midland memorial hospital

Advanced Practice Provider Initial Appointment Application

READ THIS INFORMATION FIRST

The following is required information for privileges at Midland Memorial Hospital.

Items to be completed and/or signed (Available on the MMH website under 'For Physicians'):

- Texas Standardized Credentialing Application (TSCA) use the following website: http://www.tdi.texas.gov/forms/forms9credential.html **(Mark "NA" on all questions that do not need to be completed)**
- Applicable Specialty Core Privileges **(Documentation of clinical competence is required as noted on the privileges)**
- Moderate Sedation Privileges (If applicable)

Items to be completed and/or signed included in this packet:

- Addendum to the TSCA
- Peer Reference & Evaluation Contact Information
- Statement from Sponsoring/Supervising Medical Staff Member and Addendum
- Operating Room Orientation Checklist – Form does not need to be returned; Contact number on the form
- Temporary Privileges Request Form
- Medicare/Champus Acknowledgment
- Confidentiality and Security Agreement
- Restraint & Seclusion Acknowledgment
- DEA Signature Card
- TMLT Insurance Claim History Opt-In Form (If Applicable)
- Practitioner Acknowledgement (Code of Conduct, Bylaws, Rules and Regulations)
- PT Research, Inc.

Informational Documents (Available on the MMH website under 'For Physicians' for review):

- AHP Policy
- Restraint & Seclusion Policy
- Medical Staff and Practitioner Code of Conduct
- Disruptive Behavior Policy
- Fees for Membership and Privileges Policy
- HIPAA 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

In addition, the following must be included with your application in order to assist us in preparing your file:

- Current 2" x 2" color photograph of head/shoulders - i.e., passport photo, snapshot, etc.
- Copy of current driver's license
- Proof of education – i.e., copy of diploma, training and continuing education certificates (**please include address/phone and fax numbers** of all educational institutions).
- Proof of licensure and/or certification, including health training certifications and courses.
- Proof of professional liability insurance (**please include address/phone and fax numbers** of all liability insurance).
- Documentation of CPR: BLS/ACLS/PALS/ATLS/NRP (as applicable to your requested privileges).

Your prompt response to ensure timely completion of your appointment is necessary. For your convenience you may email your information to mmhcredentialing@midlandhealth.org .

Should you have any questions, please feel free to contact the Medical Staff Services Department at 432-221-4629.

Midland Memorial Medical Staff Department
400 Rosalind Redfern Grover PKWY
Midland, Texas 79701
432-221-4253 – fax

Thank you,
Rebecca Pontaski, MHA, CPMSM, CPCS, RHIT
Manager, Medical Staff Services

ADDENDUM TO TEXAS STANDARDIZED CREDENTIALING APPLICATION

Policy Tech Reference #: 6943 Date Approved: 10/02/2017 Last Review: 10/02/2017 Next Review: 10/02/2019

Please answer the following disclosure questions and provide an explanation for any question answered "YES".

LICENSE, DEA, DPS

Are there currently any pending challenges to any of your state licenses, DEA or state controlled substance registrations? ___Yes___No

Has your license to practice in your profession ever been denied, suspended, revoked, restricted, or voluntarily surrendered? ___Yes___No

HOSPITAL PRIVILEGES

Have your clinical privileges ever been involuntarily terminated, surrendered, suspended, limited or reduced? ___Yes___No

Have you voluntarily surrendered your privileges, limited your privileges or not reapplied for privileges ___Yes___No

MALPRACTICE CLAIMS HISTORY

Have you had any malpractice claims filed for the time period not accounted for in question #16, page 9 of the TDI application? (Question 16 asks for claims within activity within the past 5 years. For initial applicants, we need to know if you have ever had any claims filed.) ___Yes___No

Has your professional liability insurance policy ever been canceled or renewal refused? ___Yes___No

Have limitations ever been placed on the scope of coverage or have you received notice of intent? ___Yes___No

HEALTH STATUS

Have you been diagnosed with or received treatment for a physical, mental, chemical dependency or emotional condition which could impair your ability to practice medicine in your specialty? ___Yes___No

Are you currently limited by a physical, mental or chemical dependency problem, which could impair your ability to take care of patients now or in the next two years? ___Yes___No

Have you been placed under a monitoring or rehabilitation contract/agreement at any institution for problems associated with alcohol, drug dependence, emotional illness or disruptive behavior? ___Yes___No

Have you received a TB screening in the last 12 months? If no, please call Occupational Health at 432-221-1866 to get a test done. Documentation must be provided to the MSO once the test is completed. ___Yes___No

CRIMINAL

Have you ever been convicted of a felony or misdemeanor other than those listed in question 17 and 18, application? (Questions 17 & 18 ask for actions related to the medical profession and acts of violence, child abuse or sexual offense. We are asking for information regarding felonies or misdemeanors filed for any other actions.) ___Yes___No

SANCTIONS OR INVESTIGATIONS

Have you been declared an ineligible person by any regulatory agency? ___Yes___No

CONTINUING MEDICAL EDUCATION

Have you met the minimum continuing medical education requirements for renewal of your license in the past two years? ___Yes___No

Please attach a list of the CME credits attained during the past two years.

EMERGENCY CONTACT INFORMATION

Name: _____

Address: _____

Phone Number: _____

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Peer Reference & Evaluation Contact Information

REFERENCES MUST HAVE A FAX NUMBER and/or EMAIL ADDRESS

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: _____

ALLIED HEALTH PROFESSIONAL

STATEMENT FROM SPONSORING/SUPERVISING MEDICAL STAFF MEMBER

I hereby verify that _____ will function in the capacity of
(Name of AHP)

_____, that he/she will be under my direction/supervision at all
(Indicate capacity)

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:

1). Allied Health Professionals may practice in the hospital only as long as the sponsoring and/or supervising physician maintains appointment on the medical staff;

2). 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;

3). 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,

4). 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

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 the surgical educator at 221-1616 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.*

MIDLAND MEMORIAL HOSPITAL
TEMPORARY CLINICAL PRIVILEGES AND LOCUM TENENS PRIVILEGES

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

- ☐ Provisional Medical Staff
- ☐ Provisional Allied Health Professional
- ☐ Locum Tenens *
- ☐ Affiliate

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

NOTICE TO PHYSICIANS:

Medicare/CHAMPUS payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fine, imprisonment, or civil penalty under applicable federal laws.

One time signature as of the Federal Register (59FR9452).
Medicare Revision effective April 18, 1994.
CHAMPUS revision effective May 1, 1994.

RECEIPT OF THIS IS ACKNOWLEDGED:

_____ _____

Physician Signature Date

_____

Printed Name

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.

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

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	

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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

DEA SIGNATURE CARD

DEA Number: _____

Signature of Practitioner: _____

Printed Name of Practitioner: _____

Date: _____

TMLT
TEXAS MEDICAL LIABILITY TRUST

P.O. BOX 160140
AUSTIN, TEXAS 78716-0140

01 MOPAC EXPRESSWAY S.
BARTON OAKS PLAZA V
SUITE 500
AUSTIN, TEXAS 78746-5943

512-425-5100
800-580-8458
fax 512-328-5637

tmlt@tmlt.org
www.tmlt.org

Claim history opt-in form

I authorize TMLT to enroll me in the Claim History Release Program (*Program*) to be effective _____. By enrolling in the *Program*, I give TMLT permission to release my Claim History on current and previous policies to any and all Hospitals & Credentialing Companies that request this information.

I understand my enrollment in the *Program* will continue until cancelled by me. I may terminate my participation in the *Program* at any time by submitting a verbal, written, or electronic request to TMLT.

Policy #: _____

Name: _____

Signature: _____

Date: _____

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: _____

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.