

# Mountain Valley Regional Rehabilitation Hospital

## DELINEATION OF PRIVILEGES

### CORE COMPETENCY: Rehabilitation Physician

**Applicant Name :** \_\_\_\_\_

**Education:**             M.D.     D.O.     Other (list): \_\_\_\_\_

**Training:**            Post graduate training in one of the following (check at least one):  
                                   PM&R             Other (list): \_\_\_\_\_

**Experience:**            Years of experience in post training:  
                                   2-5 yrs             6-10 yrs             11 yrs and greater

**Care:**                    Admit and provide consultation for patients with rehabilitation needs. Provide all types of physical modalities.

<b>Core Privileges</b>	Admit Patients H&P Assessments/ Evaluations Disease Management Medication Management Trigger Point Injection	Simple Laceration I&D Abscess Skin Biopsy/Excision EKG Interpretation Intermediate Laceration Repair
------------------------	---	--

**Staff Privileges Requested:**

- Appointment to Medical Staff - Plan to be involved in patient care and / or medical staff functions.
- Re-appointment to Medical Staff – Continue involvement in patient care and / or medical staff functions.

### Special Privileges Requested

Complete by Applicant	Complete by MEC			
Requested	Granted	Granted with Conditions*	Not Granted ^	
_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	
_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	
_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	
_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	
_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	

Signature Applicant \_\_\_\_\_      Initials (as used in medical record) \_\_\_\_\_      Date \_\_\_\_\_

**Focused Practitioner Practice Evaluation (FPPE)**  
 FPPE (initial privileges)       FPPE (added privileges)       No FPPE (re-appointments only)

\*Granted with Conditions: Reason(s)/ Period:

^Not Granted: Reason(s):

**Recommend:**             Appointment to Medical Staff with all privileges granted above  
                                   Re-Appointment to Medical Staff with all privileges granted above  
                                   Denial of Appointment / Re-Appointment: Reason: \_\_\_\_\_

MEC Voting Member \_\_\_\_\_      Date \_\_\_\_\_

**Governing Body**             Granted as recommended by MEC  
                                   Denied as recommended by MEC  
                                   Recommend further review by MEC regarding \_\_\_\_\_

Governing Body Member \_\_\_\_\_      Date \_\_\_\_\_

MOUNTAIN VALLEY REGIONAL  
REHABILITATION HOSPITAL  
3700 Windsong Drive  
Prescott Valley, AZ 86314

**PHYSICIAN ACKNOWLEDGEMENT**

NOTICE TO PHYSICIANS: Medicare and other Federal payment programs to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresent, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonments, or civil penalty under applicable Federal laws.

---

Printed Name

---

Signature

---

Date



Medical Staff Tuberculosis Screen

Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

*To all members of the Medical Staff:*

*The Arizona Department of Health Services Hospital Licensure Rules requires that all members of the medical staff provide evidence of freedom from infectious pulmonary tuberculosis no less than every 24 months. **All Medical Staff must therefore provide evidence by one of the following. Please check one box and attach the required documentation.***

- Report of negative Mantoux skin test (test must have been performed within the last year) – Please attach documentation.*
- If Mantoux skin test positive, report of a current negative chest xray – Please attach radiology report.*
- If Mantoux skin test positive, **another physician's statement** that you are free from infectious pulmonary tuberculosis.–Please complete either the following questionnaire or attach documentation.*

For Physicians with a history of a positive PPD or history of an adverse reaction to the PPD skin test, please complete the following questionnaire.

**Have you had any of the following within the past year?**

**Please explain any yes answer.**

- |  |     |          |
|--|-----|----------|
| <input type="radio"/> Fever for more than 2 weeks?               | YES | NO _____ |
| <input type="radio"/> Cough for more than 2 weeks?               | YES | NO _____ |
| <input type="radio"/> Night sweats (new or changed in nature)?   | YES | NO _____ |
| <input type="radio"/> Hemoptysis?                                | YES | NO _____ |
| <input type="radio"/> Unexplained weight loss?                   | YES | NO _____ |
| <input type="radio"/> Shortness of breath, difficulty breathing? | YES | NO _____ |
| <input type="radio"/> Have you ever taken Isoniazide (INH)?      | YES | NO _____ |
| <input type="radio"/> Have you ever been treated for active TB?  | YES | NO _____ |

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

Date: \_\_\_\_\_

**MEDICAL REVIEW OF NON-INFECTIVE TB STATUS**

The physician listed above currently exhibits no signs or symptom of active TB disease. *(This form cannot be reviewed and signed by above listed physician.)*

\_\_\_\_\_  
Physician/Provider Signature/Title

\_\_\_\_\_  
Date

Printed Name: \_\_\_\_\_

## Confidentiality and Security Agreement

I understand that the hospital in which I have been credentialed by the Medical Staff and Governing Body, involving the exchange of health information, the hospital, has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of the patient's health information. Additionally, the hospital must assure the confidentiality of its human resources, payroll, fiscal, strategic planning, communications, computer systems and management information (collectively, with patient identifiable health information, "Confidential Information").

In the course of my interactions with patients and systems within the hospital, 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 patient care and/or administrative functions in accordance with the hospital's Privacy and Security Policies. I further understand that I must sign and comply with this Agreement in order to access to Confidential Information.

I \_\_\_\_\_ (please print name), as a credentialed or referring practitioner Mountain Valley Regional Rehabilitation Hospital (the hospital)

- Understand that it is my legal and ethical responsibility to maintain the confidentiality of all Patient Medical Records, Employee Information, Financial Information, Proprietary Information, and other confidential information relating to hospital or company business.
- Agree not to disclose any such information or records to any person outside the hospital without proper authorization.
- Recognize that unauthorized release of confidential information may make me subject to legal action and/or disciplinary action.
- Understand that my access to all electronic systems is audited, and that any inappropriate access to information may make me subject to legal action and/or disciplinary action.
- Understand that I am not to share my log-in or user ID and/or password with anyone, and that any access to hospital systems made under my log-in or use ID and password is my responsibility. I will notify the Medical Staff Office or Hospital Administration if my password has been seen, disclosed, or otherwise compromised.
- Understand that within the course of any clinical documentation that the use of my electronic signature is acceptable and I am the only person who has possession of my user ID and/or password and will be the only one who uses it. I will notify the Medical Staff Office or Hospital Administration if my password has been seen, disclosed, or otherwise compromised.
- Understand that violation of any portion of the policies and procedures related to confidentiality of patient records or any violation of federal regulations governing the patient's right to privacy may result in disciplinary actions or reports to entities as required by Medical Staff Bylaws and Rules and Regulations, State Boards, or other agencies..

I acknowledge that I have read and understand the above agreement. Signing this document, I acknowledge that I have read this agreement and I agree to comply with all terms and conditions stated above.

X \_\_\_\_\_  
Signature Date