			
Settlement paid on your behalf:		Total Settlement:	
PROFESSIONAL LIABILITY INFORMATION			
Name of Insurance Carrier:		Policy Number:	
Address:			
PLAINTIFF'S COUNSEL			
Name of attorney		Phone Number:	
Address:			
OTHER APPLICABLE INFORMATION			

PROFESSIONAL SANCTIONS REPORTING FORM

Name: ______________________ **Dept./Section**: ______________ **Date:** __________

Facility Name: ____

Contact Person: ______________________________ Phone: ______________

Date incident occurred: ________________________ **Status (check one):** ☐ Pending ☐ Closed

Substance of allegations: ____

If closed, disposition (check one): ☐ Dismissed ☐ Disciplinary Action Taken

Substance of findings: ____

Additional Information (optional): ____

Name: ______________________ **Dept./Section**: ______________ **Date:** __________

Facility Name: ____

Contact Person: ______________________________ Phone: ______________

Date incident occurred: ________________________ **Status (check one):** ☐ Pending ☐ Closed

Substance of allegations: ____

If closed, disposition (check one): ☐ Dismissed ☐ Disciplinary Action Taken

Substance of findings: ____

Additional Information (optional): ____

******SEND DIRECTLY TO YOUR PROFESSIONAL LIABILITY INSURANCE CARRIER******

(this includes both recent past and current carrier)

STATEMENT OF AUTHORIZATION AND RELEASE FROM LIABILITY

Name and Address of Professional Liability Insurance Carrier:

____

____

____

POLICY #: ____________________________

To Whom It May Concern:

I, ______________________________________, am applying for appointment, clinical privileges and/or scope of service at Kettering Medical Center and hereby authorize my professional liability insurance carrier to release to the individual and facility listed below all information regarding my claims history, including, but not limited to:

- Judgments entered
- Claims settled
- Cases pending
- Procedures not covered by my policy

This information shall be submitted to:

Melissa Walters, MHA, CPMSM, CPCS
Manager, Medical Staff Services
Kettering Medical Center
3535 Southern Blvd.
Kettering, OH 45429
937-395-8324 (phone)
937-395-8357 (FAX)

The above named person and facility is to hereinafter be listed as a Certificate Holder and shall be notified of the amount of my coverage and any future changes in my insurance status.

Your prompt and full response will be appreciated. My signature below constitutes a consent to this inquiry and to your response, and releases you from liability if you observe certain conditions of good faith and reasonableness in reporting your observation and knowledge to representatives of Kettering Medical Center.

Sincerely,

____________________________________ ______________________________

Signature of Applicant/Insured Date

MEDICARE PHYSICIAN ACKNOWLEDGEMENT STATEMENT

By signing this document, I attest that I have received and read the following statement:

Medicare payment to hospitals is based in part on each patient's principal and secondary diagnosis and the major procedures performed on the patient, as attested to by 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 laws.

_________________________________ _________________

Signature Date

____

Print Name

AGREEMENT

I understand that it is a condition of staff membership at Kettering Medical Center that each practitioner has malpractice insurance coverage in the amounts of $1,000,000 per incident $1,000,000 aggregate.

I hereby agree to notify Kettering Medical Center at once if my current coverage is canceled, terminated or restricted in any way.

SIGNATURE: ____

PRINT NAME: ____

DATE: ________________________

MANDATORY: MUST BE COMPLETED IN ORDER TO RECEIVE PRIVILEGES

KETTERING MEDICAL CENTER

PLEASE FAX TO 937-395-8822
Attn: Melinda Cushman

In an effort to update the Emergency Department **"Authorization for Treatment"** records and expedite medical care of your private patients, please complete this form.

Name (please print) ______________________________ Office Name __________________________

Office Address ____________________________ City __________________ Zip ______________

Office # __________________ Home # ____________________ Private Office # _______________

Fax Number # __________________________________ Beeper # __________________________

Cell Phone # ___________________________________ Med Society # _______________________

AUTHORIZATION:

Please indicate preference after initial Emergency Department screening:

- ☐ Contact me for routine notification of admission and/or referral.
- ☐ Contact me upon arrival of patient.
- ☐ Contact me after workup of patient.
- ☐ Special Instructions: ____

REFERRALS: (Print legibly)

List specialists to be called in the event specialist services are indicated.
******If NO PREFERENCE is listed, the specialist on the ED call rotation schedule will be utilized.******

Acute/Critical Care ________________________

Cardiology ________________________

Colorectal ________________________

Gastroenterology ________________________

General Surgery ________________________

Hand Surgery ________________________

Neurology ________________________

Neurosurgery ________________________

OBGYN ________________________

Ophthalmology ________________________

Oral Surgery ________________________

Orthopedics ________________________

Otolaryngology ________________________

Pediatrics ________________________

Plastic Surgery ________________________

Psychiatry ________________________

Pulmonology ________________________

Thoracic Surgery ________________________

Urology ________________________

Hospitalist ________________________

HIPAA REVIEW FOR PHYSICIANS

WHAT IS RELEVANT TO A KETTERING MEDICAL CENTER NETWORK PHYSICIAN

Introductory

This review addresses the requirements of the Privacy and Security rules under the Health Insurance and Portability and Accountability Act of 1996 (HIPAA).

While reference is mainly made of the Privacy provisions, both the Privacy and Security rules work in tandem in strengthening patient rights and privacy protections. The regulations boil down to 1) for the physician – more responsibility to protect the patient's privacy, and 2) for the patient – more control.

Primary reasons we comply with these requirements:

- *HIPAA supports our institution's commitment to respect patient privacy and confidentiality*
- *Privacy violation complaints can jeopardize the hard earned reputation and respect of the institution and the individual physician*
- *It is part of the good care and services we provide our patients*

Secondary reasons we comply with these requirements:

- *Patients can file complaints directly with the Department of Health and Human Services (HHS)*
- *Violations are subject to both civil and criminal penalties*

What are we protecting, and how?

Protected Health Information (PHI), which is any information about a patient that we (KMCN) create or collect which can be linked back to an individual.

We protect PHI from uses (internal) or disclosures (external) that are not authorized by the patient or are for appropriate use in treatment, payment or KMCN operations.

Internally we must only use PHI only to conduct the duties for which we are responsible. This is why only certain individuals have access to PHI and the level of access is controlled to minimize the ability to see certain PHI. This is what is called Minimum Necessary and Need-to-Know. This also applies to access in restricted areas of the hospital. Minimum Necessary also impacts:

- Looking only at the PHI of the patients for which you are involved in treating
- Do not look at your own PHI, your family member, or a friend. Unless you are participating in the care of this individual.
- Even when sharing information for treatment or payment purposes, make sure it is only what is appropriate

Safeguards

Safeguarding PHI can become time consuming and costly. For this reason the regulations refer to **reasonable measures**, as a way to comply with how we protect PHI. Here are a few tips:

- Although being overheard by others when talking to patients/family members in non-private rooms, small waiting areas, or other areas can be considered an *incidental disclosure (this is an allowed type of disclosure under the regulation),* we must make every effort to:
  - Speak softly
  - Move to an area of the room where the most privacy is available
  - Use private rooms to communicate with family or patients, when available
  - Ask the family or patient if they feel comfortable discussing this information at the current location you have chosen
- Close and lock doors leading to rooms that hold PHI

- Do not leave documents with PHI where they can be accessed by others
- Do not discuss PHI in public areas (hallways, elevators, etc.)
- Keep your laptop or personal digital assistant's (PDA) secure, and with passwords if possible
- Dispose of documents with PHI in the available bins, not the regular trash
- Do not share your computer password or access to restricted areas with anyone under any circumstances

Patient rights

Accounting of disclosures

- Patients can request a list of the individuals/entities to which you disclosed their information. This means that you or your staff will have to log and track the disclosures you make to external entities for purposes other than treatment, payment or certain healthcare operations and for which no patient authorization was obtained.

Access to Medical Record

- Although the patient has always had this right, HIPAA enforces their ability to access the record in a timely manner.

Request to Amend Medical Record

- A patient can request in writing to have their medical record amended if they feel the information is incorrect. The physician responsible for the information in question determines if in fact a correction is or is not required. Even if the change is not made, a copy of the request is kept in the medical record.

Facility Directory

- A patient can choose to be excluded from the facility directory. At KMCN this classification is known as a Do Not Announce (DNA). As a DNA the patient will appear to anyone calling or stopping by, as if he/she were not at our facility. This classification can be found on LastWord and several census reports. A patient is not DNA, and therefore part of our directory can be reached by someone asking for him/her by full name. We can then provide patient location, and general condition of a non-DNA patient.

Family / Friend Involvement

- The patient chooses whom we can and cannot communicate with regarding their care. At KMCN we ask the patient to provide one or two names that we can share information with. This person(s) then becomes our point of contact and we direct anyone else asking detail information about the patient to the person(s).

Alternate Means of Communications and Restrictions to Use and Disclose PHI

- A patient can request to be contacted via an alternate route. Temporary number, different address, use cell phone. The patient can also request that their information not be used or disclosed a certain way. These requests must be evaluated individually to verify that KMCN can assure 100% compliance before it is agreed to.

File a Complaint

- Patients can file a complaint regarding their privacy directly with the US Department of Health and Human Services. That information is provided to them in our Notice of Privacy Practices. Or they can contact the KMCN Privacy Officer to file their complaint.

Contact Information

For Privacy or Information Security related questions, please contact the Information Security and Privacy Officer at (937) 395-8581 or e-mail: privacy.officer@khnetwork.org.