Kettering HEALTH
PHYSICIAN PARTNERS

KHPP Provider Credentialing Form

(please print or type all information)

Section I
History/Additional Questions

	Y	N
Have you ever entered into any agreement (voluntarily or involuntarily) with any licensing organization or accrediting board that limits your medical practice as a result of any mental or physical condition you suffer including, but not limited to, alcoholism or substance abuse which could cause the inability to perform the essential functions as a healthcare provider?	☐	☐
Do you currently use any illegal substances?	☐	☐
Have you ever had your license to practice in any state (voluntary or involuntary) denied, limited, suspended, reprimanded, revoked or relinquished?	☐	☐
Have you ever had your employment, staff appointment or clinical privileges in any state (voluntary or involuntary) suspended, limited, reprimanded, revoked, refused or relinquished?	☐	☐
Have you ever been arrested, charged with, convicted of, pled guilty to or pled no contest to any felony or misdemeanor (excluding minor traffic violations)? Or, been found liable or responsible for any civil offense that is reasonably related to your qualification, competence, functions or duties as a medical professional? If yes, date: _____	☐	☐
Is your staff appointment or clinical privileges and/or scope of practice at any hospital or other healthcare facility currently under investigation?	☐	☐
Have you experienced any sanctions, restrictions and/or limitations on your licenses?	☐	☐
Have you ever been the subject of disciplinary proceedings or investigation at any hospital or healthcare facility?	☐	☐

If "Yes" to any of the questions above in this section, please "attach" the appropriate information and/or explanation in a separate document.

Do you understand and acknowledge that it is your responsibility to notify Kettering Health Physician Partners of any occurrence/event which renders the foregoing answers incorrect or incomplete when such information is received by you?	☐	☐
Do you acknowledge that all information that has been provided in the application process is accurate, complete and given proper explanation, if applicable?	☐	☐

Section II
Malpractice

Malpractice Insurance: _____

Expiration Date: _____ Spec/Ag Coverage: _____

Section III
Release of Information

AUTHORIZATION FOR RELEASE OF CREDENTIALING INFORMATION

I hereby authorize the Medical Staff Office of _____ to release upon request any and all credentialing information in its custody to determine my eligibility to participate in Kettering Health Physician Partners, LLC ("CIN")

Concerning: _____ ("Physician" or "APP")

CAQH ID: _____

GROUP NPI: _____

Tax ID: _____

Group Name (if participating in a group): _____

This authorization includes, but is not limited to, any and all information or documents related to licensure, federal or state controlled substance certification, medical education and training, medical board certification or eligibility, participation in Medicare/Medicaid and other public assistance programs, malpractice coverage and criminal history, kept in either hardcopy or electronic form, related to my status as a credentialed physician with the applicable hospital(s).

This authorization is effective now and will remain in effect until termination of my participation in CIN. I understand that I have a right to revoke in writing my consent to this disclosure at any time.

I understand that I have a right to receive a copy of this authorization. Any copy of this document shall have the same authority as the original, and may be substantial in its place.

I HEREBY AUTHORIZE THE RELEASE OF MY CREDENTIALING INFORMATION AS PROVIDED ABOVE.

Signed: _____ **Date: _____**