

Instructions to Initiate Temporary Privileges - Medical Staff:

1. Completion and submission of the COVID-19 Temporary Privilege Request Form found below.
 - a. Print Form below: Request for Temporary Privileges
 - b. Complete the attestation form. Sign and Date

2. Completion and submission of the applicable Delineation of Privileges (for the privileges being requested) is submitted to the Centralized Credentialing Office.
[\(<https://www.ketteringhealth.org/medstaff/physician.cfm>\)](https://www.ketteringhealth.org/medstaff/physician.cfm)
 - a. Choose Facility
 - b. Choose Current Dept / Current Specialty
 - c. Print the DOP Form, Complete, Sign and Date

3. Communication of temporary privilege, and input of approved clinical privileges shall be communicated by the Medical Staff Services department.

4. Options for Delivery:
 - a) Fax all documents to Central Credentialing: **937-522-9990**
 - b) Sent all documents via email: CCO@ketteringhealth.org

REQUEST FOR TEMPORARY PRIVILEGES
Important Patient Care Need
(COVID-19 Pandemic)

Applicant Name: _____ Date Requested: _____

Current Member of Medical Staff with Clinical Privileges at following KHN Hospital(s) (*list all that apply*):

Current Medical Staff Category: _____

Current Clinical Services Department: _____ Current Specialty: _____

I am requesting temporary privileges to meet an important patient care need at the following additional Kettering Health Network hospital(s):

- Fort Hamilton Hospital
- Grandview/Southview Medical Center
- Greene Memorial Hospital
- Kettering Medical Center
- Soin Medical Center
- Sycamore Medical Center (includes KBMC)
- Troy Hospital

To fulfill an important patient care, treatment, and/or service need (*please provide explanation for this request*)

- COVID-19 Pandemic
- Other (*please specify below*)

Attestation

I hereby request temporary privileges (for an important patient care need) to exercise the clinical privileges specified in the attached Delineation(s) of Privileges at the additional Kettering Health Network hospital location(s) noted above. I am requesting only those clinical privileges for which by licensure, education, training, current experience, and demonstrated performance, I am qualified and clinically competent to perform. I agree to abide by the Medical Staff governing documents and applicable policies and procedures of the applicable KHN hospital(s) with respect to any clinical privileges granted.

Signature of Applicant

Date

Note: Applicant must complete, date, sign, and provide (with this application) the applicable Delineation of Privileges for each KHN hospital at which temporary privileges are requested.

Applicable KHN hospital signature page to be completed by those individuals responsible for the temporary privileging process at the applicable KHN hospital location(s) specified above.