

# DELINEATION OF PRIVILEGES

## ANESTHESIOLOGY

### General Information

1. Minimum Criteria

To be eligible to request privileges in Anesthesiology, the following minimum criteria must be met:

**Basic Education:** MD or DO

**Training:** Successful completion of a postgraduate residency training program approved by the American Board of Medical Specialties in a specialty relevant to that in which these privileges are requested.

**Experience:** Administration of anesthesia for at least 100 procedures during the preceding 18 months.

2. If you meet the above criteria, you may request 'CORE' privileges in Anesthesia. You will be expected to be competent in selection and provision of anesthesia and pre-, intra- and post-procedure monitoring for infants, children, adolescents, adults and geriatric patients undergoing:

- General surgery
- Gynecological surgery/procedures
- Ophthalmologic surgery/procedures
- Oral dental surgery/procedures
- Orthopedic surgery/procedures
- Otolaryngological surgery/procedures
- Pediatric surgery/procedures, including neonates
- Urological surgery/procedures
- Vascular surgeries
- Obstetrical procedures including cesarean sections
- Newborn resuscitation
- Selected pain consultation and therapy
- Application of endobronchial and endotracheal intubation and extubation, hypotension, nasal tracheal intubation and extubation regional anesthesia, including spinal, epidural, caudal, brachialplexus invasive monitoring including arterial lines, Swan Ganz and central venous

I understand that in making this request for privileges, I am bound by the applicable Bylaws and Rules and Regulations and policies/procedures of the Medical Staff of Los Alamos Medical Center. I hereby state that I meet the threshold criteria for each request.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Credentials Committee

\_\_\_\_\_  
Date

Approved: Surgery Svs Committee 11/30/95  
              Credentials Committee 12/15/95  
              Executive Committee 1/18/96

\_\_\_\_\_  
Service Chief

\_\_\_\_\_  
Date

# ICU PRIVILEGES

\_\_\_\_ I do not wish to have ICU privileges at Los Alamos Medical Center.

These privileges may be requested by physicians seeking privileges in Adult Medicine or in General Surgery as appropriate. Application for these privileges is evaluated on an individual basis and is subject to the approval of the Credentials and Executive Committees. Proof of competency may be required.

PROCEDURE	REQUESTED	REQUEST WITH SUPERVISION	RECOMMEND	RECOMMEND WITH SUPERVISION
Medical				
Complicated Myocardial				
Uncomplicated Myocardial				
Surgery				

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Service Chief

\_\_\_\_\_  
Date

\_\_\_\_\_  
Credentials Committee

\_\_\_\_\_  
Date

# LOS ALAMOS MEDICAL CENTER

## APPOINTMENT/REAPPOINTMENT INFORMATION FORM

NAME \_\_\_\_\_

DATE \_\_\_\_\_

	YES	NO
1) Do you wish to be appointed/reappointed to the Medical Staff/Allied Health Professional Staff of Los Alamos Medical Center?	[ ]	[ ]
2) Please request desired privileges (see attached form) and add or delete according to your current clinical practice patterns. (All requests for additional clinical privileges must be accompanied by information demonstrating current competence.)	[ ]	[ ]
3) Since your last re/appointment:		
A) Has your license (MD, DO, DDS, DPM) in any jurisdiction ever been limited, suspended or revoked?	[ ]	[ ]
B) Has your medical license ever been subjected to any successful or pending challenges?	[ ]	[ ]
C) Has your DEA registration ever been limited, suspended or revoked?	[ ]	[ ]
D) Has your DEA registration ever been subjected to any successful or pending challenge?	[ ]	[ ]
4) Have your privileges at any hospital ever been denied, suspended, limited (reduced), revoked or not renewed?	[ ]	[ ]
5) Has your specialty board status ever been denied, suspended, reduced, revoked or not renewed?	[ ]	[ ]
6) Have you ever been denied appointment, clinical privileges/renewal of clinical privileges or been subject to disciplinary action by any medical/hospital organization?	[ ]	[ ]
7) Has your faculty membership in any medical or other professional school ever not been renewed or subject to disciplinary action?	[ ]	[ ]
8) Have you ever requested a fair hearing or board appeal?	[ ]	[ ]

	<b>YES</b>	<b>NO</b>	
9) Have you ever received any type of sanction from a professional review organization (PRO) or third-party payer?	[ ]	[ ]	
10) Have you ever voluntarily reduced, limited, or suspended your clinical privileges at any hospital?	[ ]	[ ]	
11) Have you ever voluntarily resigned from a medical staff or relinquished your privileges at any hospital?	[ ]	[ ]	
12) Have you ever been named as a defendant in any criminal proceeding?	[ ]	[ ]	
13) Have any disciplinary actions ever been initiated or are any pending against you by any state licensure board?	[ ]	[ ]	
14) Have you ever been asked to surrender your medical license?	[ ]	[ ]	
15) Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program (i.e. Medicare or Medicaid)?	[ ]	[ ]	
16) Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program?	[ ]	[ ]	
17) Have your employment, medical staff appointment or clinical privileges ever been suspended, reduced, revoked, refused, or limited at any hospital or other health care facility involuntarily?	[ ]	[ ]	
18) Have you ever withdrawn your application for appointment, reappointment or clinical privileges or resigned from the medical staff before a decision was made by a hospital's or health care facility's Governing Board?	[ ]	[ ]	
19) Have you ever been the subject of focused individual monitoring at any hospital or health care facility?	[ ]	[ ]	
20) Is there any investigation pending against you?	[ ]	[ ]	
21) Have you passed a board examination?	[ ]	[ ]	
22) If you are not board certified, have you applied for the certification exam?	[ ]	[ ]	
23) If no, do you intend to apply for the certification examination?	[ ]	[ ]	
24) Have you been accepted to take the certification examination?	[ ]	[ ]	N/A [ ]

- |   | <b>YES</b> | <b>NO</b> |            |
|---|------------|-----------|------------|
| 25) If yes, what dates are scheduled to take the certification examination? _____   |            |           | N/A<br>[ ] |
| 26) What are the date(s) of the next required recertification examination? _____  |            |           | N/A<br>[ ] |
| 27) Have you ever been named in a professional liability suit?  | [ ]        | [ ]       |            |
| 28) Are there any professional liability suits in which you<br>Have been named presently pending?   | [ ]        | [ ]       |            |
| 29) Have any judgments or settlements been made on your<br>behalf?  | [ ]        | [ ]       |            |
| 30) Have you ever left a hospital while you were under<br>Investigation or involved in disciplinary proceedings?  | [ ]        | [ ]       |            |
| 31) Have you ever filed legal proceedings of any kind against<br>an individual physician, medical practice, professional<br>corporation or healthcare organization or facility? | [ ]        | [ ]       |            |

**\*\*Please provide additional information for any “YES” answers on a separate sheet of paper. Thank you.**

# LOS ALAMOS MEDICAL CENTER

## APPOINTMENT/REAPPOINTMENT STATUS

I hereby apply to the Los Alamos Medical Center for Appointment to the:

Active Staff \_\_\_\_\_

Courtesy Staff \_\_\_\_\_

Consulting Staff \_\_\_\_\_

Locum Tenens \_\_\_\_\_

Honorary Staff \_\_\_\_\_

Allied Health Prof  
(AHP) \_\_\_\_\_

I have received, read and agree to be bound by the Bylaws and the Rules and Regulations of the Medical Staff of **Los Alamos Medical Center**.

Also, I specifically acknowledge my obligation to provide continuous care and supervision of my patients, and other obligations as defined in the Bylaws, Rules and Regulations, and I further agree to be bound by the terms thereof if I am granted membership and/or clinical privileges, and to be bound by the terms thereof without regard to whether or not I am granted membership and/or clinical privileges in all matters relating to consideration of my application.

***I fully understand that any misstatements in or omissions from this application constitute cause for summary dismissal from the staff.***

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Applicant

**LOS ALAMOS MEDICAL CENTER**

**HEALTH STATEMENT**

**I certify that I am in good health and have no conditions which would interfere with my ability to practice medicine.**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

## MEDICARE ACKNOWLEDGMENT STATEMENT

**Notice to Physicians:** Medicare payment to hospitals is based in part on each patient's principle and secondary diagnosis, and the major procedure 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.

\_\_\_\_\_  
Physician Name (please print legibly or type)

\_\_\_\_\_  
UPIN

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date Signed

## **STATEMENT OF RELEASE & IMMUNITY FROM LIABILITY**

I hereby apply for Medical Staff appointment and/or Privileges as requested in this application and, whether or not my application is accepted, I acknowledge, consent and agree as follows:

### **APPLICANT'S BURDEN**

As an applicant for appointment or reappointment, I have the burden of producing adequate information for proper evaluation of my qualifications.

During the processing of my application, I agree to inform the CEO of any change in the areas of inquiry contained herein no later than seven (7) days after any such changes. I agree to provide any additional information as may be requested by the Hospital or its authorized Representatives. Failure to produce any such information will prevent my application from being evaluated and acted upon.

I hereby signify my willingness to appear for an interview, if requested, in regard to my application.

Information given in or attached to this application is accurate and complete to the best of my knowledge. I fully understand and agree that as a condition to making this application, any misrepresentations or misstatement in, or omission from it, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of appointment and/or Clinical Privileges.

### **RELEASE & IMMUNITY FROM LIABILITY**

I accept the following conditions:

- (1) I extend immunity to, and release from any and all liability, the Hospital, its authorized Representatives and any Third Parties, for any acts, communications, recommendations or disclosures performed without intentional fraud or malice involving me; made, requested or received by this Hospital and its authorized Representatives from any Third Party, including otherwise privileged or confidential information, relating, but not limited to, the following:
  - (i) applications for appointment or Clinical Privileges, including Temporary Privileges;
  - (ii) periodic reappraisals;
  - (iii) proceedings for suspension or reduction of Privileges or for denial or revocation of appointment, or any other disciplinary action;
  - (iv) summary suspension;
  - (v) hearings and appellate reviews;
  - (vi) proctoring or monitoring evaluations;
  - (vii) utilization reviews;

- (viii) any other Hospital, Medical Staff, service or committee activities;
  - (ix) inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and
  - (x) any other matter that might directly or indirectly affect or reflect on my competence, on patient care or on the orderly operation of this Hospital.
- (2) I specifically authorize the Hospital and its authorized Representatives to consult with any Third Party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, clinical competence, mental or emotional stability, physical condition, ethics, or behavior bearing on my satisfaction of the criteria for continued appointment to the Medical Staff, as well as to inspect or obtain any communications, reports, records, statements, documents, recommendations and/or disclosure of 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.
- (3) The applicant agrees that any lawsuit brought by the applicant against a Hospital Representative or against a Third Party providing information to a Hospital Representative shall be brought in a court, federal or state, in the state in which the defendant resides or is located.

## **ACKNOWLEDGEMENT & AGREEMENT**

I acknowledge that:

- (1) Medical Staff appointments and Privileges at this Hospital are not a right;
- (2) my request will be evaluated in accordance with the procedures defined in these Bylaws;
- (3) all Medical Staff recommendations relative to my application are subject to the ultimate action of the Board whose decision shall be final;
- (4) if appointed, my appointment and Clinical Privileges shall be provisional;
- (5) I have the responsibility, as noted in Section 3.3(j), to notify the CEO of changes to the information provided in this application regarding malpractice actions, liability insurance, felony or fraud charges or professional sanctions no later than seven (7) days after I am-notified of any such changes;
- (6) appointment and continued Clinical Privileges remain contingent upon my continued demonstration of professional competence and satisfaction of the Basic Responsibilities listed in Section 3.3; and
- (7) reappointment and continued Clinical Privileges shall be granted only on formal application according to these Bylaws and subject to final approval by the Board.

## **ADMINISTRATIVE REMEDIES**

I understand that before this application will be processed that:

- (1) I will be provided a copy of the Medical Staff Bylaws including the Rules and Regulations along with a list of all Hospital policies. Copies of such policies are available on request from the CEO.
- (2) I must sign a statement acknowledging receipt and an opportunity to read and agreement to abide by all such Bylaws, policies, and Rules and Regulations as are in force, and as they may thereafter be amended, during the time I am appointed to the Medical Staff or exercise Clinical Privileges at the Hospital.

## **ETHICS PLEDGE**

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 care of hospitalized patients to any other Practitioner or AHP 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 individual providing treatment or services;
- (4) seek consultation whenever necessary;
- (5) abide by generally recognized ethical principles applicable to my profession;
- (6) provide or arrange suitable coverage for, continuous care and supervision to all patients in the Hospital for whom I have responsibility; and
- (7) accept committee assignments and such other duties and responsibilities as shall be assigned to me by the Board or Chief of Staff.

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Applicant's Signature

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Date

# Los Alamos Medical Center

## **SAFETY INFORMATION FOR LOS ALAMOS MEDICAL CENTER**

Los Alamos Medical Center is accredited by the Joint Commission on Accreditation of Healthcare Organizations. “All staff members, licensed independent practitioners...can describe or demonstrate their roles and responsibilities, based on specific job duties or responsibilities relative or safety.” The information provided below satisfies this requirement. **Please read this information below, sign your name and return the signature page in your appointment/reappointment packet to the Quality Department at Los Alamos Medical Center. (If you have any questions regarding this information, please call 505-661-9170). Not returning this signature page may result in a delay in processing your application for appointment/reappointment.**

## **MISSION, VISION, VALUES**

The mission of Los Alamos Medical Center is “We believe that the heart of healthcare is service to others.” Our single goal is to provide affordable, accessible healthcare that improves the health and well-being of the people we serve and raises the quality of life for all concerned. Working in a partnership with communities, we constantly seek to build healthcare systems that are locally focused and nationally recognized as the standard by which community hospitals are judged. Our vision is “Los Alamos Medical Center will be the cost effective provider of quality healthcare for Northern New Mexico.”

## **PERFORMANCE IMPROVEMENT**

Performance Improvement (PI) is continuous improvement of processes and services to meet and exceed the needs and expectations of our patients and customers. These improvement efforts are guided by the Performance Improvement Council. Suggestions for improvement are welcome from staff, physicians, patients and customers of the hospital. Annually, medical staff service committees select at least one performance improvement activity to track. Methods used for improvement include PDMAI (our PI Model: Plan, Design, Measure, Analyze, Improve), PI teams, departmental critical indicators, participation in the JCAHO Core Measures, CMS Hospital Compare Initiative and the CMS/NMMRA Seventh Scope of Work.

## **PATIENT RIGHTS AND RESPONSIBILITIES**

Los Alamos Medical Center respects the rights of patients by recognizing that each patient is a unique individual with unique healthcare needs. Considerate and respectful care focused on the patient’s individual needs show that we acknowledge each patient’s personal dignity. Patient rights include, but are not limited to, right to participate in decisions regarding their care, right to pain management, right to safety and privacy, right to access to care, right to confidentiality, right to security, personal privacy and confidentiality of information, right to protective services, right to complete and current information, including the names of the persons responsible for their care and their diagnosis, treatment and prognosis in easily understandable terms.

Patient’s responsibilities include, but are not limited to providing complete and accurate information about their complaints, illnesses, hospitalizations, etc., asking questions for clarification, following instructions, following the hospital’s rules and regulations, acting with consideration and respect for other patients and hospital personnel and working together with their providers to establish goals, implement a plan to meet those goals and to attempt to meet the goals.

## **ETHICS**

Los Alamos Medical Center has an Ethics Committee, composed of providers (physicians, nurses, etc.), social workers, attorneys, clergy, representatives from Los Alamos National Laboratory and Performance Improvement department. The group can provide consultation for any ethical issue that may arise. Confidentiality is maintained. Employees, patients or physicians may access the committee through the Nursing Supervisor, the Chief Nursing Officer, the CEO or the Director or Performance Improvement.

## CODES

Los Alamos Medical Center recognizes the following codes:

- Code Blue – Cardiac/respiratory arrest
- Code Pink – Infant abduction
- Code Amber – Child abduction
- Code White – Bomb threat
- Code Magenta – Radioactive accident
- Code Red – Fire
- Code Yellow – Security incident
- Code Haze – Hazardous spill
- Activate Incident Command – Disaster or emergency situation

Physicians should know the location of the fire alarm pull station and the fire extinguisher nearest their offices and how to **RACE: rescue, alarm, contain, extinguish** in the event of a fire. ABC fire extinguishers are all-purpose extinguishers and are available throughout the buildings.

It may be necessary in the event of a fire or disaster or emergency situation to shelter in place or to evacuate the facility. Physicians must report to the Emergency Room for assignment when the “activate incident command” code is called overhead. Patients will be evacuated to an area of safety in the hospital (another smoke compartment) or an alternative care site (Sombrillo Nursing Home or Griffith Gym at Los Alamos High School) in this order:

- Patients closest to danger
- Ambulatory patients
- Wheelchair patients
- Stretcher patients

## INCIDENT COMMAND

Los Alamos Medical Center uses the Incident Command model for handling disaster or emergency situations. The Chief of Staff, if available, is the Medical Care Director and will assign physician to particular duties when and if needed. Each physician who is on campus at the time that Incident Command is called on the overhead paging system is expected to report to the Emergency Room and sign in so that the Medical Care Director knows who is available for potential assignments. There is a process for granting “disaster/emergency privileges” to non-LAMC physicians who may wish to assist in a disaster/emergency situation.

## SMOKING

At the request of the Medical Staff, Los Alamos Medical Center is a **SMOKE-FREE CAMPUS**. No patient, hospital employee, **physician, employee of a physician or visitor may smoke in any building or on any part of the campus (including the off-site clinics)**. **There are no exceptions**. Physicians may order nicotine patches for patients who smoke while they are hospitalized.

## INFECTION CONTROL/BLOODBORNE PATHOGENS

Los Alamos Medical Center uses “standard precautions” to prevent the spread of infectious agents to patients and to staff and physicians. Body fluids (blood, urine, feces, wound drainage, oral secretions, vomitus, sputum) may be contaminated with HIV, HBV, HCV or other bloodborne pathogens; therefore, all blood and body fluids, materials or devices contaminated with them are treated as potentially infectious. Personal protective equipment (gloves, gowns, masks, booties, etc.) is available on every unit. Needles must not be recapped and should be disposed of in the puncture-proof sharps containers in every patient room and throughout the facility. Trash contaminated with blood or body fluid is disposed of in red bags. Used linen is bagged in clear plastic bags. If you have an unprotected exposure to blood or body fluid, report to the Emergency Room immediately. If you have questions regarding infection control, contact the Infection Control Coordinator at extension 1390.

## **SAFETY**

Safety of patients, staff and visitors is the responsibility of every employee and every physician. Watch for and report any unsafe condition immediately, using an occurrence report, phone call to extension 1603 or notification of the Risk Manager at extension 1346.

## **COMPLAINTS**

Los Alamos Medical Center views concerns, issues and complaints expressed by patients, visitors and other customers as valuable data to help identify and prioritize opportunities for improvement. It is everyone's responsibility to report any complaint they may hear, by speaking with any member of the Administrative Team, calling extension 1603 or completing an occurrence report. Patients and their families have the right to register a complaint and are informed of both the mechanism to follow in registering the complaint and the fact that submitting a complaint will not adversely affect their current or future care at any of our facilities. The Occurrence Report form is available in all departments of the hospital. Once completed, the form is kept by the Risk Manager or the Director of Community Relations for follow-up and trending. Those registering a complaint are given as much feedback as possible.

## **CONFIDENTIALITY**

A patient has the right, according to HIPAA regulations, to personal and informational privacy, including the right to refuse to talk with or see anyone who is not officially connected with the hospital or directly involved in his/her care, to expect that discussion concerning his/her case/care will be conducted discretely and only with those directly involved in his/her care to allow his/her medical record to be read only by those directly involved in his/her care or in the monitoring of the quality of that care.

**LOS ALAMOS MEDICAL CENTER**

**My signature below verifies that I have received and read the Safety Information for Los Alamos Medical Center and that I am familiar with the information contained therein.**

\_\_\_\_\_  
**Signature of Practitioner**

\_\_\_\_\_  
**Date**

# LOS ALAMOS MEDICAL CENTER

## VOLUNTARY/INVOLUNTARY RELINQUISHMENT OF PRIVILEGES

**Please check the appropriate box and return this form with your application for appointment/reappointment. Thank you.**

	<b>YES</b>	<b>NO</b>
I have not changed any of my privileges at LAMC.	[ ]	[ ]
I have voluntarily reduced or limited my privileges at another medical facility.	[ ]	[ ]
I have voluntarily relinquished my privileges to practice at another medical facility.	[ ]	[ ]
My privileges to practice at another medical facility were involuntarily reduced or limited.	[ ]	[ ]
My privileges to practice at another medical facility were suspended or revoked.	[ ]	[ ]
I have privileges at another medical facility.	[ ]	[ ]
I wish to request additional privileges at Los Alamos Medical Center.	[ ]	[ ]

If privileges were limited, reduced, suspended or revoked at another medical facility, either voluntarily or involuntarily, please specify the name of the facility.

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If you wish to add any new procedures, treatments, etc. to the list of privileges you have requested at Los Alamos Medical Center, please submit evidence of your training and competency in performing same.

\_\_\_\_\_  
Signature of Practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Practitioner

# Los Alamos Medical Center

## Patient Restraint Physician Information

Physicians and other Licensed Independent Practitioners (LIPs) are required to have a “working knowledge” of Los Alamos Medical Center’s policy on restraint. Following are the most important points from the restraint policy:

### Definitions

**Physical Restraints** - any manual method that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. Holding a patient in a manner that restricts his/her movement constitutes restraint for that patient.

**Chemical Restraints** - drug used as a restraint; a medicine used to control behavior or to restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s medical or psychiatric condition.

**Restraint to Promote Medical Recovery (non-violent):** refers to the use of restraints in those patients who require various medically essential therapies while hospitalized and who demonstrate a state of confusion or altered cognition that puts those therapies at risk OR those patients who require management of non-psychiatric behaviors that put them at risk for injury.

**Restraints for Violent or Self-Destructive Behavior:** refers to the use of restraints in those patients who require management of violent or self-destructive behavior towards themselves or others (including caregivers or other patients) or, who require physical restraint to manage suicidal or homicidal behaviors in ANY setting.

**Restrictive Devices Applied by Law Enforcement Officials** - handcuffs and other restrictive devices applied by law enforcement officials for custody, detention, and public safety reasons and not for the provision of health care are not considered restraints

**Seclusion-** seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others. **Seclusion is not used at Los Alamos Medical Center**

**Use of restraint is assessment driven and is only implemented when:**

Deemed necessary to protect the physical safety of patients, staff members or others AND less restrictive measures have been considered and/or attempted and found ineffective.

**ORDERING**

**Medical Recovery Restraint:** to protect the patient from self injury and to promote healing (prevention of dislodging of ET tube, lines, etc.) must be ordered by a LIP with a NEW order every calendar day based on the LIP's evaluation of the patient.

- ✓ A registered nurse may initiate restraints and obtain an order from an LIP who is responsible for the patient, as soon as possible after restraint is initiated
- ✓ The attending physician must be notified as soon as possible (can be through review of the restraint order) but no later than the end of the calendar day following initiation of the restraint order), if he/she was not LIP initiating restraint

**Restraint for violent and/or self destructive behavior:** jeopardizes the immediate safety of the patient, a staff member or others shall remain in effect until the patient's behavior or situation no longer requires the use of restraint, but no longer than

- ✓ 4 hours for adults 18 years of age or older;
- ✓ 2 hours for children and adolescents 9 to 17 years of age; or
- ✓ 1 hour for children 8 years of age or younger.

Renewal orders may be given for the above durations if the indications for restraint or seclusion persist. However, continuation of restraint or seclusion for longer than 24 hours shall be based on an in-person evaluation by a responsible licensed independent practitioner.

PRN orders for restraint are NOT to be used.

**Face-to-Face Assessment performed within one-hour:** A responsible licensed independent practitioner, a registered nurse or a physician's assistant shall perform a face-to-face assessment of the patient's physical and psychological status within 1 hour of the initiation of restraint.

**Documentation of the LIP assessment for violent self destructive behavior restraint must include**

- ✓ evaluation of the patient's immediate situation
- ✓ patient's reaction to the intervention
- ✓ patient's medical and behavioral condition
- ✓ need to continue or terminate restraint

*The complete policy is available for your review in the Clinical Policy Manual on request. If any member of the medical staff has any questions regarding Los Alamos Medical Center's policy on restraint, please contact the Quality Department or Medical Staff Coordinator at hospital extension 1946, 1170.*

I have read and understand the information on management of the patient in restraint at Los Alamos Medical Center.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name

# HCA

<b>DEPARTMENT:</b> Information Technology & Services	<b>POLICY DESCRIPTION:</b> Information Confidentiality and Security Agreements
<b>PAGE:</b> 1 of 3	<b>REPLACES POLICY DATED:</b> August 15, 2001; Nov. 1, 2001; Jan. 27, 2004
<b>EFFECTIVE DATE:</b> April 30, 2005	<b>REFERENCE NUMBER:</b> IS.SEC.005

**SCOPE:** All Company-affiliated facilities including, but not limited to, hospitals, ambulatory surgery centers, physician practices, home health agencies, service centers, and all Corporate Departments, Groups and Divisions.

**PURPOSE:** To provide awareness of the importance of information security and confidentiality and to authorize and require agreements with individuals 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 information systems 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. A non-Company owned physician practice, vendor, or other external entity may make and shall enforce such Agreements on behalf of employees working off-site (*e.g.*, contracted transcription service, electronic claims submissions support contractor, physician office practice), if stipulated in the Company's contract with the external entity (see B. below). Each individual working on Company premises accessing Company and/or patient information must sign an Agreement.
3. The Information Security Steering Committee reviews and approves recommended changes to the Agreement, and Information Technology & Services (IT&S) publishes and maintains the Agreement. The Agreement is an official corporate document and must not be altered in any manner without prior approval from IT&S.

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

1. A Company representative authorized to approve access to the Company information system and/or the disclosure of the sensitive Company information must sign the Contract.
2. The Contract must include provisions governing the entity's information security policies and practices, as well as requirements to support Company compliance with

# HCA

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regulatory requirements.

3. Current required Contract provisions are provided by the Legal Department.

C. **Contracts for IT&S Services.** All contracts for services will include appropriate standard security language approved by IT&S.

D. **Sanctions.** Violations of this policy could lead to disciplinary measures up to and including termination of employment or business relationship. Suspected violations of this policy are to be handled in accordance with the Information Security Policy, IS.SEC.001 and the Discipline section of the Code of Conduct. The Company encourages resolution at the local level and each Customer (an organization, business entity or organizational unit that has an established business relationship with IT&S as described in this policy's scope) will designate a process for reporting violations. In addition, violations may be reported to the Ethics Line at 1-800-455-1996.

E. **Policy Exceptions.** Exceptions to Security Policy are to be submitted to the IT&S Security Policy key contact for review and approval.

## **PROCEDURE:**

A. The Confidentiality & Security Agreement form will be posted and maintained by IT&S on the Company Intranet located under Security.

B. Each Company employee must sign the Agreement at the time of employment and acknowledge the Agreement at the time of the Code of Conduct refresher training. 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 and during the reappointment process thereafter. Completed Agreements will be maintained in the individual's credentials file.

D. Each volunteer must sign the agreement before beginning his or her service and annually thereafter. The agreement signature process and subsequent annual verifications can be completed during Code of Conduct training (if the volunteer attends such training), volunteer orientation or separately. The completed agreement will be maintained with the Company's records of the volunteer's service.

E. Physician office staff must sign the Agreement at the time information access is granted, and on an annual basis thereafter. Completed Agreements must be maintained in a central location by the Physician Support Coordinator or individual with a similar role in the business

# HCA

<b>DEPARTMENT:</b> Information Technology & Services	<b>POLICY DESCRIPTION:</b> Information Confidentiality and Security Agreements
<b>PAGE:</b> 3 of 3	<b>REPLACES POLICY DATED:</b> August 15, 2001; Nov. 1, 2001; Jan. 27, 2004
<b>EFFECTIVE DATE:</b> April 30, 2005	<b>REFERENCE NUMBER:</b> IS.SEC.005

unit.

- F. Representatives of vendors and other external entities must sign the Agreement at the time information access is granted and at contract renewal or, at a minimum, every two years thereafter. Completed agreements must be maintained in the individual contract folder by the Facility CFO or designee.

**REFERENCES:**

Code of Conduct  
Confidentiality & Security Agreement  
Information Systems Security Policy, IS.SEC.001  
Electronic Communications Policy, IS.SEC.002  
CPCS Appropriate Access Toolkit

# Confidentiality and Security Agreement

I understand that the facility or business entity (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 patient identifiable 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 access and use this information only when it is necessary to perform my job related duties in accordance with the Company’s Privacy and Security Policies, which are available on the Company intranet (on the Security Page) and the internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

- |   |  |
|---|--|
| <ol style="list-style-type: none"> <li>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.</li> <li>2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.</li> <li>3. 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.</li> <li>4. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.</li> <li>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.</li> <li>6. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.</li> <li>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.</li> <li>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.</li> <li>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.</li> <li>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.</li> <li>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.</li> <li>12. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.</li> </ol> | <ol style="list-style-type: none"> <li>13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.</li> <li>14. I will:             <ol style="list-style-type: none"> <li>a. Use only my officially assigned User-ID and password (and/or token (e.g., SecurID card)).</li> <li>b. Use only approved licensed software.</li> <li>c. Use a device with virus protection software.</li> </ol> </li> <li>15. I will never:             <ol style="list-style-type: none"> <li>a. Share/disclose user-IDs, passwords or tokens.</li> <li>b. Use tools or techniques to break/exploit security measures.</li> <li>c. Connect to unauthorized networks through the systems or devices.</li> </ol> </li> <li>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.</li> </ol> <p><b>The following statements apply to physicians using Company systems containing patient identifiable health information (e.g. CPCS/Meditech):</b></p> <ol style="list-style-type: none"> <li>17. I will only access software systems to review patient records when I have that patient’s consent to do so. By accessing a patient’s record, I am affirmatively representing to the Company at the time of each access that I have the requisite patient consent to do so, and the Company may rely on that representation in granting such access to me.</li> <li>18. I will insure that only appropriate personnel in my office will access the Company software systems and Confidential Information and I will annually train such personnel on issues related to patient confidentiality and access.</li> <li>19. I will accept full responsibility for the actions of my employees who may access the Company software systems and Confidential Information.</li> </ol> |
|---|--|

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



### Signature/Initial Page

This form will be placed in your medical staff file and in Medical Records for a signature and initial comparison on your charts. Please sign and initial where indicated.

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Practitioner Printed Name

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Practitioner Initials

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Practitioner Signature

## Applicant's Attestation

I, \_\_\_\_\_, certify that the information I have provided and the statements I have made on this application are correct, true, and complete to the best of my knowledge. I will abide by the applicable bylaws, rules and regulations, and policies and procedures of the designated health care entity. I acknowledge that I have received and reviewed a copy of the bylaws, if applicable, of the designated health care entity. I further agree that, in the event there should arise an adverse ruling with respect to my status and/or clinical privileges, I will exhaust the administrative remedies afforded by the entity's bylaws before resorting to litigation.

**Signature stamps and date stamps are not acceptable.**

\_\_\_\_\_  
Signature  
type) \_\_\_\_\_  
Date (do not

**All applicants have the right to be informed of their application status. Application status inquiries should be directed to the appropriate health care organization. Practitioners may utilize any or all of the following to ensure accurate file information.**

- **The right of practitioners to review information submitted to support their credentialing application.**
- **The right of practitioners to correct erroneous information.**
- **The right of practitioners to be informed of the status of their credentialing or recredentialing application upon request.**
- **The right of practitioners to be notified of these rights.**

**This application has been designed to streamline the credentials verification process for providers, and meets the standards of many accrediting organizations. The application will be processed in accordance with the customer's required standards.**

**Hospital Services Corporation, a subsidiary of the New Mexico Hospitals and Health Systems Association, maintains this form, as well as a user's mailing list, to distribute any subsequent revisions. If you have any questions about this form or if you would like to be included on the user's list, please contact one of our credentials analysts at (505) 343-0070, or by e-mail at [cvs@nmhsc.com](mailto:cvs@nmhsc.com). This application has been copyrighted and is intended for the sole use of our customers and approved users.**

# LOS ALAMOS MEDICAL CENTER

## RELEASE OF INFORMATION

By signing this application, I hereby agree to cooperate fully with this institution, its medical staff, administrator, owner, operator and their agents, employees, attorneys and such other persons or entities as may be necessary or appropriate in the sole and exclusive discretion and judgment of the institution during its investigation and processing of this application. I further signify my willingness to appear for all interviews, submit documents, written or oral evidence or such other information as may be requested of me with regard to my application and I hereby expressly authorize the **Los Alamos Medical Center**, its medical staff, administrator, owner, operator and their agents, employees and attorneys to consult with and obtain oral or written information from such other persons or entities as they may deem appropriate who may have information or evidence bearing on my competence, background, education, experience, character, physical and mental condition and ethical qualifications. I further consent to this institution and its medical staff, administrator, owner, operator and their agents, employees and attorneys examining all records, documents and information that in their judgment and discretion may be material or relevant to an evaluation of this application and my professional qualifications and competence to perform the clinical privileges I have or may request as well as my moral, physical and ethical qualifications. I hereby release, acquit and forever discharge the above named institution, its medical staff, administrator, owner, operator and their agents, employees and attorneys and any and all other entities and persons who may furnish or submit documents, written or oral evidence or information in connection with the investigation and processing of this application from and of any liability, claim, cause of action or demand for or by reason of any matter, cause or thing in connections with the investigation and processing of this application, including, but not limited to, liability, causes of action or claims for invasion of privacy, libel, slander and negligence which may or could arise from the submission, giving, transmission, furnishing or discussion of documents, written or oral evidence or information touching on or related to my competence, education, background, character, experience, physical and mental condition and ethical qualifications.

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Signature of Applicant

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Date

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Printed Name of Applicant



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.





**By signing this page I acknowledge that I have received, read and have been given the opportunity to ask questions about the following documents:**

*"As an applicant for medical staff membership and clinical privileges I acknowledge that I have received a copy of the hospital's Medical Staff Bylaws, Rules and Regulations, Policies and Procedures, and Code of Conduct; and (i) if granted medical staff membership and clinical privileges, I agree to be bound by the terms of these documents, (ii) without regard to whether or not the application is granted, I agree to be bound by the terms thereof in all matters relating to consideration of the application and acknowledge the provisions in the bylaws for release and immunity from civil liability."*

1. Medical Staff Bylaws
2. Medical Staff Rules and Regulations
3. Fair Hearing Plan

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*Practitioner Signature*

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*Date Signed*

