

# RIVER PARISHES HOSPITAL DELINEATION OF PRIVILEGES

REHAB MEDICINE

<b>LEVEL OF PRIVILEGES REQUESTED:</b> 1 - FULL PRIVILEGES 2 - PRIVILEGES WITH CONSULTATION OF APPROPRIATE PRIVILEGES 3 - EMERGENCY ONLY 4 - PRIVILEGES NOT REQUESTED
<b>MEDICAL STAFF DECISION:</b> A - PRIVILEGES APPROVED B - PRIVILEGES ARE NOT APPROVED C - PRIVILEGES ARE CHANGED, APPROVED LEVEL OF PRIVILEGES

**PHYSICIAN NAME:**

INDICATE THE APPROPRIATE LEVEL OF EACH PRIVILEGE REQUESTED	LEVEL OF PRIVILEGES	MED STAFF DECISION
	1 2 3 4	A B C

**PHYSICAL EXAMINATION**

To include:		
Pain-weakness-numbness syndromes (both neuromuscular and musculoskeletal) with a diagnostic pain and /or prescription for treatment which may include the use of the physical agents and/or other interventions.		
Including evaluation, prescription and supervision of medical and supervision of medical and comprehensive rehabilitation goals and treatment plans for:		
Stroke Syndromes		
CNS degenerative diseases		
CNS demyelinating diseases		
Cranial nerve palsies and brainstem syndromes		
Cerebral Palsy		
Cognitive disorders		
Traumatic brain and/or head injury		
Spinal cord syndromes		
Spina bifida and/or myelomeningocele disorders		
Scoliotic disorders		
Chronic neuromusculoskeletal pain syndromes		
Acute neuromusculoskeletal pain syndromes		
Weakness (including poor endurance)		
Amputation (both congenital and acquired)		
Hand and/or foot disorders		
Impairments after trauma, fracture and/or contracture		
Burn disorders		
Peripheral nerve disorders		
Pressure ulcers (decubitus)		
Arthritis and related rheumatic conditions		
Cardiac/circulatory diseases		
Peripheral vascular disorders		
Pulmonary disorders		

**PERFORMANCE AND INTERPRETATION OF:**

Physical medicine and rehabilitation department supervision		
Routine non-procedural medical care		
Prescription of medication		

**RIVER PARISHES HOSPITAL  
DELINEATION OF PRIVILEGES**

**REHAB MEDICINE**

Venipuncture		
Advanced cardiac life support		
Rehabilitation potential determination		
Rehabilitation placement propriety		
Prescription/administration/supervision of therapies		
Prescription/administration/supervision of physical modalities		
Prescription of prosthetic/orthotic and durable medical equipment		
Prosthetic/orthotic and durable medical equipment checkouts		
Arthrocentesis; both aspiration and injection: Joints (small, intermediate and major)		
Bursae		
Joint manipulation/mobilization		
Peripheral		
Spinal		
Serial casting		
Soft tissue injection		
Ligament		
Tendon		
Sheath		
Muscle		
Fascia		
Anesthetic and/or motor blocks		
Peripheral nerve disorders		
Myoneural junction		
Sympathetic chain/ganglia		
Caudal		
Facet nerve/joint (may include use of steroid)		
Work determination status		
Impairment and disability evaluation		
Other:		

**I have requested only those specific privileges for which my education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at River Parishes Hospital.**

SIGNATURE OF APPLICANT	DATE
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SIGNATURE OF APPROVAL	DATE
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## 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: \_\_\_\_\_



# HEALTH STATEMENT

## TO SECTION CHIEF/CHIEF OF STAFF

1. I HEREBY CERTIFY THAT I POSSESS THE NECESSARY MOTOR SKILLS AND CLINICAL EXPERTISE TO JUSTIFY PRIVILEGES IN THOSE AREAS THAT I HAVE REQUESTED, AND I AM FREE OF ANY INFECTIOUS DISEASE.

\_\_\_\_\_ YES                      \_\_\_\_\_ NO

2. IF NO, DO YOU HAVE A PHYSICAL OR MENTAL CONDITION WHICH COULD AFFECT YOUR ABILITY TO EXERCISE THE CLINICAL PRIVILEGES REQUESTED OR WOULD REQUIRE AN ACCOMMODATION IN ORDER FOR YOU TO EXERCISE THE PRIVILEGES REQUESTED SAFELY AND COMPETENTLY? TO ANSWER THIS QUESTION APPROPRIATELY, PLEASE REPORT ANY CONDITION WHICH IS INFECTIOUS, WHICH AFFECTS MOTOR SKILLS, COGNITIVE ABILITY OR JUDGMENT, OR WHICH MAY ADVERSELY AFFECT YOUR ABILITY TO CARE FOR PATIENTS OR TO INTERACT APPROPRIATELY WITH OTHER CAREGIVERS.

\_\_\_\_\_ YES                      \_\_\_\_\_ NO

If yes, please explain:

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3. HAVE YOU TESTED POSITIVE FOR THE TUBERCULIN SKIN TEST?

\_\_\_\_\_ YES                      \_\_\_\_\_ NO

If yes, please give date of positive skin test. \_\_\_\_\_  
If no, when was your last PPD test? \_\_\_\_\_

REGARDLESS OF HOW THIS QUESTION IS ANSWERED, THE APPLICATION WILL BE PROCESSED IN THE USUAL AND CUSTOMARY MANNER. IF YOU HAVE ANSWERED THIS QUESTION AFFIRMATIVELY AND ARE FOUND TO BE PROFESSIONALLY QUALIFIED FOR MEDICAL STAFF APPOINTMENT AND ABLE TO PERFORM THE CLINICAL PRIVILEGES REQUESTED, YOU WILL BE GIVEN AN OPPORTUNITY TO MEET WITH THE EXECUTIVE COMMITTEE TO DETERMINE WHAT ACCOMMODATIONS, IF ANY, ARE NECESSARY TO ALLOW YOU TO PRACTICE SAFELY.

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

\_\_\_\_\_  
DATE



3. \_\_\_\_\_  
**Employer Name** \_\_\_\_\_ **City, State** \_\_\_\_\_ **Phone Number** \_\_\_\_\_  
 \_\_\_\_\_  
**Dates: To / From** \_\_\_\_\_ **Job Title** \_\_\_\_\_ **Reason for Leaving** \_\_\_\_\_

**Education (use additional page if needed)**

\_\_\_\_\_ **Institute Name** \_\_\_\_\_ **City, State** \_\_\_\_\_  
 \_\_\_\_\_  
**Dates Attended** \_\_\_\_\_ **Graduated?**  Yes  No \_\_\_\_\_ **Degree Earned** \_\_\_\_\_

\_\_\_\_\_ **Institute Name** \_\_\_\_\_ **City, State** \_\_\_\_\_  
 \_\_\_\_\_  
**Dates Attended** \_\_\_\_\_ **Graduated?**  Yes  No \_\_\_\_\_ **Degree Earned** \_\_\_\_\_

**Please provide three (3) Professional References**

1. \_\_\_\_\_  
**Reference Name** \_\_\_\_\_ **City, State** \_\_\_\_\_ **Phone Number** \_\_\_\_\_  
 \_\_\_\_\_  
 2. \_\_\_\_\_  
**Reference Name** \_\_\_\_\_ **City, State** \_\_\_\_\_ **Phone Number** \_\_\_\_\_  
 \_\_\_\_\_  
 3. \_\_\_\_\_  
**Reference Name** \_\_\_\_\_ **City, State** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

Have you ever been convicted of a crime?  No  Yes If yes, please provide city and state of conviction and details of conviction.  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAIR CREDIT REPORTING ACT NOTICE:**

In accordance with the Fair Credit Reporting Act (FCRA, Public Law 91-508, Title VI), this information may only be used to verify a statement(s) made by an individual in connection with legitimate business needs. The depth of information available varies from state to state. Status of updates are available on request. Although every effort has been made to assure accuracy, General Information Services, Inc. cannot act as guarantor of information accuracy or completeness. Final verification of an individual's identity and proper use of report contents are the user's responsibility. General Information Services, Inc.'s policy requires purchasers of these reports to have signed a Service Agreement. This assures General Information Services, Inc. that users are familiar with and will abide by their obligations, as stated in the **FCRA**, to the individuals named in these reports. If information contained in this report is responsible for the suspension or termination of an employee or the application process, have the Candidate/employee contact General Information Services, Inc.

**NOTICE TO CALIFORNIA CANDIDATES**

You have a right to obtain a copy of any consumer report or investigative consumer report obtained by LIFEPOINT HOSPITALS, INC by checking the box provided below. The report will be provided to you within three (3) business days after we receive the requested reports related to the matter investigated.

I request to receive a free copy of this report by checking this box.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by GIS during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at GIS in person or by mail. You may also receive a summary of the file by telephone. The agency is required to have personnel available to explain your file to you and the agency must explain to you any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.

<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

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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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**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.

### **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