midland memorial hospital

Allied Health Professional Initial Application

READ THIS INFORMATION FIRST

The following is required information for medical staff membership and privileges at Midland Memorial Hospital.

You will be required to submit all outlined documentation.

Your application will not be accepted if it is incomplete and will be returned to you until you are able to provide all required items.

The following items are REQUIRED to be completed and/or signed and submitted with your application:

Required Forms:

- ☐ Midland Memorial Allied Health Professional Application **We are unable to accept blank pages. If the question or page does not apply to you, please mark out that page or indicate "N/A" for that item.**
- ☐ Delineation of Privileges for Applicable Specialty **Documentation of clinical competence is required as noted on each privilege set. Please ensure this is signed by your sponsoring physician(s)**
- ☐ Sponsoring Physician Form and Addendum **(Please ensure this is signed by your sponsoring physician(s) if the addendum is not needed, indicate "N/A")**
- ☐ Peer Reference & Evaluation Contact Information
- ☐ Applicant's Supplemental Consent and Release
- ☐ Temporary Privileges Request Form
- ☐ Professional Liability Form
- ☐ Restraint & Seclusion Acknowledgment
- ☐ Confidentiality and Security Agreement
- ☐ Practitioner Acknowledgement (Code of Conduct, Bylaws, Rules and Regulations)
- ☐ PT Research, Inc. Release
- ☐ **Curriculum Vitae (CV) (MM/YYYY) dates required**

Other Required Documentation:

- ☐ Legible, color copy of your driver's license
- ☐ Current Photograph
- ☐ Specialty Board Status or Certification (if applicable)
- ☐ Current TB Test or Symptoms Form (attached)
- ☐ CME Statement Form (attached)
- ☐ Copy of current malpractice insurance and **all policies you have held within the past seven (7) years.**
- ☐ Copy of your current Medical License (if applicable)
- ☐ Copy of any applicable current certifications including: CPR, BLS, ACLS, PALS, ATLS, NRP, etc. as applicable to your requested privileges. (If you are unsure of required certifications, please contact the Medical Staff Office)
- ☐ Additional case logs/volume activity per the requirements of your requested core and non-core privileges.
- ☐ Copies of the following degrees/certificates:
  - ☐ Diploma
  - ☐ Completion of Training Certificate (if applicable)

☐ Before the Medical Staff Office will begin processing your application, you must submit your fees for membership and privileges.

On the following page, you will find an outline of resources, forms, and tools available to you on our website.

***Your prompt response to ensure timely completion of your appointment is necessary. For your convenience, please submit your completed application to* mmhcredentialing@midlandhealth.org.**

Should you have any questions, please feel free to contact Medical Staff Services at 432-221-5800.

Midland Memorial Medical Staff Services
400 Rosalind Redfern Grover Parkway
Midland, Texas 79701
Fax: 432-221-4253
Email: mmhcredentialing@midlandhealth.org

Thank you,
Medical Staff Services

midland memorial hospital

Allied Health Professional Initial Application

READ THIS INFORMATION FIRST

Please visit our website at: https://www.midlandhealth.org/main/credentialing ***to find the following tools, forms and resources:***

Information on Fees for Membership and How to Submit Payment:

- **You will find a link that will take you to our payment portal and information on how to proceed.**

Information Available for Review:

- **Bylaws**
- **Rules and Regulations**
- **Medical Staff Practitioner Code of Conduct**
- **AHP Policy**
- **Disruptive Behavior Policy**
- **Restraint and Seclusion Policy**
- **United Healthcare Network**
- **Fees for Membership and Privileges Policy**
- **HIPPA Section 19- Medical Staff Obligations and Sanctions Regarding the Confidentiality of PHI**
- **Continuum of Depth of Sedation**
- **Practice Guidelines for Sedation**
- **Provision of Anesthesia Services- The Continuum from Local to General Anesthesia**

Forms and Documents:

- **Applicable Specialty Privilege Sets**
- **Moderate Sedation Privileges**
- **Initial Application Packets**
- **Reappointment Application Packets**
- **Required forms**

Should you have any questions, please feel free to contact Medical Staff Services.

Midland Memorial Medical Staff Services
400 Rosalind Redfern Grover Parkway
Midland, Texas 79701
Phone: 432-221-5926.
Fax: 432-221-4253
Email: mmhcredentialing@midlandhealth.org

Thank you,
Medical Staff Services

MIDLAND MEMORIAL HOSPITAL
ALLIED HEALTH PROFESSIONAL
INITIAL APPLICATION

Instructions:
1. Please type or print clearly.
2. Attach additional sheets if more space is needed.

Medical Staff Services (432) 221-5800 phone
Midland Memorial Hospital (432) 221-4253 fax
400 Rosalind Redfern Grover Parkway
Midland, TX 79701
mmhcredentialing@midlandhealth.org

SECTION ONE – PERSONAL INFORMATION			
Last Name:	First Name:	M.I.:	Title (i.e. R.N., P.A.):
Emergency Contact Name:	Emergency Contact Phone Number:		E-Mail Address:

Mobile/Cellular Phone #:	Pager #:	Social Security #:	Driver's License # (State):
NPI #:	E-mail Address:	UPIN:	TIN/EIN:
Date of Birth:	Birth Place:	Citizenship:	Gender:

Office Address:	City, State, Zip:	Office Phone #:	Office Fax #:
Correspondence/Home Address:	City, State, Zip:	Phone #:	Fax #:

Requesting:
☐ Audiologist ☐ Certified Surgical Tech ☐ Perfusionist ☐ Psychologist
☐Nurse Anesthetist ☐ Licensed Surgical Assistant ☐ Physician Assistant ☐ Registered Nurse
☐ Nurse Midwife ☐ Orthotics & Prosthetics ☐ Physicist ☐ RN First Assistant
☐ Nurse Practitioner ☐ Pathology Assistant ☐ Scrub Technologist
☐ Other _____

Specialty:
☐ Medicine ☐ OB-GYN ☐ Psychiatry ☐ Surgery ☐ Family Practice
☐ Emergency ☐ Laboratory ☐ Anesthesia ☐ Pediatrics ☐ Radiology

Employing/Supervising/Recommending Active Medical Staff Member:		Specialty:	
Office Address:	City, State, Zip	Phone#	Fax #:

Please list each additional supervising physician (if different from or in addition to above)

Physician Name:	Address:	
City, State, Zip Code:	Office Phone#:	Fax#:
Physician Name:	Address:	
City, State, Zip Code	Office Phone#:	Fax#:

Physician Name:	Address:
City, State, Zip Code:	Office Phone#: Fax#:

SECTION TWO – EDUCATION/ TRAINING INFORMATION

High School:	City, State, Zip:	Highest Grade Attended:	Dates of Attendance:
College:	Address:	City, State, Zip:	
Dates Attended:	Date of Graduation:	Degree:	
Nursing School:	Address:	City, State, Zip:	
Dates Attended:	Date of Graduation:	Degree:	

Other Health Training (certifications, courses, etc):

CPR Certification (BLS, ALS):	Date:
Other:	Date:

Postgraduate Education/Training:	Address:	City, State, Zip:
Dates Attended:	Date of Graduation:	Degree:
Postgraduate Education/Training:	Address:	City, State, Zip:
Dates Attended:	Date of Graduation:	Degree:

List Continuing Education for the past 2 years in your specialty.

Continuing Education:	Hours:
Continuing Education:	Hours:
Continuing Education:	Hours:

Are you able to perform all the scope of practices that you have requested competently and safely, with or without reasonable accommodations, according to accepted standards of professional performance? (If you require reasonable accommodations, please describe.) ☐ **Yes** ☐ **No**

Please attach copies of shot record including the following document:

Annual tuberculosis (TB) screening Date:

SECTION THREE - PROFESSIONAL INFORMATION

Certification/Registration:

Certifying Organization:

Address:	City, State, Zip	Phone #:	Fax #:

Type of Certificate/Registration:	Date Issued:	Expires:

License(s): ***List all licenses held.***

License #:	State:	Date Issued:	Expires:
License #:	State:	Date Issued:	Expires:

License #:	State:	Date Issued:	Expires:

Professional/Peer References: Of the three references required, one must be from a physician. Two must have the same profession/ specialty as you. ***Please provide complete address and fax number.***

Name:	Complete Address:	
City, State Zip:	Phone #:	Fax#:
Occupation:	Time Known:	
Name:	Complete Address:	
City, State Zip:	Phone #:	Fax#:
Occupation:	Time Known:	
Name:	Complete Address:	
City, State Zip:	Phone #:	Fax#:
Occupation:	Time Known:	

SECTION FOUR – PROFESSIONAL LIABILITY INSURANCE & CLAIMS HISTORY

Current Type of Policy:

Enclose certificate of Insurance. If your name does not appear on the certificate, provide proof that you are covered.

Present Insurance Carrier:

Complete Address: **Phone:** **Fax#**

Policy #:	**Amount of Coverage:**	**Effective Dates:**

Is your scope of practice activities at MMH covered under this policy? **□ Yes □ No**

1. Has your professional liability insurance coverage ever been terminated by action of an insurance company? **□ Yes □ No**
2. Have you ever been denied professional liability insurance coverage or rated in a higher than average risk class for your specialty? **□ Yes □ No**
3. Have any professional liability claims or suits ever been filed against you? **□ Yes □ No**
4. Have any professional liability claims or suits been filed against you, which are presently pending? **□ Yes □ No**
5. Have any judgments been made against you in a professional liability case(s) or claim(s), or have you entered into any settlements? **□ Yes □ No**
6. Have you *EVER* had any malpractice actions (pending, settled, arbitrated, mediated or litigated)? **□ Yes □ No**

Please provide malpractice insurance carrier information for the past 3 years of employment or 5 prior practice locations, whichever is less in the space provided below. If Additional space is needed please supply the information on an attachment.

Prior Carrier's Name:	**Policy #:**	**Dates of Coverage:** **From: / / To: / /**

Complete Address:	City, State, Zip:	Phone #: ( ) Fax # ( )
Coverage Amounts:	**Effective Date:**	**Type of Policy:** **Occurrence:** **Claims-Made:**

SECTION FIVE – MEDICAL/PROFESSIONAL SOCIETIES

Name of Society:	Date of Membership: From: / / To: / /
Name of Society:	Date of Membership: From: / / To: / /

Has your membership in any medical/professional society been voluntarily or involuntarily, challenged, denied, limited, suspended, revoked or relinquished, or are there any actions pending that would affect your membership in any medical/professional society?

☐ **Yes** ☐ **No** **If yes, please explain. If additional space is needed, please supply the information as an attachment.**

SECTION SIX –WORK HISTORY/APPOINTMENTS/AFFILIATIONS

Please provide work/affiliation information for the past 3 years of employment or 5 prior practice locations, whichever is less in the space provided below. If Additional space is needed please supply the information on an attachment.

Name of Affiliation:		**Dates of Affiliation:** From: / / To: / /
Title or Position:		Were you employed here? ☐ Yes ☐ No **-OR-** Were you granted privileges here? ☐ Yes ☐ No
Complete Address:	City, State, Zip:	Phone #: ( ) Fax #: ( )
Reason for discontinuance if no longer affiliated:		
Name of Affiliation:		**Dates of Affiliation:** From: / / To: / /
Title or Position:		Were you employed here? ☐ Yes ☐ No **-OR-** Were you granted privileges here? ☐ Yes ☐ No
Complete Address:	City, State, Zip:	Phone #: ( ) Fax #: ( )
Reason for discontinuance if no longer affiliated:		
Name of Affiliation:		**Dates of Affiliation:** From: / / To: / /
Title or Position:		Were you employed here? ☐ Yes ☐ No **-OR-** Were you granted privileges here? ☐ Yes ☐ No
Complete Address:	City, State, Zip:	Phone #: ( ) Fax #: ( )
Reason for discontinuance if no longer affiliated:		

If you have additional professional work history and/or affiliations, please use a separate sheet.

Please provide explanation for any time gaps greater than six months:

SECTION SEVEN - HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

Have you ever had any adverse action and/or limitations placed on your practice by any committee or

any health care entity, organization or plan relative to quality assurance, utilization review or risk management and/or your provisions of professional services as a result of an investigation?	□ **Yes**	□ **No**
Do you or a member of your immediate family member maintain ownership (direct or indirect), or receive compensation from any company or entity providing health care services (e.g. clinical labs, hospitals or diagnostic testing center) where you could benefit financially from patient referrals (excluding syndications and/or retirement plans)?	□ **Yes**	□ **No**
Has your application for appointment to the medical staff of any other health care facility ever been relinquished, denied, revoked, suspended, reduced or not renewed?	□ **Yes**	□ **No**
Have you ever withdrawn your application from a health care entity or managed care organization?	□ **Yes**	□ **No**
Have you voluntarily or involuntarily resigned from the medical staff, or any other staff, of a health care facility?	□ **Yes**	□ **No**
Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?	□ **Yes**	□ **No**
Do you currently use alcohol in a manner likely to affect your ability to perform your or clinical duties?	□ **Yes**	□ **No**
Do you currently use, or have you used illegal drugs without rehabilitation or treatment?	□ **Yes**	□ **No**
Do you currently use prescription/nonprescription drugs in a manner likely to affect your ability to perform your professional or clinical duties?	□ **Yes**	□ **No**
Have you ever been a defendant in a criminal action or convicted of a crime? (A criminal background check is conducted on each AHP applicant)	□ **Yes**	□ **No**
If the answer to any of the above questions is "yes," please provide detailed information. Use separate sheet if necessary.		

I attest that all information submitted by me in this application is true to the best of my knowledge. Furthermore, I understand that I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualification. I understand that false statement in or omissions from this application constitute cause for denial of appointment or sufficient cause for the administration to forbid the further use of the hospital's premises by me.

_____ _____

Applicant's Signature **Date**

_____

Applicant's Printed Name

Peer Reference & Evaluation Contact Information

*****Phone number AND Email Address ARE REQUIRED for each Reference and Evaluator*****

Provider Name: _____

Peer Reference #1:

Name: _____ **Address: _____**
Phone: _____ **_____**
Fax: _____
Email: _____
Provider Type: _____

Peer Reference #2:

Name: _____ **Address: _____**
Phone: _____ **_____**
Fax: _____
Email: _____
Provider Type: _____

****Evaluation must come from a Program Director or Supervisor of a current affiliation.***

***Evaluation #1:**

Name: _____ **Address: _____**
Phone: _____ **_____**
Fax: _____
Email: _____
Provider Type: _____

APPLICANT'S SUPPLEMENTAL CONSENT AND RELEASE

I hereby apply for Allied Health Professional staff appointment and or reappointment and clinical privileges at Midland Memorial Hospital as requested in this application and, whether or not my application is accepted, I acknowledge, consent, and agree as follows:

1. I specifically authorize Midland Memorial Hospital (hereinafter referred to as "the hospital") and its authorized representatives to consult with any third party who may have information, including but not limited to, education and employment history, driving record, social security verification, civil and criminal background checks, other public records history or otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on my satisfaction of the criteria for continued appointment to the Allied Health Professional staff, as well as to inspect or obtain any and all communications, reports, records statements, documents, recommendations and/or disclosures of said third parties relating to such questions. I also specifically authorize said third parties to release said information to the hospital and its authorized representatives upon request.
For purposes of this Supplemental Consent, the term "hospital and its authorized representatives" means the hospital partners, hospital corporation, the hospital to which I am applying, and any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application or conduct in the hospital; the members of the hospital's Board and their appointed representatives, the Chief Executive Officer or his designees, other hospital employees, consultants to the hospital, the hospital's attorney and his/her partners, associates or designees, and all appointees to the medical staff. The term "third parties" means all individuals, including appointees to the hospital's medical staff, and appointees to the medical staffs of other hospitals or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether hospitals, health care facilities or not, from whom information has been requested by the hospital or its authorized representatives or who have requested such information from the hospital and its authorized representatives.

2. I acknowledge that (1) Allied Health Professional appointment and clinical privileges at this hospital are not a right; (2) my request will be evaluated in accordance with prescribed procedures defined in the hospital and medical staff bylaws, rules, and regulations; (3) all medical staff recommendations relative to my application are subject to the ultimate action of the hospital Board whose decision shall be final; (4) if appointed, my appointment and clinical privileges shall be provisional; (5) I have the responsibility to keep this application current by informing the hospital, through the Medical Staff Services office, of any change in the areas of inquiry contained herein; and (6) appointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the hospital as evidenced by treatment and continuous care and supervision of patients for whom I have responsibility; and acceptable performance of all responsibilities related thereto, as well as other factors that are relevant to the effective and efficient operation of the hospital. Appointment and continued clinical privileges shall be granted only on formal application according to hospital and medical staff bylaws, rules and regulations, and upon final approval of the hospital Board.

3. I understand that before this application will be processed that (1) I will be provided a copy of the Allied Health Professional staff bylaws and such hospital policies and directives as are applicable to appointees to the Allied Health Professional staff, including the bylaws and rules and regulations of the Allied Health Professional staff presently in force, and (2) I must sign a statement acknowledging receipt and an opportunity to read the copies and agreement to abide by all such bylaws, policies, directives and rules and regulations as are in force, and as they may thereafter be amended, during the time I am appointed to the Allied Health Professional staff at the hospital.

4. If appointed or granted clinical privileges, I specifically agree to: (1) refrain from fee-splitting or other inducements relating to patient referral; (2) refrain from delegating responsibility for diagnoses or care of hospitalized patients to any other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised; (3) refrain from deceiving patients as to the identity of any practitioner providing treatment or services; (4) seek consultation whenever necessary; (5) abide by generally recognized ethical principles applicable to my profession; (6) provide continuous care and supervision as needed to all patients in the hospital health plan for whom I have responsibility; and (7) accept committee assignment and such other duties and responsibilities as shall be assigned to me by the hospital Board and medical staff.

I UNDERSTAND AND AGREE TO THE TERMS OF THIS SUPPLEMENTAL CONSENT, WHICH SHALL REMAIN VALID THROUGHOUT THE TERM OF MY HOSPITAL APPOINTMENT AND/OR REAPPOINTMENT.

APPLICANT'S SIGNATURE _____ Date _____

APPLICANT'S PRINTED NAME _____

MIDLAND MEMORIAL HOSPITAL
PROFESSIONAL LIABILITY INFORMATION FORM

All applicants are required to provide information on any professional liability claims, complaints or causes of action that have been lodged against him/her and the status of such issues. Please complete an individual form for each incident in which you have been involved during the past two years.
If not applicable, please note and sign.

Regarding:____vs.__________________________________

Identify your professional relationship to the alleged injured party:

_____ Assisted primary (attending physician/dentist)
_____ Assisted secondary physician (i.e., surgeon)
_____ Assisted/Consulted
_____ Other

Please provide an explanation of the alleged issues:

____
____
____
____
____
____
____

Claim filed in County of:___________________________________ State of:_______________________

Date filed:____________________________

_____ Pending
_____ Allegations removed/dismissed Date:______________
_____ Closed without payment Date:______________
_____ Pretrial settlement ($_________) Date:______________
_____ Lawsuit filed

Insurance Carrier handling the incident:____

Name of:____ Policy No.______________________

* *

☐ Not Applicable; no claims reported during past two years.

____ _________________________
Name (print) Date

____
Signature

ALLIED HEALTH PROFESSIONAL

STATEMENT FROM SPONSORING/SUPERVISING MEDICAL STAFF MEMBER

I hereby verify that _____ will function in the capacity of _____, that he/she will be under my direction/supervision at all times, and I agree to assume full responsibility for his/her actions in caring for my patients who are treated and/or hospitalized in Midland Memorial Hospital.

I understand that:

- Allied Health Professionals may practice in the hospital only as long as the sponsoring and/or supervising physician maintains appointment on the medical staff;
- The sponsoring and/or supervising physician must inform the Allied Health Committee if the Allied Health Professional is no longer employed or that the physician will no longer supervise the Allied Health Professional;
- After consultation with the sponsoring and/or supervising physician, approval of any Allied Health Professional may be modified or terminated by the Credentials Committee; and,
- In making application for privileges to provide a specific service in the hospital, the Allied Health Professional must agree to abide by the Hospital and Medical Staff Bylaws, Rules and Regulations, Policy on Allied Health Credentialing and General Rules for All Allied Health Professionals.

An Allied Health Professional is not considered an Appointee to the medical staff and shall not have the rights and privileges of an Appointee to the medical staff.

_____ _____

Signature of Sponsoring/Supervising Medical Staff Member Date

_____

Printed Name of Sponsoring/Supervising Medical Staff Member

This form is not valid without its attached addendum, which provides the name and signature of all sponsoring/supervising physicians who will oversee_____.

ALLIED HEALTH PROFESSIONAL
STATEMENT FROM SPONSORING/SUPERVISING MEDICAL STAFF MEMBER
ADDENDUM

Additional Sponsoring/Supervising Physicians who will oversee the activities of _____ in his/her duties at Midland Memorial Hospital.

(Add names and attach additional sheet if necessary)

_____	_____
Name of Physician	Signature of Physician
_____	_____
Name of Physician	Signature of Physician
_____	_____
Name of Physician	Signature of Physician
_____	_____
Name of Physician	Signature of Physician
_____	_____
Name of Physician	Signature of Physician
_____	_____
Name of Physician	Signature of Physician
_____	_____
Name of Physician	Signature of Physician

Midland Memorial Hospital – Midland, TX 79701
Confidentiality and Security Agreement

I understand that Midland Memorial Hospital (the "Hospital") for which I work, volunteer or provide services, or with which the entity (*e.g.*, physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information with the Hospital, has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of the patients' health information. Additionally, the Hospital must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with patient health information, "Confidential Information"). In the course of my employment/assignment or working relationship with the Hospital, I understand that I may come into the possession of this type of Confidential Information. I will access, use and disclose this information only when it is necessary to perform my job related duties in accordance with the Hospital's Privacy and Security Policies. I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

(1) I will only access the Confidential Information for patients with whom I have a patient care relationship and for whom I have a need to access their Confidential Information in the course of such care, or for whom I have a need to access their Confidential Information in the course of the services I am providing to the Hospital, under a contract for services. I will access only the amount of information necessary to perform my job related to the care of the patient, or for treatment, payment or healthcare operations, or to perform the services I am providing to the Hospital. For any other access, I will obtain the express permission of the Hospital. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.

(2) I will act in the best interest of the Hospital and in accordance with its Code of Conduct at all times during my relationship with the Hospital.

(3) I will not disclose or discuss any Confidential Information with others, including friends or family who do not have a need to know it. I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information even if the patient's name is not used.

(4) I will not in any way divulge, copy, release, sell, loan, alter or destroy any Confidential Information except as properly authorized.

(5) I will not make any unauthorized transmissions, inquiries, modifications or purgings of Confidential Information.

(6) I will practice good workstation security measures such as locking up portable media when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.

(7) I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.

(8) I will:

a. Use only my officially assigned User-ID and password (and/or token (e.g., SecurID card).
b. Use only approved licensed software.
c. Use a device with virus protection software.

(9) I will never:

a. Share/disclose user-Ids, passwords or tokens with any other person.
b. Use another person's user-Id, password or token to access Confidential Information.
c. Use tools or techniques to break/exploit security measures.
d. Connect to unauthorized networks through any systems or devices.

(10) I will notify my manager, the Hospital's HIM Director or designee, or appropriate Information Services person if my password has been seen, disclosed or otherwise compromised, and will report to such person any activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information. I understand that I am responsible and will be held accountable for any activity for which my User-Id, password or token is used by another party.

(11) In the event of an unauthorized acquisition, access, use or disclosure of Protected Health Information (which generally includes individually identifiable health information transmitted or maintained in any medium) which compromises the security or privacy of such information (a "breach"), I will report the breach immediately to the Hospital's Privacy Officer.

(12) I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with the Hospital. Furthermore, I understand that the Hospital has the right to audit any technology and processes I use to access Confidential information, which may include, but not necessarily be limited to, any computer and files accessed by me, paper or electronic, related to such Confidential Information, and I will grant the Hospital access to such technology and files as requested to perform these audits.

(13) I understand that I should have no expectation of privacy when using Hospital information systems. The Hospital may log, access, review and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce privacy and security.

(14) I understand that a violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, and/or termination of authorization to work within or with the Hospital, in accordance with the Hospital's policies.

(15) I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Hospital. Upon termination, I will immediately return any documents or media containing confidential Information to the Hospital.

<u>The following statements apply to physicians using Hospital systems containing patient identifiable health information (e.g. CPRS, IDX, CareVue, CPN)</u>:

(16) I will only access software systems to review patient records or Hospital information when I have a legitimate need to know in caring for and treating the patient, as well as any necessary consent. By accessing a patient's records or Hospital information, I am affirmatively representing to the Hospital at the time of each access that I have the requisite legitimate need to know and appropriate consent, and the Hospital may rely on that representation in granting such access to me.

(17) I will insure that only appropriate personnel in my office will access the Hospital software systems and Confidential Information and I will annually train such personnel on issues related to patient confidentiality and access.

(18) I will accept full responsibility for the actions of my employees who may access the Hospital software systems and Confidential Information, including any breach, and will remove an employee's access to Confidential Information if necessary.

(19) I understand that the Hospital may decide at any time without notice to no longer provide access to any systems to physicians on the medical staff unless other contracts or agreements state otherwise. I understand that if I am no longer a member of the facility's medical staff, I may no longer use the facility's equipment to access the Internet. I further understand that the Hospital reserves the right to remove my and my employees' access to Confidential Information for violating this Agreement.

Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Employee/Consultant/Vendor/Office Staff/Physician/Volunteer Signature	Facility Name and COID	Date
Employee/Consultant/Vendor/Office Staff/Physician/Volunteer Printed Name	Business Entity Name	

Allied Health Professional
Operating Room Orientation Checklist

_____ has been oriented to the following within the Surgical Department:

1. Patient schedule board _____
2. Policy and Procedure Manual _____
3. Appropriate OR Attire _____
4. Viewed OR Surgical Fire Video _____
5. Maintenance of Sterile _____
6. Technique during Surgical case _____

Allied Health Professionals:

1. Proper Scrub Technique _____
2. Successful return demonstration of:
    a. Initial 5 minute scrub _____
    b. 3 minute between case scrub _____

_____ _____

Signature of Applicant Signature of Surgical Educator

_____ _____

Date Date

Please call surgical educator at 432-221-3219 to set up an appointment. This form must be completed within a week of orientation (start date at MMH) and returned to the Medical Staff Office by faxing it to 432-221-4253.

*Temporary privileges will only be given under the following circumstances: Patient care need or when an application is complete and without any negative or adverse information. On a recommendation from a member of the Medical Executive Committee or member of the Credentials Committee, Chief of the Medical Staff, medical director or Administrator/designee for a period of time not to exceed 120-days. *Refer to Section 7.5.2 of the Bylaws for Locum Tenens privileges which state Locum Tenens privileges may be granted for a period of time not to exceed six (6) months.*

Policy Tech Reference #: 6527 Approved on: 02/02/2021 Last Reviewed: 02/02/2021 Next Review: 02/02/2023

MIDLAND MEMORIAL HOSPITAL
TEMPORARY CLINICAL PRIVILEGES

In signing this request, I acknowledge that I have turned in a completed application for staff membership requesting:

- ☐ Provisional Active
- ☐ Provisional Consulting
- ☐ Provisional Allied Health Professional
- ☐ Locum Tenens*

And

Staff status in the Department of:

- ☐ Surgery
- ☐ Medicine
- ☐ Hospital-based Physicians

With clinical privileges in: _____.
I agree to be bound by the Bylaws of the medical staff in all matters relating to my clinical privileges.

_____ _____
Date Signature

Sufficient information has been received to justify awarding of temporary clinical privileges while the application is considered by the appropriate Medical Staff and Board Committees.

From: _____ to _____

_____ _____
Department Chair / Designee Date

_____ _____
Medical Executive /Credentials Committee Member Date

_____ _____
Administrator or Designee Date

midland memorial hospital

I have received and read the Restraint or Seclusion policy from Midland Memorial Hospital. I also understand my obligation to the patients at Midland Memorial Hospital as stated in this policy.

_____ _____

Please Print your Name Date

_____

Please Sign your Name

PRACTITIONER ACKNOWLEDGEMENT

Midland Memorial Hospital Medical Staff

I, _____, have received, read and understand the Midland Memorial Hospital Medical Staff Bylaws, Rules and Regulations, and Medical Staff Code of Conduct and hereby agree to abide by these provisions, requirements, policies and procedures.

I have also received, read and understand the Midland Memorial Hospital policies and procedures related to ensuring the maintenance of the privacy and security of patient medical records that I access, both at Midland Memorial Hospital and at my practice. These include the rules governing my ultimate responsibility to maintain the privacy and integrity of the paper medical records as well as the security, through encryption, of the electronic medical records I access and that personnel in my practice access. I hereby agree to abide by these policies and procedures. I further acknowledge that failure to follow the policies and procedures for maintaining the privacy and security of patient medical records may subject the practitioner to disciplinary proceedings under the Midland Memorial Medical Staff Bylaws.

I further understand that, as a Medical Staff member of Midland Memorial Hospital, I will strive to comply with all applicable bylaws, rules and regulations and policies and procedures and will, at all times, display the utmost integrity and moral conduct and fulfill my responsibilities in an ethical manner.

Practitioner # (assigned by the medical staff department): _____

Practitioner Name: _____ Date: _____

(Please print your full legal name)

Practitioner Signature: _____

ANNUAL TUBERCULOSIS (TB) EVALUATION

Midland Memorial Hospital, 400 Rosalind Redfern Grover Pkwy, Midland, TX 79701

_____	_____	_____	_____
Please Print Your Name	Department	Employee Number	Date

TB Exposure Risk

____ I have not travelled outside the USA in the last year.* *If yes, list purpose of visit*_____

____ I do not have a health condition that puts me at high risk for TB.

**Discuss with Occupational Health Nurse if you think you do*

____ I have not been exposed to/worked with people at high risk for TB (except in our facility)

Annual TB Symptom Survey **Place a check mark on the appropriate line*

	Yes	No		Yes	No
Productive cough > 2 weeks	_____	_____	Persistent weight loss without dieting?	_____	_____
Persistent low grade fever?	_____	_____	Loss of appetite?	_____	_____
Shortness of breath?	_____	_____	Night sweats?	_____	_____
Coughing up blood?	_____	_____	Swollen glands, usually in the neck?	_____	_____
Chest pain?	_____	_____	Recurrent kidney or bladder infections?	_____	____

Screening for Fit testing **Please initial the appropriate lines below:*

_____ I have no patient interaction and therefore no Fit testing is needed

_____ I have been Fit tested for the N95 respirator at Midland Memorial Hospital

_____ I have not lost or gained more than 10 pounds since my last Fit test

_____ I have not grown facial hair since my last Fit test

_____ *I understand that each time I don the mask, I must do a fit check by inhaling sharply. If the mask contracts, it fits correctly. If it does not contract after readjustment, I will schedule an appointment for a Fit test*

_____ I need to be Fit tested

_____ No follow up needed _____ IGRA drawn

_____ _____

Occupational Health Nurse Date

midland memorial hospital

To: The Credentials Committee

CC: Midland Memorial Hospital Medical Staff Services

Re: _____

Subject: CME – Statement of Continuing Medical Education

The Texas Medical Board requires physicians to complete at least 48 credit hours of continuing medical education (CME) per 24-month period. At least half of the required CME credits must be formal, category I or 1A courses related to the privileges you currently hold/are requesting. At least two of the Category I or 1A hours must involve the study of medical ethics and/or professional responsibility. Professional responsibility includes but is not limited to courses in: Risk Management, Domestic Abuse or Child Abuse.

Board Certification exemption is valid for a maximum of one registration.

Please mark one of the following selections as it pertains to you:

☐ I hereby attest that I am in compliance with the CME requirements of the applicable Texas licensure board (48 hours (MD), 24 hours (DDS) or 50 hours (DPM) of CME (Category I and Category II) credits every 24 months.) I attest that, upon request, I can and will provide documentation of such compliance. I acknowledge that failure to produce the requested documentation could result in disciplinary action up to and including removal from the medical staff.

☐ I hereby attest that I have completed residency / fellowship training within 6 months prior to the renewal of my TMB license or am currently in residency / fellowship training; such training satisfies my CME requirements.

☐ I hereby attest that I am currently in the TMB renewal period following my board certification exemption which I used for my _/ _/___TMB renewal or residency / fellowship training exemption; I have until _/_/____to obtain all required CME credits.

Printed Name: _____ Date: _____

Signature: _____

Consumer Report / Investigative Consumer Report Disclosure and Authorization

I understand that, in connection with my application for employment or at any time during my employment, **MIDLAND MEMORIAL HOSPITAL** may conduct a background investigation on me for employment purposes.

I understand MIDLAND MEMORIAL HOSPITAL may utilize PT Research, Inc., a consumer-reporting agency, to prepare a consumer report or investigative consumer report, as defined under the Fair Credit Reporting Act (15 U.S.C. § 1681, *et seq.*), in connection with the background investigation. A "consumer report" means any written, oral, or other communication of any information by a consumer reporting agency bearing on my credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living, which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in establishing my eligibility for employment purposes. An "investigative consumer report" means a consumer report or portion thereof in which information on my character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with my neighbors, friends, or associates or with others with whom I am acquainted or who may have knowledge concerning any such items of information. Information for a consumer or report and/or investigative consumer report may be retrieved from several sources, including but not limited to public records, educational institutions, financial institutions, law enforcement and other government agencies, credit bureaus, and personal interviews with my current and former employers, friends, neighbors and associates. The information received may include, but is not limited to, academic, residential, achievement, job performance, attendance, litigation, personal history, credit reports, driving history, and criminal history records consistent with federal and state law. I understand that this information may be transmitted electronically and I authorize such transmission.

I further acknowledge that I have received a copy of the "Summary of Your Rights Under the Fair Credit Reporting Act" which is attached to this Authorization. In the event an investigative consumer report is prepared, I understand that I may submit a written request for additional disclosures regarding the nature and scope of the investigation requested as well as a summary of my rights under the FCRA.
If information from a consumer report or an investigative consumer report is used in whole or in part in making an *adverse decision* concerning my employment or application for employment, before making the adverse decision MIDLAND MEMORIAL HOSPITAL will provide me with a copy of the consumer report or investigative consumer report and a description in writing of my rights under the Fair Credit Reporting Act.

I understand that if I disagree with the accuracy of any information contained in the report, I must notify MIDLAND MEMORIAL HOSPITAL within 10 days of my receipt of the report.

AUTHORIZATION

I hereby authorize MIDLAND MEMORIAL HOSPITAL to obtain a consumer report and/or an investigative report about me. If I am hired by MIDLAND MEMORIAL HOSPITAL, this authorization shall remain on file and shall serve as an ongoing authorization for MIDLAND MEMORIAL HOSPITAL to procure consumer reports and/or investigative consumer reports at any time during my employment. I agree that a photocopy of this authorization may be accepted with the same authority as the original.

Signature _____ Date _____

Background Investigation & Release of Information Authorization

I, _____, hereby authorize, without reservation, PT Research and any party or agency contacted by PT Research, to furnish the above information. I further release and forever discharge MIDLAND MEMORIAL HOSPITAL, PT Research, and any person/entity from which they obtained information from any liability resulting from providing such information.

I understand that this information will be transmitted electronically and authorize such transmission. I am willing that a photocopy of this authorization be accepted with the same authority as the original, and that if employed by MIDLAND MEMORIAL HOSPITAL this authorization will remain in effect throughout my employment.

_____ _____ _____

Signature Social Security Number Date

The following information is provided voluntarily to identify you in the background screening process, and is not part of your employment application. Please print clearly.

Last Name: First Name: Middle Name:

Street Address: City: State: ZIP:

Driver's License Number: State of License: Expires On: Date of Birth:

List any other CITIES AND STATES in which you have lived during the previous 7 years.

List any other LAST NAMES you have used during the previous 7 years.

List any other LAST NAMES under which you received your GED, high school diploma, or other degrees.

Are you applying for employment in CALIFORNIA*, MINNESOTA, or OKLAHOMA? ☐Yes ☐ No
If so, would you like to request a copy of any report prepared on you? ☐Yes ☐ No

***CALIFORNIA APPLICANTS:** Under California law, the reports ordered about you for employment purposes within the State of California are defined as "Investigative Consumer Reports." These reports may contain information on your character, general reputation, personal characteristics, and/or mode of living. Under California Civil Code §1786.22, you may view the report(s) maintained at the CRA during normal business hours. You may also obtain a copy by submitting proper identification and paying the cost of duplication by appearing at the CRA in person, by mail, or by telephone. The CRA is required to have personnel available to explain the report(s) and to explain any coded information. If you appear in person, you may be accompanied by a person of your choice, if s/he furnishes proper identification

NEW YORK and MAINE APPLICANTS: You have the right, upon written request, to be notified whether a consumer report was requested about you by the above-named company.

NEW YORK APPLICANTS: Should a consumer report received by an employer contain criminal conviction information, the employer must provide to the applicant or employee who is the subject of the report, a printed or electronic copy of Article 23-A of the New York Correction Law, which governs the employment of persons previously convicted of one or more criminal offenses.

_____ Please initial here to acknowledge receipt of Article 23-A of the New York Correction Law.