

NORTHERN IDAHO ADVANCED CARE HOSPITAL

**DELINEATION OF PRIVILEGES**

**CORE COMPETENCY: Orthopedics**

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

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

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

**Experience:** Years of experience in post training:  
 0-5 yrs  6-10 yrs  11 yrs and greater

**Care:** Provide consultation for patients with orthopedic needs.

**Core Privileges**

|                          |                                |                           |
|--------------------------|--------------------------------|---------------------------|
| H&P                      | Injection of Joint             | Casting/Splinting/Bracing |
| Assessments/ Evaluations | Simple Laceration              |                           |
| Disease Management       | I&D Abscess                    |                           |
| Medication Management    | Skin Biopsy/Excision           |                           |
| Trigger Point Injection  | 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 \_\_\_\_\_

*NORTHERN IDAHO  
ADVANCED CARE HOSPITAL  
600 North Cecil  
Post Falls, ID 83854*

**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.

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Printed Name

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Signature

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Date



## Confidentiality and Security Agreement

I understand that the hospital in which or for whom I work, 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 employment / assignment at 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 my job related duties 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 an employee, student or volunteer:

- 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 my manager or the Information Technology Department 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 my manager or the Information Technology Department 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 immediate termination of my employment/professional relationship with the hospital.

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