Appendix A

UT/UTP Practice Locations Pre-Approved by the Executive Vice President for Clinical Affairs

- Community Care Clinic (all locations)
- Dana Cancer Center
- Fallen Timbers (3100 Main Street, Maumee)
- Glendale Medical Center
- Glendale Medical East
- Kobacker Center
- Main Campus Medical Center
- Maumee Cardiology Clinic
- ProMedica Facilities
    - ProMedica Bay Park Hospital
    - ProMedica Bixby Hospital
    - ProMedica Center for Health Services
    - ProMedica Defiance Regional Hospital
    - ProMedica Flower Hospital
    - ProMedica Fostoria Community Hospital
    - ProMedica Health and Wellness Center
    - ProMedica Herrick Hospital
    - ProMedica Hickman Cancer Center
    - ProMedica Memorial Hospital
    - ProMedica Monroe Regional Hospital
    - ProMedica Parkway Surgery Center
    - ProMedica Toledo Hospital
    - ProMedica Toledo Children's Hospital
    - ProMedica Wildwood Orthopaedic and Spine Hospital
- Regency Office (1000 Regency Court, Toledo)
- Regional Center for Sleep Medicine (4041 W. Sylvania Ave., Toledo)
- Rehabilitation Hospital of Northwest Ohio (1455 W. Medical Loop, Health Science Campus)
- Rocket Pediatrics – Waterville (1089 Pray Blvd., Waterville)

- Ruppert Health Center
- Sports Medicine Program (Various school locations)
- The University of Toledo Medical Center (including Medical Pavilion and Isaac Surgery Center)
- UT Collaborative Medical Practice at Falzone

UT Pediatrics – Perrysburg (1103 Village Square Dr., Perrysburg)

Appendix B
PRACTICE LOCATION APPROVAL FORM

- Use one Approval Form for each practice location.
- Attach fully completed forms specific to this location:
  - ✓ Practice Location Fact Sheet
  - ✓ Procedure Checklist
- Forward Approval Form & attachments to Department Chairperson.

Practitioner Name: ________________________________ Date of Request: ________________

Specialty: ____ Department: ____________________

Location Name: ____

Please check one: √

☐☐ This location request is part of my initial employment process.

-- OR --

☐☐ This location is being requested as a new location to my existing approved locations.

Approval Process

Department Chairperson: ☐ ☐☐ Approved ☐☐ Not Approved Comments: ____ Signature: ______________________________________ Date: ____________________
Executive Vice President for Clinical Affairs: ☐☐ Approved ☐☐ Not Approved Comments: ____ Signature: ______________________________________ Date: ____________________

UTP Executive Director: ☐ ☐☐ Approved ☐☐ Not Approved Comments: ____ Signature: ____ Date: ____________________

3-24-16

Return Fully Signed Approval Form and Attachments to
UTMC Administrator for Risk Management

Appendix C
Practice Location Fact Sheet

The University of Toledo Insurance Program
The University of Toledo Physician, LLC Provider Enrollment

Fully complete a separate Fact Sheet & Procedure Checklist for each of your practice locations.
(Note: The Procedure Checklist is completed ONLY for physicians)

1. Practitioner's Name:
____

2. Practice Location Name:
____

3. Practice Location Address:
____

4. Practice Location Phone: _________________________________ Fax:
____

5. Type of Privileges (as applicable): ___ Admitting ___ Non-admitting (Explain ________________________)

5a. Approximately how many hours per week will be spent at this location:
____

6. Does or are you requesting UTP provide the professional liability insurance coverage at this location? If another insurer provides insurance, please give the name of the insurance company: ____	UT Physicians	Yes ☐ No ☐

7. Does or will UTP bill for the services provided at this location? If you use another billing service, please give the name of that billing service: ____________________________	UT Physicians	Yes ☐ No ☐
8. By practicing at this location, is the **TEACHING MISSION** of UT is supported? Please explain whether you teach students other than medical students, residents/fellows and any other teaching activities: ____________________________ ____________________________	I Do Teaching At Site Medical Students Residents/Fellows Other Students (explain)	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
9. By practicing at this location, is the **RESEARCH MISSION** of UT directly supported (e.g. patients will be recruited for clinical/non-clinical trials)? Explain a 'Yes' answer: ____________________________ ____________________________		Yes ☐ No ☐
10. By practicing at this location, is the **STRATEGIC MISSION** of UT directly supported (e.g. promoting outreach and business growth UTMC or UTP)? Explain a 'Yes' answer: ____________________________ ____________________________ ____________________________		Yes ☐ No ☐

11. The service provided at this location will be [check the appropriate boxes]:

Inpatient (Hospital)	Yes ☐ No ☐	Clinic/Office	Yes ☐ No ☐	Long Term Care	Yes ☐ No ☐
Outpatient (Hospital)	Yes ☐ No ☐	Emergency Medicine	Yes ☐ No ☐	Other	Yes ☐ No ☐

12. Additional comments or information about this location:

____

____

____

Practice Location Procedure Checklist

(Note: The Procedure Checklist is completed ONLY for physicians)

The University of Toledo Insurance Program
The University of Toledo Physicians, LLC Provider Enrollment

1. Practitioner's Name:

____

2. Practice Location Name:

____

Please classify your surgical practice at this indicated location, if applicable:			

☐ Abdominal
☐ Cardiac
☐ Cardiovascular Disease
☐ Colon and Rectal
☐ Emergency Medicine
☐ Gastric Bypass/Bariatric Surgery
☐ General
☐ Gynecological
☐ Hand
	☐ Head and Neck
	☐ Laryngology
	☐ Neurology
	☐ Obstetrics
	  ☐ Normal Deliveries
	  ☐ C-Sections
	  ☐ Vaginal Birth after C-Section
	☐ Ophthalmology
		☐ Orthopedic
		  ☐ Spine Surgery
		  ☐ No Spine Surgery
		☐ Otology
		☐ Otorhinolaryngology
		  ☐ Including elective cosmetic procedures
		  ☐ Not including elective cosmetic procedures
		☐ Plastic
			☐ Podiatry
			☐ Rhinology
			☐ Thoracic ____% of Practice
			☐ Urology
			☐ Vascular ____% of Practice
			☐ Other ________________

Please check any of the following procedures you want to perform, at this indicated location, under the insurance coverage you are applying for:

☐ Abortion - Elective
☐ Acupuncture
☐ Adenoidectomy
☐ Anesthesia
  ☐ Spinal
  ☐ Caudal
  ☐ Conc. Sedation
  ☐ General
  ☐ Other
☐ Angiography
☐ Angioplasty
☐ Appendectomy
☐ Arteriography
☐ Assist in Major Surgery
  ☐ On own patients
  ☐ On patients of others
☐ Blepharoplasty
☐ Breast Biopsy
☐ Breast Implant
  ☐ Cosmetic _____% of practice
  ☐ Reconstructive _____% of practice
☐ Bronchoscopy
☐ Chemonucleolysis
☐ Cholecystectomy
☐ Cholecystectomy, Laparoscopic
☐ Colonoscopy
☐ Cyrosurgery (other than external lesions)

☐ Dermatological Procedure
  ☐ Chemical Peel
  ☐ Chemobrasion
  ☐ Dermabrasion
  ☐ Fat Transfer
  ☐ Hair Transplant
  ☐ Silicone Injection
  ☐ Tumescent Liposuction
  ☐ Other
☐ Dermatopathology
☐ D&C
☐ Encephalography
☐ Endoscopic laser therapy
☐ Endoscopy other than Proctoscopy, Sigmoidoscopy, Coloscopy & Cystoscopy
☐ ERCP
☐ Exchange transfusion in newborns
  How many per year?________
☐ Fluoroscopy
☐ Fracture Reduction
  ☐ Open
  ☐ Closed
☐ Gastroscopy
☐ Hip nailing
☐ Hyperbaric Medicine
☐ Hysterectomy

☐ Intensive Care for Newborns Within a Tertiary Care Unit
☐ Laminectomy
☐ Laparoscopy
☐ Laser Hair Removal
☐ Laser Skin Resurfacing
☐ Laser Surgery
☐ Left Heart Catheterization
☐ Liposuction
☐ Lithotripsy
☐ Mammography
☐ Myelography
☐ Norplant Insertion/Extraction
☐ Organ Transplant
☐ Pain Management
  ☐ Medication Only
  ☐ Dorsal Root Gangliotomy
  ☐ Sympathectomy
  ☐ Spinal Cord Stimulator
  ☐ Implantation/Removal Drug Infused Pump
  ☐ Sphenopalatine Lesioning
  ☐ Trigeminal Lesioning
  ☐ Cordotomy
  ☐ Other
____

☐ Pedicle Screws for Spinal Surgery
☐ Permanent Pacemaker
☐ Polypectomy
☐ Prenatal Care
☐ Radiation/X-Ray Therapy
☐ Radiopaque Dye
☐ Robotic Surgery
☐ Scoliosis Surgery
☐ Shock Therapy
☐ Spinal Fusion
☐ Thyroidectomy
☐ Tonsillectomy
☐ Tubal ligation
☐ Vasectomy
☐ Weight Control ____% of practice
  ☐ Gastric Bubble
  ☐ Gastric Stapling
  ☐ Medications Prescribed:
    ____
    ____
    ____
☐ Other Procedures (please list):
    ____
    ____
    ____