



State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.state.oh.us/med/

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

GENERAL INFORMATION AND INSTRUCTIONS

This application must be completed by any provider of chemical dependency treatment services who wishes to obtain approval from the State Medical Board of Ohio to treat impaired practitioners in accordance with Section 4731.25, Ohio Revised Code. Thoroughly read these instructions and the enclosed rules, Chapter 4731-16, Ohio Administrative Code, before completing the application. After the State Medical Board of Ohio has received and reviewed the properly completed application, it will schedule and conduct an on-site inspection, and any further investigation deemed necessary to assure compliance with the applicable laws, before notifying the applicant of its decision.

- 1) Complete the entire application and attach all required documentation. An application submitted with questions left blank or with documentation missing will be considered an incomplete application, and will not be processed by the State Medical Board of Ohio.
- 2) If additional space is required to answer any question(s), attach an additional sheet or sheets, designating the question(s) referred to.
- 3) Complete the applicant's portion of the VERIFICATION OF STATE CERTIFICATION Form and mail it to the Ohio Department of Alcohol and Drug Addiction Services, or, if the applicant is located outside Ohio and not certified by the Ohio agency, to the appropriate certifying agency in the state where treatment services are provided.
- 4) There is NO FEE required for this application.
- 5) The applicant's chief executive officer and medical director must properly execute the Affidavit and Release of Applicant. The signatures must be notarized.
- 6) Return the completed application to:

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43215-6127

(1) Treatment Provider (applicant) Name: _____

(2) Mailing Address (NOTE: Do not use a Post Office Box Number):

Street

City State Zip Code

(3) Telephone Number: () _____

(4) Complete the Applicant's portion of the VERIFICATION OF STATE CERTIFICATION form and mail it to the appropriate certifying agency.

(5) Name of Treatment Provider Owner. If a sole proprietor, give full name.

Mailing Address (NOTE: Do not use a Post Office Box Number):

Street

City Street Zip Code

Telephone Number

(6) Legal Structure of Treatment Provider Owner:

___ Sole Proprietor

___ Partnership

___ Corporation For Profit Chartered in the State of _____

___ Corporation Not For Profit Chartered in the State of _____

___ Professional Association

___ Other (Please Describe): _____

(7) Type of Governing Body (e.g. - Board of Trustees; Board of Directors):

(8) Describe composition and method of appointment of members of Governing Body:

(Attach a table of organization that reflects lines of authority and relationship with the Governing Body.)

(9) Provide the following information for each Program Site operated by the applicant. If the applicant operates more than one Program Site, photocopy this page and complete and attach for each Program Site.

PROGRAM SITE (where treatment services are delivered)	
Name: _____	
Street Address: _____	
City: _____	
State: _____	Zip Code: _____
County: _____	
Telephone Number: () _____	
Hours of operation for services at this site:	
Monday through Friday: _____	
Saturday: _____	
Sunday: _____	
Holidays: _____	
Indicate treatment services provided at this site. Place a check mark in the box of each service listed below that is available at this program site:	
<input type="checkbox"/> Intensive inpatient.	<input type="checkbox"/> Medical/somatic.
<input type="checkbox"/> Intensive outpatient (day/night treatment).	<input type="checkbox"/> Hospital detoxification.
<input type="checkbox"/> Extended residential care.	<input type="checkbox"/> Freestanding residential detoxification.
<input type="checkbox"/> Assessment.	<input type="checkbox"/> Ambulatory medical detoxification.
<input type="checkbox"/> Individual and group counseling.	<input type="checkbox"/> Ambulatory social detoxification.
<input type="checkbox"/> Case management.	<input type="checkbox"/> Aftercare.
<input type="checkbox"/> Crisis intervention.	<input type="checkbox"/> Toxicology screening.
<input type="checkbox"/> Referral and information.	<input type="checkbox"/> Methadone administration.
Please list other services provided at this program site: _____	

(10) Is the applicant subject to the confidentiality requirements of Title 42, Part 2, of the Code of Federal Regulation? YES NO

(11) Is the applicant accredited by JCAHO to provide substance abuse treatment? YES NO

If not, has it applied for accreditation? YES NO

(Attach a copy of JCAHO accreditation certificate and JCAHO reports reflecting the most recent review of inspection)

(12) Are costs of the applicant's treatment program covered by most insurance policies that provide coverage for alcohol/substance abuse treatment? YES NO

(13) List any insurance companies or other third party payers that have given pre-approval to cover treatment. _____

(14) Describe the applicant's procedures to arrange payment for treatment costs not covered by insurance. _____

(15) Does the applicant offer advocacy services at a cost to the patient? YES NO

If yes, attach a copy of the standard advocacy contract(s).

(16) Describe in detail the medical and nursing services the applicant provides for patients in each stage of treatment, including detoxification treatment. _____

(17) List the names, position titles and specialties of all licensed physicians on staff, indicating which if any are certified by the American Society of Addiction Medicine. _____

(Attach copies of ASAM Certificates)

(18) List treatment plan options which the applicant provides (e.g. - inpatient, outpatient, extended residential care, aftercare), indicating number of days, weeks, or months in each stage of treatment. _____

(19) 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. _____

(20) Describe in detail the applicant's facilities and procedures for conducting toxicology screens, including measures taken to prevent tampering with specimens, to assure proper chain of evidence, and to verify positive screens. Attach copy of submission/chain of evidence form (custody and control form) and any associated instructions. (See below if testing is done by an independent facility.) _____

(21) If toxicology testing is done by contract with an independent facility or facilities, attach copy of contract(s). If no written contract exists, describe in detail the agreement between the applicant and the testing facility, and explain the mechanics of testing. _____

(22) Describe in detail the evaluation process and procedures used to identify patterns, progressions, and stages of recovery during treatment. _____

(23) Describe services available to family and significant others. _____

(24) Describe how the applicant involves family and significant others in the patient's treatment. _____

- (25) Does the applicant adhere to the principle that treatment of chemical dependency requires total abstinence from alcohol and other mind-altering drugs? YES NO
- (26) Does the applicant base its philosophy and individualized treatment plan on the disease concept of chemical dependency? YES NO
- (27) Does the applicant base its model of treatment on a twelve-step program such as Alcoholic's Anonymous? YES NO
- (28) Describe any procedures the applicant uses to assess treatment success rates (e.g. - surveys of former patients).
- (29) 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? YES NO
- (30) Is the applicant able and willing to comply with the provisions of Rule 4731-16-08(A)(13), Ohio Administrative Code, requiring that all patients under the State Medical Board's jurisdiction receive at least 28 days of inpatient or residential treatment by a Board approved treatment provider?
 YES NO

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 the general information and instructions and that we have answered all questions in compliance with those instructions.

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.

(NOTARY SEAL)

Signature of Chief Executive Officer

Title

Signature of Medical Director

Title

Subscribed and sworn to before me this _____ day of _____ 200_

Notary Public Signature

Date Commission Expires

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 which could effect its eligibility for approved status under Section 4731.25, Ohio Revised Code, or Chapter 4731-16, Ohio Administrative Code; and
- (5) It shall notify the State Medical Board of Ohio of any transfer of ownership of the program or change in location or locations of the program prior to such transfer or change becoming effective.



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TREATMENT PROVIDER FOR IMPAIRED MEDICAL PRACTITIONERS

VERIFICATION OF STATE CERTIFICATION

MAIL TO THE OHIO DEPARTMENT OF ALCOHOL AND DRUG ADDICTION SERVICES OR
TO CERTIFYING AGENCY IN STATE WHERE TREATMENT SERVICES ARE PROVIDED.

Dear Sir:

_____ is applying for a Certificate of Good Standing to provide treatment to impaired practitioners in accordance with Section 4731.25, Ohio Revised Code. The State Medical Board of Ohio requires that the applicant's status with your agency be certified. Please complete this form and return it directly to the State Medical Board of Ohio.

TO BE COMPLETED BY APPLICANT

Name of Applicant

Complete Street Address (number & street, city, state and zip code) of Program Site Certified

Complete Street Address (number & street, city, state and zip code) of Program Site Certified

(If more than two program sites are certified, list additional addresses on a separate sheet and attach.)

TO BE COMPLETED BY VERIFYING AGENCY

NOTE: The applicant is responsible for payment of any fees charged for the completion of this form. Such fees will not be paid by the STATE MEDICAL BOARD OF OHIO.

TREATMENT PROVIDER FOR IMPAIRED MEDICAL PRACTITIONERS
VERIFICATION OF STATE CERTIFICATION
PAGE TWO

State Agency Title

Complete Mailing Address (number, street, city, state and zip code)

Telephone Number

The above named applicant has been granted a certificate or certificates to provide treatment for substance abuse/addiction at the following sites on the dates indicated below:

Site address Date Certified

Site address Date Certified

Are all listed certificates current? Yes No If not, please explain: _____

**(AFFIX AGENCY SEAL)
(NOT VALID WITHOUT SEAL)**

Signature

Title

Date

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OHIO 43215-6127