midland memorial hospital

Advanced Practice Providers Reappointment Application

READ THIS INFORMATION FIRST

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

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

- Pre-populated Texas Standardized Credentialing Application (TDI)
  (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)
- Profile (update as needed)

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

- Reappointment Form A
- Addendum to the TDI
- DPS Computerized Criminal History
- Restraint & Seclusion Acknowledgment
- Statement from Sponsoring/Supervision Medical Staff Member
- Practitioner Acknowledgement (Code of Conduct, Bylaws, Rules and Regulations)

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

- AHP Policy
- Medical Staff and Practitioner Code of Conduct
- Disruptive Behavior Policy
- Restraint & Seclusion 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

If you have NOT provided the following documents since your last appointment, please provide them to the medical staff office with this packet.

- Malpractice Insurance Face Sheet
- Current Texas License (renewal certificate showing current expiration)
- Current Federal Controlled Substance Certificate (DEA)
- Current Texas Controlled Substance Certificate (DPS)
- Specialty Board Status
- BLS/ACLS/PALS Certificates

Your prompt response to ensure timely completion of your reappointment is necessary and to avoid any lapse in privileges. For your convenience you may email your information to mmhcredentialing@midlandhealth.org

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

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

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

REAPPOINTMENT FOR ALLIED HEALTH PROFESSIONALS
FORM A

Name: _____ Specialty_____

Please update your information below.

Office # _____ Home # _____ Beeper #_____ Cell #_____

E-mail address: _____

_____
Office Address City State Zip

_____
Home Address City State Zip

Please include the following items:

- ***A list of CME credits obtained within the last two years***.
- ***An updated copy of your CV.***
- ***Copies of current malpractice insurance, DEA, DPS, license and any other applicable certifications including BLS, PALS, ACLS, etc.***
- ***Provide current case load information if you have no activity at MMH.***

I hereby request that my reappointment for clinical privileges be considered.

_____ _____
Practitioners Signature Date

FORM A continued

1. Status

Based on my use of the facility during the last two years**,** I hereby request that my clinical privileges to be moved from:

❒ Provisional to Active

OR

❒ Active with no changes

2. Clinical Privileges

- I request that my clinical privileges be ❒Changed ❒Unchanged.
- Have you performed the spectrum of services for which you are requesting reappointment of privileges? ❒Yes ❒No

If you request a change, what do you wish to be added or deleted? _____

_____

(Please attach appropriate documentation supporting clinical expertise for any clinical privileges you wish to add).

3. Hospital Affiliations

List complete names, addresses, telephone and fax numbers of other hospitals where you hold affiliation. Attach a separate sheet if needed.

Facility	Address	Phone	FAX/email
Facility	Address	Phone	FAX/email
Facility	Address	Phone	FAX/email
Facility	Address	Phone	FAX/email

4. Peer References

Please provide complete names, addresses, telephone and fax numbers of three peer references, preferably in your specialty, even if they are not members of this medical staff.

Peer	Address	Phone	FAX/email
Peer	Address	Phone	FAX/email
Peer	Address	Phone	FAX/email

ADDENDUM TO TEXAS STANDARDIZED CREDENTIALING APPLICATION

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 since your last reappointment? 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, page 19, of the TDI 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

EMERGENCY CONTACT INFORMATION

Name: _____

Address: _____

Phone: _____

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I, _____ , have been notified that a Computerized Criminal
APPLICANT or EMPLOYEE NAME (Please print)
History (CCH) verification check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB identifiers I supply.

Because the name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history, the organization conducting the criminal history check for background screening is not allowed to discuss any criminal history record information obtained using the name and DOB method. Therefore, the agency may request that I have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search.

For the fingerprinting process I will be required to submit a full and complete set of my fingerprints for analysis through the Texas Department of Public Safety AFIS (Automated Fingerprint Identification System). I have been made aware that in order to complete this process I must make an appointment with L1 Enrollment Services, submit a full and complete set of my fingerprints, request a copy be sent to the agency listed below, and pay a fee of $24.95 to the fingerprinting services company L1 Enrollment Services.

Once this process is completed and the agency receives the data from DPS, the information on my fingerprint criminal history record may be discussed with me.

(This copy must remain on file by your agency. Required for future DPS Audits)

_____
Signature of Applicant or Employee

_____
Date

_____
Agency Name (Please print)

_____
Agency Representative Name (Please print)

_____
Signature of Agency Representative

_____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES ___ ___ NO ____ _____ initial

Purpose of CCH: _____

Hire _____ Not Hired _____ initial

Date Printed: _____ ___ initial

Destroyed Date: _____ _____ initial

Retain in your files

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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

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

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: _____