

Dear Medical Staff Member:

In accordance with the medical staff bylaws, appointments to the medical staff require biennial reappraisal and reappointment. Enclosed is an application for reappointment from LA Credentials, our credentials verification program. Please complete this application and return to them as soon as you receive it. Applications take time to process, therefore, it is very important that you complete the application and return it to LA Credentials at your earliest convenience.

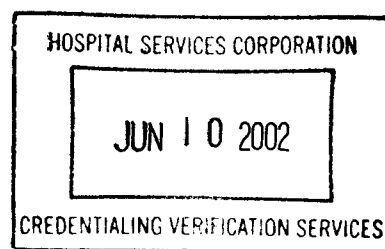
In order to be reappointed, there is a processing fee of \$75.00 that needs to be made payable to River Parishes Hospital and sent to the following address:

Kristi Hymel, MS, RHIA  
River Parishes Hospital  
Medical Staff Office  
500 Rue de Sante  
Laplace, LA 70068

Thank you for your prompt response in this matter.

Sincerely,

***Kristi Hymel, RHIA, MSHA***  
***Director of HIMS/Medical Staff***



# ASSESSMENT OF COMPETENCE FOR REAPPOINTMENT

CONFIDENTIAL

TO:

DATE:

FROM:

SUBJECT: Assessment of Competence for Reappointment Procedure

Subject:

Satisfactory      Unsatisfactory      Unable to Evaluate

	Satisfactory	Unsatisfactory	Unable to Evaluate
Professional Competence			
Ethics & Conduct			
Performance of Assigned Duties			
Resolves Patient Problems			
Relations with Other Practitioners			
Performance of Assigned Teaching Duties			
Adherence to Bylaws, Rules and Regulations			

Are there any indications of physical or mental disability, which would impair professional functioning?  
 Yes       No (If yes, detail below)

Any unsatisfactory evaluations must have appropriate comments below detailing specific areas of deficiency and recommended corrective measures.

COMMENTS:

\_\_\_\_\_  
Signature of Supervising Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Supervising Physician

\_\_\_\_\_  
Date

## AHP PERFORMANCE EVALUATION

\_\_\_\_\_  
Allied Health Professional

\_\_\_\_\_  
Supervising Physician

**PART I – CLINICAL COMPETENCE (please complete applicable box)**  
(If you mark “yes” please provide information)

<b>NURSE ANESTHETIST (CRNA)</b>	<b>YES</b>	<b>NO</b>
Anesthesia record complete		
Possesses Knowledge of & Practices sterile technique		
Shares knowledge of case with surgical team		
Maintains proper dress code		
Interaction with team members and patients is satisfactory		
Demonstrates ability to interpret problems		
Demonstrates ability to initiate appropriate intervention		
Handles emergency situations efficiently		
Induce maintain and reverse general anesthesia		
Provide intravenous sedation for MAC anesthesia		
Start intravenous and arterial lines		
Intravenous regional anesthesia		
Emergency management of respiratory care and intubations		
Follows hospital policies and procedures		
Mandatory testing completed		

<b>SURGICAL SCRUB TECHNICIAN</b>	<b>YES</b>	<b>NO</b>
Possesses knowledge of and practices sterile technique		
Maintains proper dress code		
Interaction with team members and patients is satisfactory		
Knowledge of instrumentation		
Follows hospital policies and procedures		
Mandatory testing completed		

<b>OR PHYSICIAN'S ASSISTANT</b>	<b>YES</b>	<b>NO</b>
Possesses knowledge of and practices sterile technique		
Shares knowledge of case with surgery team (patient history, etc.)		
Maintains proper dress code		
Interaction with team members and patients is satisfactory		
Follows hospital policies and procedures		
Mandatory testing completed		

<b>NURSE PRACTITIONER (ARNP)</b>	<b>YES</b>	<b>NO</b>
Demonstrates the ability to perform multi-system assessment		
Demonstrates the ability to interpret problems		
Demonstrates the ability to initiate appropriate intervention		
Follows hospital policies and procedures		
Mandatory testing completed		

## AHP PERFORMANCE EVALUATION

### PART II – CONDUCT AND HEALTH EVALUATION

	<u>Acceptable</u>	<u>Unacceptable</u>
Relationship with others	_____	_____
Patient relationship	_____	_____

Has this Allied Health Professional ever shown signs of any drug or alcohol problems?  
\_\_\_\_\_ No \_\_\_\_\_ Yes. If yes, please attach details.

Do you presently have a physical or mental health condition that affects or is reasonably likely to affect your ability to perform medical duties or your clinical privileges? \_\_\_\_\_ No \_\_\_\_\_ Yes

**OVERALL EVALUATION:**    \_\_\_\_\_ **Above Average**    \_\_\_\_\_ **Average**    \_\_\_\_\_ **Below Average**

\_\_\_\_\_  
Signature of Supervising Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Supervising Physician

\_\_\_\_\_  
Date

## RIVER PARISHES HOSPITAL ICU PROCEDURE LIST

PHYSICIAN NAME: \_\_\_\_\_

SPECIALTY: \_\_\_\_\_

DATE: \_\_\_\_\_

The following is a list of special procedures which require credentialing prior to performing them in the ICU at River Parishes Hospital. Please indicate with a checkmark those procedures which you wish to perform. **Emergency is defined as the urgent medical need of the procedure being performed without the presence of a physician with the elective privileges to do so.**

Procedure	Privileges Requested		Approved	Denied	Modifications
	Emergency	Elective			
Insertion of a central line					
Nasal or endotracheal intubation					
Ventilator management*					
Insertion of transvenous pacemaker					
Thoracentesis					
Paracentesis					
Insertion of A-line					
Insertion of Swan Ganz cath					

*\*Note: Consult required after 72 hours if patient cannot be extubated.*

SIGNATURE OF APPLICANT: \_\_\_\_\_

SIGNATURE OF APPROVAL: \_\_\_\_\_  
Department Chairman

DATE OF APPROVAL: \_\_\_\_\_

**RIVER PARISHES HOSPITAL  
ALLIED HEALTH PROFESSIONAL STAFF  
REQUEST FOR PRIVILEGES**

\_\_\_\_\_ Certified Surgical Technician  
 \_\_\_\_\_ Operating Room Technician  
 \_\_\_\_\_ Certified Registered Nurse Anesthetist  
 \_\_\_\_\_ Physician Assistant

\_\_\_\_\_ Nurse Practitioner  
 \_\_\_\_\_ LPN - Employed By Physician  
 \_\_\_\_\_ RN - Employed by Physician  
 \_\_\_\_\_ Other

\_\_\_\_\_  
 Applicant's Name (Print)

\_\_\_\_\_  
 Date

Requested

ASSIST - UNDER DIRECTION OF ANESTHESIOLOGIST

(Requirements consist of : RN degree, CRNA degree,  
 completion of an approved rprogram in Nurse Anesthesia  
 and maintenance of current CRNA Recertification)

Approved

- |  |       |
|--|-------|
| _____ Local infiltration anesthesia, topical application and minor nerve blocks  | _____ |
| _____ Specific anesthetic procedures in addition to local infiltration, topical application and minor nerve blocks. These privileges are extended normally for the care of healthy patients. | _____ |
| _____ General or monitored care anesthesia   | _____ |
| _____ Intravenous regional anesthesia (*Bier-Block)  | _____ |
| _____ Dental analgesia by IV sedation/inhalation techniques  | _____ |
| _____ Support of life functions under stress of anesthetic and surgical manipulations  | _____ |
| _____ Clinical management of problems in pain relief by PCA, IM, Regional technique  | _____ |
| _____ Management of problems in cardiac respiratory resuscitation  | _____ |
| _____ Application of specific methods of respiratory therapy   | _____ |
| _____ Clinical management of various fluid, electrolyte and metabolic disturbances   | _____ |
| _____ Spinal/epidural anesthesia for various surgeries only under direct supervision   | _____ |
| _____ Insertion of Invasive Line: A-Line   | _____ |
| _____ Cricothyrotomy   | _____ |
| _____ Ventilatory care or general management in ICU/RR   | _____ |
| _____ Care of the newborn and/or resuscitation   | _____ |
| _____ Conduct a pre-anesthesia visit and assessment with appropriate documentation   | _____ |
| _____ Develop an Anesthesia Care Plan  | _____ |
| _____ Maintain anesthesia at the required levels   | _____ |
| _____ Hypotensive Anesthesia   | _____ |
| _____ Conduct post-anesthesia visit and assessment with appropriate documentation  | _____ |
| _____ Write pre/post-op orders per instructions of anesthesiologist or surgeon (countersigned within 24 hours)   | _____ |

**RIVER PARISHES HOSPITAL  
ALLIED HEALTH PROFESSIONAL STAFF  
REQUEST FOR PRIVILEGES**

Requested

ASSIST - UNDER DIRECTION OF SURGEON IN OR

Approved

<u>          </u>	Organize instrumentation and supplies	<u>          </u>
<u>          </u>	Drape patient	<u>          </u>
<u>          </u>	Set up surgical back table and mayo	<u>          </u>
<u>          </u>	Pass surgical instrumentation from mayo (1st Scrub)	<u>          </u>
<u>          </u>	Assist with shaving and marking	<u>          </u>
<u>          </u>	Retract	<u>          </u>
<u>          </u>	Assist with patient positioning	<u>          </u>
<u>          </u>	Cut suture	<u>          </u>
<u>          </u>	Superficial wounds	<u>          </u>
<u>          </u>	Debridement	<u>          </u>
<u>          </u>	Suture (with physician in room) skin	<u>          </u>
<u>          </u>	Suture (with physician in room) sub q	<u>          </u>
<u>          </u>	Handle suction and/or sponge surgical field	<u>          </u>
<u>          </u>	Assist surgeon in utilizing specialized equipment	<u>          </u>
<u>          </u>	Remove and/or apply dressings and/or packing	<u>          </u>
<u>          </u>	Apply electro-cautery to instrument held by surgeon	<u>          </u>
<u>          </u>	Break down surgical field, deliver instruments to instrument room for reprocessing	<u>          </u>

Requested

ASSIST - UNDER DIRECT SUPERVISION OF PHYSICIAN  
ON NURSING UNITS

Approved

<u>          </u>	Instertion/removal of drains	<u>          </u>
<u>          </u>	Anterior nasal packing for epistaxis	<u>          </u>
<u>          </u>	Application of traction	<u>          </u>
<u>          </u>	Apply cast and remove cast	<u>          </u>
<u>          </u>	Removal of impacted cerumen	<u>          </u>
<u>          </u>	Sprains	<u>          </u>
<u>          </u>	Strapping	<u>          </u>
<u>          </u>	Casting	<u>          </u>
<u>          </u>	Splinting	<u>          </u>
<u>          </u>	Fractures	<u>          </u>
<u>          </u>	Strapping	<u>          </u>
<u>          </u>	Casting	<u>          </u>
<u>          </u>	Splinting	<u>          </u>

**RIVER PARISHES HOSPITAL  
ALLIED HEALTH PROFESSIONAL STAFF  
REQUEST FOR PRIVILEGES**

Requested

Approved

MAY PERFORM INDEPENDENTLY AT THE DIRECTION OF  
PHYSICIAN WITHOUT DIRECT SUPERVISION

_____ Dressing changes	_____
_____ Provide patient education	_____
_____ Transcribe verbal orders from the physician to be countersigned within 24 hrs	_____
_____ Urinary bladder catheterization	_____
_____ Take wound cultures	_____
_____ Remove suture at direction of surgeon	_____

Requested

Approved

OTHER

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby request the above privileges for which I am trained and experienced to perform. I understand that the privileges requested may differ from those finally approved. I further understand that the completion of this form does not preclude me from requesting additional privileges in the future.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

I hereby sponsor above signed applicant while acting under my direction and/or while attending to the needs and concerns of my patients only.

\_\_\_\_\_  
Signature of Sponsoring Physician

\_\_\_\_\_  
Date

**RECOMMEND AS NOTED:**

\_\_\_\_\_  
Department Chairman's Signature

\_\_\_\_\_  
Date

## **CONTINUING EDUCATION**

1. Do you wish to request additional privileges in recognition of education enhancement?      \_\_\_\_\_ Yes      \_\_\_\_\_ No
  
2. If yes, please list these on the enclosed delineation of privilege request form.

### **STATEMENT OF CONTINUING MEDICAL EDUCATION ATTESTATION**

The Louisiana State Board of Medical Examiners requires no less than 20 hours of Category I CMEs each year for license renewal. I hereby certify that within the past two years I have completed at least the minimum number of hours of continuing education credits required by the board through which I am licensed, and have participated in all performance improvement activities as specified by the hospital(s) at which I have privileges. If audited, I will be able to provide documentation of the seminars or courses attended. I recognize that failure to produce documentation upon request will jeopardize my membership on the medical staff.

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Provider Name (Printed)

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Provider Signature

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Date

<b>DEPARTMENT:</b> Information Technology & Services	<b>POLICY DESCRIPTION:</b> Confidentiality and Security Agreements
<b>PAGE:</b> 1 of 4	<b>REPLACES POLICY DATED:</b> 3/19/01, 1/20/03 LifePoint Policy: IS.AA.013, 1/20/03 (retired)
<b>APPROVED:</b> 6/28/10	<b>RETIRED:</b>
<b>EFFECTIVE DATE:</b> 6/29/10	<b>REFERENCE NUMBER:</b> LPNT.IS.SEC.005

**SCOPE:** All facilities affiliated with the Company including, but not limited to, hospitals, ambulatory surgery centers, home health agencies, physician practices, and all corporate departments and divisions.

**PURPOSE:**

To provide awareness of the importance of information security and confidentiality and to authorize and require agreements with workforce members, and external entities to protect Company information resources, including confidential patient information.

**POLICY:**

**A. Information Confidentiality and Security Agreements with Individuals**

1. All Company employees and other individuals granted access to Company and/or patient protected health information (PHI) must sign and abide by the Confidentiality and Security Agreement (Agreement). The Agreement acknowledges specific responsibilities the individual has in relation to information security and the protection of sensitive information, including confidential patient information, from unauthorized disclosure.
2. Entities not owned and individuals not employed by the Company or an affiliate of the Company shall sign an Agreement if (i) the entity and individual provides services on premises owned or operated by the Company or an affiliate of the Company; (ii) the entity or individual has remote access to the Company's or its affiliates' information systems; or (iii) the entity or individual has access to Company's confidential information or PHI. All contracts for these services must contain enforcement provisions that are consistent with the Company's or its affiliates' disciplinary policies.
3. Any changes to the Agreement must be reviewed and approved in advance by Corporate Information Technology & Services (IT&S) and Legal Counsel.

**B. Business Contracts with Business Partners.** Relationships with an external entity involving access to Company information systems or the exchange, transmission, storage and maintenance or use of sensitive Company information require a formal contract including provisions to protect the confidentiality and security of Company information and/or systems in accordance with federal HIPAA Security Requirements.

**C. Sanctions.** Violations of this policy could lead to disciplinary measures up to and including

<b>DEPARTMENT:</b> Information Technology & Services	<b>POLICY DESCRIPTION:</b> Confidentiality and Security Agreements
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termination of employment or business relationship. Suspected violations of this policy are to be handled in accordance with the *Information Security Policy, LPNT.IS.SEC.001*, *Protected Health Information Incident Response, HIPAA.GEN.007* and the Discipline section of the Code of Conduct. Violations may be reported in accordance with the *HIPAA Complaint Process & Disciplinary Actions Policy, HIPAA.GEN.003* located on the Compliance SharePoint site. In addition, violations may be reported to the Ethics Line at 1-877-508-LIFE.

- D. **Policy Exceptions.** Exceptions to Information Security Policy are to be submitted to the Corporate IT&S Information Security Policy key contact for review and approval.

**PROCEDURE:**

- A. The Confidentiality & Security Agreement form will be posted and maintained by Corporate IT&S on the Company Intranet located under Security.
- B. Each Company and Company affiliate employee and member of the workforce (e.g. volunteers, contract labor, etc.) must sign the Agreement at the time of employment. The completed Agreement will be maintained in the individual's personnel folder.
- C. Each physician and allied health professional must sign the Agreement at the time he or she is appointed to a facility's medical staff. Completed Agreements will be maintained in the individual's credentials file.
- D. Non-employed physician office staff must sign the Agreement at the time information system access is granted. Completed Agreements must be maintained in a central location by the Physician Support Coordinator or individual with a similar role in the business unit.

Representatives of vendors and other external entities must sign the Agreement at the time information access is granted. Completed Agreements must be maintained in the individual contract folder or system (e.g., ShiftWise) by Facility personnel.

**REFERENCES:**

**Government**

American Recovery and Reinvestment Act of 2009, Title XIII, Health Information Technology, Subtitle D: Privacy  
 Medical Records Confidentiality Act of 1995 (MRCA)  
 Health Insurance Portability and Accountability Act, Security Standards for the Protection of Electronic Protected Health Information, 45 CFR Parts 160, 162, and 164

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<b>EFFECTIVE DATE:</b> 6/29/10	<b>REFERENCE NUMBER:</b> LPNT.IS.SEC.005

**LifePoint**

Information Security – Program Requirements – LPNT.IS.SEC.001  
 HIPAA Complaint Process & Disciplinary Actions – HIPAA.GEN.003  
 Protected Health Information Incident Response – HIPAA.GEN.007  
 Patient Right to Access – HIPAA.PRI.006

**HCA**

Information Security – Program Requirements, IS.SEC.001  
 Information Security - Confidentiality and Security Agreements Policy, IS.SEC.005

## Confidentiality and Security Agreement

I understand that the facility or business entity named below (the “Company”) in which or for whom I work, volunteer or provide services, or with whom the entity (*e.g.*, physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the “Company”), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients’ health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with individually identifiable health information and protected health information, “Confidential Information”).

In the course of my employment / assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will not use company systems to access patient information if it is not necessary to perform my job related duties. This includes NOT accessing my own health information or that of my child or person’s for which I am personal representative via the company systems. The Company’s Privacy and Security Policies available on the Company intranet (on the Security Page) and the internet (under

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation, even if the patient’s name is not used. I will make every reasonable attempt to refrain from practices that might lend itself to unintended breach of patient confidentiality.
4. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
5. 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 Company.
6. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with the Company.
8. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
9. I understand that 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 the Company, in accordance with the Company’s policies.
10. 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.
11. I understand that I should have no expectation of privacy when using Company information systems. The Company 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 security.
12. I will practice good workstation security measures such as locking up electronic media devices when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
14. 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.
15. I will never:
  - d. Share/disclose user-IDs, passwords or tokens.
  - e. Use tools or techniques to break/exploit security measures.
  - f. Connect to unauthorized networks through the systems or devices.
16. I will notify my manager, Local Security Coordinator (LSC), or appropriate Information Services person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.

**The following statements apply to physicians using any Company systems containing patient identifiable health information (e.g. HMS, Meditech, eCW):**

17. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient’s record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me
18. I will accept full responsibility for the actions of my employees who may access the Company software systems and Confidential Information.
19. I have no intention of varying the volume or value of referrals I make to the Company in exchange for Internet access service or for access to any other Company information.
20. I have not agreed, in writing or otherwise, to accept Internet access in exchange for the referral to the Company of any patients or other business.
21. I understand that the Company 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.

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/ <b>Physician Signature</b>	Facility Name and COID NNRH	Date
Employee/Consultant/Vendor/Office Staff/ <b>Physician Printed Name</b>	Business Entity Name	

## **CONTINUING EDUCATION**

1. Do you wish to request additional privileges in recognition of education enhancement?      \_\_\_\_\_ Yes      \_\_\_\_\_ No
  
2. If yes, please list these on the enclosed delineation of privilege request form.

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Provider Name (Printed)

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Provider Signature

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Date