State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
Phone: (614) 466-3934
Web: www.med.ohio.gov

APPLICATION FOR CERTIFICATE OF GOOD STANDING AS A TREATMENT PROVIDER FOR IMPAIRED PRACTITIONERS PACKET

Dear Treatment Provider:

This application must be completed by any provider of chemical dependency treatment services that wish to have approval from the State Medical Board of Ohio to provide treatment for impaired practitioners in accordance with Section 4731.25, Ohio Revised Code.

Thoroughly read the instructions and Ohio Administrative Code Chapter 4731-16 prior to completing this application. After the Board has received and reviewed the properly completed application, if no further information is required, you will be issued a Certificate of Good Standing, valid for a period of three years.

If you have any questions regarding this packet please contact Alexandra Murray, Esq., at (614) 466-9304.

APPLICATION FOR CERTIFICATE OF GOOD STANDING AS A TREATMENT PROVIDER FOR IMPAIRED PRACTITIONERS

Applicant Contact Information

Treatment Provider (Applicant) Name

Address

Telephone Number

Fax Number

Treatment Provider Owner Contact Information

Name of Treatment Provider Owner:
(If sole proprietor, give full name)

Address

Telephone Number

Fax Number

General Questions

YES NO

1. Does the applicant base its philosophy and individualized treatment plan on the disease concept of chemical dependency?

2. Does the applicant base its model of treatment on a twelve-step program such as Alcoholics Anonymous?

3. Does the applicant adhere to the principle that treatment of chemical dependency requires total abstinence from alcohol and other mind-altering drugs?

4. Is the applicant subject to the confidentiality requirements of Title 42, Part 2, of the Code of Federal Regulation?

5. Is the applicant able and willing to comply with the requirements of Rule 4731-16-05 in examining individuals under the jurisdiction of the State Medical Board of Ohio, including the requirement of 72 hours inpatient monitoring as applicable?

6. Is the applicant able and willing to comply with the provisions of Rule 4731-16-08(A)(12), Ohio Administrative Code, requiring that all patients under the jurisdiction of the State Medical Board of Ohio, with the exception of those patients that meet the requirements of paragraph (A)(13) of the rule, must receive at least 28 days of inpatient or residential treatment by a Board approved treatment provider?

7. Is the applicant able and willing to comply with the requirements of Rule 4731-16-5 (A)(3)(B)(i) through (v), for those individuals who qualify for an outpatient assessment?

8. Is the applicant able and willing to comply with the requirements of Rule 4731-16-08(A)(13), for those individuals who qualify for intensive outpatient treatment?

9. Is the applicant accredited by the Joint Commission to provide substance abuse treatment? **(attach a copy of Joint Commission accreditation certificate)**

10. Does the applicant hold a current state certificate to provide treatment for substance abuse/addiction at the following sites on the dates indicated below: **(attach a copy of the certificate)**

1. Describe in detail the evaluation process and procedures used to identify patterns, progressions, and stages of recovery during treatment. Include details regarding level of involvement with a certified addictionologist, the medical director, and treatment team.

2. Describe any procedures used to assess treatment success rates (e.g. - surveys of former patients, collaterals).

3. Describe how the treatment provider involves family and significant others in the patient's treatment.

4. List all agencies and professionals to which the applicant refers patients and significant others to meet needs which exceed the applicant's expertise or available facilities.

5. List other services provided at this program site and including details regarding medical and nursing services provided for patients in each stage of treatment.

6. Describe the applicant's procedures to arrange payment for treatment costs not covered by insurance.

PROGRAM SITE FORM
(location where treatment services are delivered)

Please provide the following information for each individual program site operated by the applicant. This page may be copied and attached when multiple program sites are operated. **Please attach a table of organization and a list of the names and position titles of all licensed physicians on staff.**

Treatment Provider (Applicant) Name

Address

Telephone Number

Fax Number

Medical Director

Addictionologist

Contact Name and Title

Contact Number

Contact Email

Place a check mark in the box of each service listed below that is available at this program site:

Intensive inpatient treatment (Medical, nursing care, and therapy are provided. Patients are not permitted to leave facility.)

Residential treatment (Patients reside in facility or other accommodations, but are permitted to leave while accompanied by other patients.)

Intensive outpatient treatment (Patients spend days or nights at the facility and are permitted to leave facility each day.)

Aftercare (Minimum 104 sessions over a minimum of 2 years)

72-hour evaluation to determine initial treatment needs

Fitness to return to practice evaluations

AGREEMENT OF APPLICANT

By execution of the Affidavit and Release of Applicant, the applicant agrees that upon the issuance of a Certificate of Good Standing:

1. It shall be bound by and comply with the requirements contained in Chapter 4731., Ohio Revised Code, and Chapter 4731-16, Ohio Administrative Code; and

2. It shall provide appropriate training to its staff to assure compliance; and

3. It shall provide to each patient and referral source who is under the jurisdiction of the State Medical Board of Ohio the written statements and notices required by the Board; and

4. It shall immediately notify the State Medical Board of Ohio if changes occur, including, but not limited to, transfer of ownership of the program; change in location or locations of the program; or change of directorship, which could affect its eligibility for approved status under Section 4731.25, Ohio Revised Code, or Chapter 4731-16, Ohio Administrative Code

AFFIDAVIT AND RELEASE OF APPLICANT

The affidavit and release below must be completed by BOTH the chief executive officer and the medical director of the applicant treatment provider. The form MUST be notarized. Failure to submit the affidavit and release completed and notarized with the application will result in the application being considered incomplete.

State of
County of

On behalf of _____, an applicant for a certificate of good standing as a treatment provider for impaired practitioners, the undersigned hereby certify under oath that we are the duly appointed chief executive officer and medical director, respectively, of the applicant; that we submit this application under the authority of the governing body of the applicant; that all statements we have made or shall make with respect to the application are true; and that all document forms, or copies thereof furnished or to be furnished with respect to this application are strictly true in every respect.

We acknowledge that we have read and are able to provide services in compliance with Section 4731.25, Ohio Revised Code and Chapter 4731-16, Ohio Administrative Code.

We further state that by filing this application for a certificate of good standing as a treatment provider for impaired practitioners, we hereby authorize and consent to have an investigation made as to the applicant's qualifications to provide such treatment. We agree to give any further information which may be required in reference to the applicant's qualifications or eligibility for approval.

We further understand that this application of a certificate of good standing as a treatment provider for impaired practitioners is an ongoing process. We will immediately notify the State Medical Board of Ohio in writing of any changes to the answers of any questions contained in the application if such changes occur at any time prior to a certificate of good standing being granted by the State Medical Board of Ohio.

On behalf of the applicant, we authorize every person, hospital, clinic governmental agency (local, state, or federal), court, association, institution, or law enforcement agency having control of any documents, records, and other information pertaining to the application to furnish to the State Medical Board of Ohio any such information, documents, or records, including records regarding charges or complaints filed against the applicant, formal or informal, pending or closed, and we authorize the State Medical Board of Ohio or any of its agents or representative to inspect and make copies of such documents, records, and other information in connection with this applicant, subsequent grant of a certificate of good standing or practice thereunder.

On behalf of the applicant and acting under the authority of its governing body, we hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. We authorize the State Medical Board of Ohio to release information, material, documents, order or the like relating to the applicant or to this application to any governmental agency (local, state, or federal); or to any hospital, nursing home, clinic, health maintenance organization or similar institution; or to any professional association.

We further understand the issuance of a certificate of good standing will be considered based on the truth of the statements and documents contained herein or to be furnished, which if false, can subject the applicant to denial of said certificate.

Signature of Chief Executive Officer

Signature of Medical Director

(NOTARY SEAL) Subscribed and sworn to before me this day of 20

Notary Public Signature

Date Commission Expires