



REQUEST FOR CHANGE
IN STATUS/ADDITIONAL PRIVILEGES

Central Credentialing Office
3535 Southern Blvd., Kettering, OH 45429

FACILITY: [] Kettering Medical Center [] Sycamore Medical Center

Applicant Name: _____ Date Requested: _____

Clinical Services Department: _____ Specialty: _____

- [] Change in staff category _____ to _____
[] Resignation from staff effective _____
[] Additional privilege(s) requested:

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 Have you ever withdrawn your application for appointment, reappointment, clinical privileges and/or scope of practice, or resigned before a decision by a hospital's or healthcare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 applicable 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. <i>(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.)</i>
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



AUTHORIZATION FOR THE RELEASE OF INFORMATION AND LIABILITY

I hereby authorize and expressly consent for Kettering Medical Center (KMC), Sycamore Medical Center (SMC) hereinafter called "Hospital(s)", the members of Hospitals' Medical Staffs, and the Hospitals' employees, agents and representatives to consult with administrators and members of the medical staff and credentialing organizations, other hospitals, healthcare institutions, and healthcare providers with whom I have been associated and/or previously applied for medical staff appointment and/or privileges and with others, including past and present malpractice carriers, licensing agencies, peers, educational institutions, government programs, and credentialing reporting agencies which may have information bearing on my professional activities, competence, character, and/or ethical qualifications.

I acknowledge that the Medical Staffs of the Hospitals are comprised of licensed physicians, podiatrists, psychologists and dentists who practice their respective specialty in and around Dayton, Ohio and who have been granted medical staff appointment and/or clinical privileges at the Hospitals. The members of the Medical Staffs of the Hospitals are not, for purposes of credentialing and peer review processes and functions, employees of the Hospitals; but, rather, are licensed independent practitioners participating in Hospitals' credentialing and peer review processes.

I consent to the inspection by Hospitals, the members of its Medical Staffs, and its employees, 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 medical staff membership and/or clinical privileges at Hospitals.

I hereby release from and agree to hold Hospital, the members of their Medical Staffs, and the directors, officers, employees, agents, and representatives thereof harmless from and for any liability for performed in connection with evaluating my credentials, qualifications, and application for medical staff membership and/or privileges. I further release from any liability, and hold harmless, any individuals or organizations who provide information to the Hospitals and the members of Hospitals' Medical Staffs, 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 or addendum..

I understand and acknowledge that Hospitals, the members of Hospitals' Medical Staffs, and employees, agents and representatives thereof may be required to report to licensing agencies, (e.g. the State Medical Board), the National Practitioner 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/competence which may otherwise be protected from disclosure as confidential peer review information. I hereby release from and agree to hold Hospitals, the members of Hospitals' Medical Staffs, and employees, agents and representatives thereof harmless from and for any liability for the release of such information when Hospitals and/or its Medical Staffs, by and through their/members, employees, agents and/or representatives, disclose such information in compliance with such laws and regulations.

I further understand that, pursuant to written authorization by me or a duly entered court order, the Hospitals, Medical Staffs, And the employees, members, agents and representatives thereof may provide to other hospitals, organizations, insurers, healthcare providers, reporting and accrediting agencies and other persons information concerning my professional competence, character, ethics, credentials and credentialing status, clinical privileges and/or scope of service status, appointment and other peer review information. I hereby release from and agree to hold Hospitals, Hospitals' Medical Staffs and the members, employees, agents and representatives thereof harmless from and for any liability for release of such information, pursuant to my written authorization or a duly entered court order. I agree to sign such additional authorizations and release of information consent forms as may be necessary in conjunction with my application for medical staff membership or privileges at Hospital(s).

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

Applicant's Signature

Date

Print Name