



# **State Medical Board of Ohio**

30 East Broad Street, 3rd Floor, Columbus, Ohio 43215-6127 (614) 466-3934 Website: [www.med.ohio.gov](http://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 continued 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 Danielle Bickers, Compliance Supervisor, State Medical Board, Compliance Section at (614) 644-9085.

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

**Applicant Contact Information**

Treatment Provider (Applicant) Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**Treatment Provider Owner Contact Information**

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

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**General Questions**

1. Does the applicant base its philosophy and individualized treatment plan on the disease concept of chemical dependency?  Yes  NO
2. Does the applicant base its model of treatment on a twelve-step program such as Alcoholic's Anonymous?  Yes  NO
3. Does the applicant adhere to the principle that treatment of chemical dependency requires total abstinence from alcohol and other mind-altering drugs?  Yes  NO
4. Is the applicant subject to the confidentiality requirements of Title 42, Part 2, of the Code of Federal Regulation?  Yes  NO
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?  Yes  NO
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?  Yes  NO
7. Is the applicant able and willing to comply with the requirements of Rule 4731-16-05 (A)(3)(B)(i) through (v), for those individuals who qualify for an outpatient assessment?  Yes  NO

**General Questions (Continued)**

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?  Yes  NO

9. Is the applicant accredited by the Joint Commission to provide substance abuse treatment? (Attach a copy of Joint Commission accreditation certificate)  Yes  NO

10. If you answered NO to the previous question, have you applied for Joint Commission accreditation?  Yes  NO

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

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

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13. Describe how the applicant involves family and significant others in the patient's treatment.

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14. Describe any procedures the applicant uses to assess treatment success rates (e.g. - surveys of former patients).

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15. 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.

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**PROGRAM SITE FORM**  
(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.

Name \_\_\_\_\_

Street Address \_\_\_\_\_ County \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Medical Director \_\_\_\_\_

Contact Name and Title \_\_\_\_\_

Contact Number \_\_\_\_\_ Contact Email \_\_\_\_\_

Please attach a table of organization and a list of the names and position titles of all licensed physicians on staff.

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

- |   |  |
|---|--|
| <input type="checkbox"/> Intensive inpatient treatment (Medical, nursing care, and therapy are provided. Patients are not permitted to leave facility.)               | <input type="checkbox"/> Hospital detoxification                                 |
| <input type="checkbox"/> Residential treatment (Patients reside in facility or other accommodations, but are permitted to leave while accompanied by other patients.) | <input type="checkbox"/> Medication assisted treatment                           |
| <input type="checkbox"/> Intensive outpatient treatment (Patients spend days or nights at the facility and are permitted to leave facility each day.)                 | <input type="checkbox"/> Aftercare   |
|   | <input type="checkbox"/> 72-hour evaluation to determine initial treatment needs |
|   | <input type="checkbox"/> Fitness to return to practice evaluations               |

Please list other services provided at this program site:

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

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# TREATMENT PROVIDER FOR IMPAIRED MEDICAL PRACTITIONERS VERIFICATION OF STATE CERTIFICATION FORM

The below named applicant 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 to the applicant.

## TO BE COMPLETED BY APPLICANT

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

Name of Applicant \_\_\_\_\_

Complete Mailing Address  
of Program Site Certified \_\_\_\_\_

Complete Mailing Address  
of Program Site Certified \_\_\_\_\_

## TO BE COMPLETED BY VERIFYING AGENCY

NOTE: The applicant is responsible for payment of any fees charged for the completion of this form.

State Agency Title \_\_\_\_\_

Complete Mailing Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

**The above named applicant holds a current 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 \_\_\_\_\_

(AFFIX AGENCY SEAL)

Signature \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_

## **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.

# 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

\_\_\_\_\_  
Title

(NOTARY SEAL)

\_\_\_\_\_  
Signature of Medical  
Director

\_\_\_\_\_  
Title

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_  
Notary Public Signature

\_\_\_\_\_  
Date Commission Expires