Dear Applicant:

Thank you for your interest in Olathe Medical Center and/or Miami County Medical Center. In order to apply for Allied Health staff appointment and/or clinical privileges, the following **Request for Application** must be completed and the following baseline standards met:

1. Current unrestricted license in the State of Kansas and a current Federal DEA number (if applicable), with no record of past adverse licensure action.
2. Maintenance of professional liability insurance coverage.
3. No record of conviction of a felony or misdemeanor related to professional practice, reimbursement or controlled substance violations.
4. No record of denial, revocation or termination of appointment or clinical privileges by any hospital for reasons related to professional competence or conduct.
5. **If an exclusive contractual agreement conflicts with your request(s) for staff appointment and/or clinical privileges you will be notified of such.**

If the baseline standards are met, you may be provided applications for staff appointment and clinical privileges.

Please print, complete, and mail the following information for consideration to:

MEDICAL STAFF SERVICES
OLATHE MEDICAL CENTER, INC.
20333 WEST 151st STREET
OLATHE, KS 66061

If you have any questions regarding the application process you may call 913-791-4309.

PLEASE REMEMBER - THIS IS THE FIRST PART OF A 2-PART APPLICATION PROCESS. NO STAFF MEMBERSHIP OR CLINICAL PRIVILEGES ARE EXTENDED OR IMPLIED BY OUR PROVIDING YOU WITH THE FOLLOWING FORM; NEITHER IS STAFF MEMBERSHIP OR CLINICAL PRIVILEGES EXTENDED OR IMPLIED AS A RESULT OF THE COMPLETION AND SUBMISSION OF THE FOLLOWING FORM.

Sincerely,

Lori A. Mann
Administrative Manager
Medical Staff Services
Olathe Medical Center, Inc.
Miami County Medical Center, Inc. *CVO*
20333 West 151st Street
Olathe, KS 66061

NAME: ______________________ SPECIALTY: ______________________

DATE OF BIRTH: ______________________ SOCIAL SECURITY NUMBER: ______________________

PRACTICE NAME: ______________________ PRACTICE ADDRESS: ______________________

PRACTICE PHONE: ______________________

SPONSORING PHYSICIAN(S): ______________________

MAILING ADDRESS (for Application packet): ______________________

____

INSTITUTION(S) WHERE APPOINTMENT AND PRIVILEGES ARE BEING SOUGHT:

OLATHE MEDICAL CENTER ☐ **MIAMI COUNTY MEDICAL CENTER** ☐

PLEASE PROVIDE THE FOLLOWING DOCUMENTATION:

A. Attach a copy of your current Kansas License and a copy of your current narcotic license (if applicable). If you are in the application process for Kansas License and/or narcotic license, please provide a copy of your application.

B. Provide copy of medical training.

C. Attach a copy of your curriculum vitae.

D. **If an exclusive contractual agreement conflicts with your request(s) for staff appointment and/or clinical privileges you will be notified of such.**

E. Attach a copy of your professional liability insurance policy showing the limits of coverage and coverage effective dates.

F. Provide copies of CPR, BLS, PALS, ACLS certification.

G. Provide copy of protocol agreement with sponsoring physician(s).

1. HAVE YOU HAD ANY ARRESTS FOR PROBLEMS ASSOCIATED WITH ALCOHOL OR DRUG USE? -------- ☐ YES ☐ NO
2. HAS YOUR LICENSE TO PRACTICE IN ANY JURISDICTION BEEN LIMITED, SUSPENDED, REVOKED, DENIED OR SUBJECT TO PROBATIONARY CONDITIONS, OR IS SUCH ACTION PENDING? ------------- ☐ YES ☐ NO
3. HAS YOUR NARCOTICS REGISTRATION BEEN SUSPENDED, DENIED, REVOKED, REDUCED OR NOT RENEWED OR IS SUCH ACTION PENDING? --- ☐ YES ☐ NO
4. HAVE YOU BEEN DENIED MEMBERSHIP TO ANY HOSPITAL MEDICAL STAFF OR HAS REAPPOINTMENT TO ANY HOSPITAL MEDICAL STAFF BEEN DENIED, OR IS SUCH ACTION PENDING?- ☐ YES ☐ NO
5. HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR HAS DISCIPLINARY ACTION BEEN TAKEN AGAINST YOU BY ANY OTHER HOSPITAL MEDICAL STAFF OR GOVERNING BOARD OR BY ANY MEDICAL ORGANIZATION OR PROFESSIONAL SOCIETY, LOCAL, STATE OR NATIONAL, OR IS SUCH ACTION PENDING? --- ☐ YES ☐ NO
6. HAVE YOUR PRIVILEGES AT ANY HOSPITAL BEEN SUSPENDED, DIMINISHED, REVOKED OR NOT RENEWED? (Temporary suspension for delinquent charts does not warrant an affirmative answer.) -------- ☐ YES ☐ NO
7. HAVE YOU VOLUNTARILY RELINQUISHED ANY MEDICAL STAFF MEMBERSHIP, CLINICAL PRIVILEGE(S), MEDICAL ORGANIZATION OR PROFESSIONAL SOCIETY MEMBERSHIP, PROFESSIONAL LICENSE(S) OR NARCOTICS REGISTRATION? -- ☐ YES ☐ NO
8. HAVE ANY PROFESSIONAL LIABILITY JUDGMENTS OR SETTLEMENTS BEEN MADE AGAINST YOU? - ☐ YES ☐ NO
9. HAVE ANY PROFESSIONAL LIABILITY SUITS BEEN FILED AGAINST YOU? ---------------------------------- ☐ YES ☐ NO
10. HAVE YOU BEEN CONVICTED OF A FELONY -- ☐ YES ☐ NO

IF THE ANSWER TO ANY OF THE ABOVE QUESTIONS IS "YES", GIVE FULL DETAILS ON A SEPARATE SHEET OF PAPER. ***YOUR REQUEST WILL NOT BE CONSIDERED WITHOUT SUCH DOCUMENTATION*.**

By applying for staff appointment and clinical privileges at Olathe Medical Center and/or Miami County Medical Center, I accept the terms and conditions set forth and intend to be legally bound thereby, and I hereby –

- Authorize the hospital, its medical staff, and its representatives to inspect all documents that may be material to an evaluation of my qualifications and competence, and consent to the release of such information
- Release from liability all representatives of the hospital and its staff for actions performed and statements made in connection with the evaluation of my application, credentials, and qualifications to the fullest extent permitted by law
- Release from liability any and all individuals and organizations who provide information to the hospital or the medical staff concerning my professional competence, background, experience, ethics, character, utilization practice patterns, and other qualifications for staff appointment and/or clinical privileges to the fullest extent permitted by law
- Acknowledge that any material misrepresentation, misstatements, or omissions from this application, whether intentional or not, constitute cause for denial of appointment and clinical privileges or cause for summary dismissal from the staff
- Acknowledge this release may be used to obtain information from state licensing boards, that may include verification of any open or closed investigations, patient complaints and standard of care determinations reported by hospital(s) and/or specialty clinic(s)
- Acknowledge this release may be used to share information regarding any open or closed investigations, patient complaints and standard of care determinations within Olathe Health System.
- (If Sponsored), I further understand that my appointment is contingent upon the medical staff membership and/or privileges of my sponsor.

APPLICANT SIGNATURE: ____ DATE: _____________________________________

SPONSOR SIGNATURE: ____

The Risk Consulting Company
Kroll Background America, Inc.

AUTHORIZATION AND RELEASE FOR THE PROCUREMENT OF
A CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORT
(PLEASE PRINT OR TYPE)

I, the undersigned consumer, do hereby authorize**, OLATHE HEALTH SYSTEMS, INC.**, by and through its independent contractor, **KROLL BACKGROUND AMERICA, INC. ("KBA")**, to procure a consumer report and/or investigative consumer report on me.

THESE ABOVE-MENTIONED REPORTS MAY INCLUDE, BUT ARE NOT LIMITED TO, INFORMATION AS TO MY CHARACTER, GENERAL REPUTATION, PERSONAL CHARACTERISTICS AND MODE OF LIVING, DISCERNED THROUGH EMPLOYMENT AND EDUCATION VERIFICATIONS; PERSONAL REFERENCES; PERSONAL INTERVIEWS; MY PERSONAL CREDIT HISTORY BASED ON REPORTS FROM ANY CREDIT BUREAU; MY DRIVING HISTORY, INCLUDING ANY TRAFFIC CITATIONS; A SOCIAL SECURITY NUMBER VERIFICATION; PRESENT AND FORMER ADDRESSES; CRIMINAL AND CIVIL HISTORY/RECORDS; ANY OTHER PUBLIC RECORD.

I understand that I am entitled to a complete and accurate disclosure of the nature and scope of any investigative consumer report of which I am the subject upon my written request to **KBA**, if such is made within a reasonable time after the date hereof. I also understand that I may receive a written summary of my rights under 15 U.S.C. § 1681et. seq.

I further authorize any person, business entity or governmental agency who may have information relevant to the above to disclose the same to**, OLATHE HEALTH SYSTEMS, INC,**, by and through **KBA**, including, but not limited to, any and all courts, public agencies, law enforcement agencies and credit bureaus, regardless of whether such person, business entity or governmental agency compiled the information itself or received it from other sources.

I hereby release**, OLATHE HEALTH SYSTEMS, INC.**, **KBA** and any and all persons, business entities and governmental agencies, whether public or private, from any and all liability, claims and/or demands, by me, my heirs or others making such claim or demand on my behalf, for providing a consumer report and/or investigative consumer report hereby authorized. I understand that this Authorization/Release form shall remain in effect for the duration of my employment with said Company.

Further, I certify that the information contained on this Authorization/Release form is true and correct and that my application or medical staff membership and clinical privileges will be terminated based on any false, omitted or fraudulent information.

Signature: ____

Printed Name:___________________________________ Date: ______________
First Middle Last

Current Address:____
(RESIDENCE) Street /P. O. Box City State County Dates

Former Address: ____
(RESIDENCE) Street /P. O. Box City State County Dates

Former Address: ____
(RESIDENCE) Street /P. O. Box City State County Dates

Social Security Number: ________________ Daytime Telephone Number: ______________

Driver's License Number: ____________ State of Issuance: ____ Date of Birth*: Gender*: _____

- Have you ever been convicted of a crime or convicted in a military court martial? Yes____ No____
- Have you ever been sanctioned or had your licenses suspended or revoked? Yes____ No____
- Are you currently under any investigation or pending charge? Yes____ No____