
RO-ILS Enrollment Form

INSTRUCTIONS:

Please complete and email this form to radoncsupport@claritygrp.com or mail to RO-ILS Program PSO Staff at 8601 West Bryn Mawr Ave, Suite 110, Chicago, IL 60631.

Sections I, II, **and** III are **required** in all instances.

Within five to seven business days upon receipt, you will receive communication from Clarity PSO regarding the process for RO-ILS enrollment (contracting, onboarding and implementation). Please contact Clarity PSO (radoncsupport@claritygrp.com; 708-667-7730) for any questions.

I. *PRACTICE SETTING

Provide the name and address of the main entity that will be enrolling in RO-ILS and contracting with Clarity.

Practice Name: _____

Address: _____

City: _____ State: _____ Postal Code: _____

Indicate the practice type:

- Academic/University System
- Private Practice/Community-based system
- Government

Total number of facilities joining RO-ILS: _____

How did you first hear about the RO-ILS? (Select all that apply)

- Association Newsletter/Emails
- Association Website
- Association Annual Meetings
- Association Specialty Meeting
- Mailed Marketing
- Association Social Media
- Advertisement in Journals
- Referral, specify who and their institution: _____
- Other: _____

Does the practice collect/submit safety data to any of the following systems? (Select all that apply)

- Hospital patient safety organization (PSO)
- RO-specific local incident learning system
- Hospital incident learning system/database
- None, we will only be reporting to RO-ILS

*Required Section

II. *PRACTICE REPRESENTATIVES

Authorized Representative

The Authorized Representative is the designated person with authority to sign contracts with Clarity.

First Name: _____ Last Name: _____

Title: _____

Email: _____

Phone (Including Ext.): _____ Degree(s): _____ (e.g., MD, PhD, BS)

PSO Liaison

The PSO Liaison is the primary contact for RO-ILS from the practice and is responsible for overall participation in RO-ILS by all facilities covered under the contract.

First Name: _____ Last Name: _____

Title: _____

Email: _____

Phone (Including Ext.): _____ Degree(s): _____ (e.g., MD, PhD, BS)

III. *FACILITY SETTING AND CONTACTS

Please list all sites or locations that will participate in the RO-ILS program under this practice. If the location listed in Part I will be contributing data to RO-ILS, please re-enter the facility name and address here. The total number of facilities listed here should match the number provided in Part I. If you have more than 2 additional facilities participating, please complete the additional pages found at the end of the form.

1	Facility Name: _____
	Address: _____ _____
	City: _____ State: _____ Postal Code: _____
	Contact Person #1 Name: _____
	Email: _____
	Contact Person #2 Name: _____
	Email: _____
	Indicate the practice location for this facility: <input type="radio"/> Free standing/Satellite Clinic <input type="radio"/> Hospital
	Facility size based on annual total number of unique patients: <input type="radio"/> Small (0 – 499) <input type="radio"/> Medium (500 – 999) <input type="radio"/> Large (1000 – 1499) <input type="radio"/> Jumbo (1500+)
	Number of full-time radiation oncologists: _____ FTE (e.g., 5 FTE or 2.5 FTE)

IIIB. FACILITY SETTING AND CONTACTS, CONTINUED

If you have additional facilities enrolling under this practice, please complete this section. If your practice has more than 6 facilities, please contact radoncsupport@claritygrp.com.

3	<p>Facility Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>City: _____ State: _____ Postal Code: _____</p> <p>Contact Person #1 Name: _____</p> <p> Email: _____</p> <p>Contact Person #2 Name: _____</p> <p> Email: _____</p> <p>Indicate the practice location for this facility:</p> <p><input type="radio"/> Free standing/Satellite Clinic</p> <p><input type="radio"/> Hospital</p> <p>Facility size based on annual total number of unique patients:</p> <p><input type="radio"/> Small (0 – 499)</p> <p><input type="radio"/> Medium (500 – 999)</p> <p><input type="radio"/> Large (1000 – 1499)</p> <p><input type="radio"/> Jumbo (1500+)</p> <p>Number of full-time radiation oncologists: _____ FTE (e.g., 5 FTE or 2.5 FTE)</p>
4	<p>Facility Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>City: _____ State: _____ Postal Code: _____</p> <p>Contact Person #1 Name: _____</p> <p> Email: _____</p> <p>Contact Person #2 Name: _____</p> <p> Email: _____</p> <p>Indicate the practice location for this facility:</p> <p><input type="radio"/> Free standing/Satellite Clinic</p> <p><input type="radio"/> Hospital</p> <p>Facility size based on annual total number of unique patients:</p> <p><input type="radio"/> Small (0 – 499)</p> <p><input type="radio"/> Medium (500 – 999)</p> <p><input type="radio"/> Large (1000 – 1499)</p> <p><input type="radio"/> Jumbo (1500+)</p> <p>Number of full-time radiation oncologists: _____ FTE (e.g., 5 FTE or 2.5 FTE)</p>

Facility Name: _____

Address: _____

City: _____ State: _____ Postal Code: _____

Contact Person #1 Name: _____

Email: _____

Contact Person #2 Name: _____

Email: _____

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Indicate the practice location for this facility:

Free standing/Satellite Clinic

Hospital

Facility size based on annual total number of unique patients:

Small (0 – 499)

Medium (500 – 999)

Large (1000 – 1499)

Jumbo (1500+)

Number of full-time radiation oncologists: _____ FTE (e.g., 5 FTE or 2.5 FTE)

Facility Name: _____

Address: _____

City: _____ State: _____ Postal Code: _____

Contact Person #1 Name: _____

Email: _____

Contact Person #2 Name: _____

Email: _____

6

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