Northern Colorado Rehabilitation Hospital

DELINEATION OF PRIVILEGES

CORE COMPETENCY: General Surgery

Applicant Name : _____

Education: ☐ M.D. ☐ D.O. ☐ Other (list): _____

Training: Post graduate training in one of the following (check at least one):
☐ General Surgery ☐ Other (list): _____

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

Care: Evaluate, treat, and diagnose adolescents and adults for most illnesses and injuries.

Core Privileges

H&P	I&D Abscess
Assessments/ Evaluations	EKG Interpretation
Disease Management	Biopsy Vagina/Vulva/Penis
Medication Management	Cervical Biopsy
Simple Laceration	

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 ^
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

_____ _____ _____
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 COLORADO
REHABILITATION HOSPITAL

4401 Union Street
Johnstown, CO 80534
970-619-3400

PHYSICIAN ACKNOWLEDGEMENT

Notice to Physicians: Medicare and other federal payment programs to hospitals are 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 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.

_____
Printed Name

_____
Signature

_____
Date

HOSPITAL SERVICES CORPORATION
CREDENTIALS VERIFICATION SERVICE
DESIGNATION AND AUTHORIZATION FOR RELEASE AND REDISCLOSURE OF INFORMATION
("Release")

Authority to Release: I have applied to participate as a provider for _____

_____

Print the names of all organizations to which you are applying.

and its authorized representatives (hereafter "Health Care Entity") which has designated Hospital Services Corporation's Credentials Verification Service ("HSC") as their agent. I consent to complete disclosure by the recipient of this release to HSC of all relevant information pertaining to my professional qualifications, moral character, physical and mental health (hereinafter "qualifications"). I authorize the recipient to make available and/or disclose to HSC all such information in its files from any university, professional school, licensing authority, accreditation board, hospital, physician, dentist, professional society, insurance carrier, law enforcement agency, military service, or any other person or entity deemed necessary or appropriate in the investigation and processing of my application.

I request and authorize the recipient to release the requested information and I expressly waive any claim of privilege or privacy with respect to the released information bearing on my admission to, retention or termination of medical staff appointment or clinical privileges. I release and discharge HSC, the Health Care Entity and the medical, dental, podiatry and ancillary staffs or panels, credentials committees, administrators, review and approval boards or committees, governing boards, whether or not designated by these titles, and their agents, servants or employees authorized by representatives and all other persons or entities supplying information to them from liability or claims of any kind or character in any way arising out of inquiries concerning me or disclosures made in good faith in connection with my application for appointment to the Health Care Entity's Medical Staff or Provider Panel.

Authority to Redisclose: Unless I have denied authority by initialing here _____, I authorize the Health Care Entity, the Health Care Entity's Authorized Representatives, and HSC to redisclose information concerning my qualifications, or credentials and privileges to third parties who have a need to know the information (1) based upon state or federal laws or regulations, or (2) pursuant to any health care provider agreement to which I am or will be a party and in which I have an interest as an individual health care provider, or (3) to participate in the common recredentials program, if applicable.

This Release does not authorize HSC to disclose information about my qualifications to any claimant. If a claimant requests information from HSC about me or if a subpoena duces tecum is served upon HSC seeking information about me, which is in HSC's possession, I understand I will be notified immediately. If I direct HSC to resist the subpoena, I hereby agree to indemnify and hold harmless HSC, its officers, directors, employees and agents for all attorney fees, costs, fines, and expenses incurred in resisting the subpoena at my request.

This authorization is limited to the acquisition and disclosure of information required by state or federal law, and information which is acquired or disclosed pursuant to activities protected by the state's Review Organizational Immunity Act and the Health Care Quality Improvement Act of 1986. A photocopy of this Designation and Authorization for release and redisclosure of information shall be considered by the recipient to be a signed original, as long as it is transmitted to the recipient by HSC and is received within five years of its date.

The certain definitions used in this Release and set forth on the following page of this application are incorporated by reference. I understand that I may withdraw or modify this authorization at any time in writing by submitting a written request to HSC. PHOTOCOPY BOTH PAGES OF THIS FORM.

Signature stamps and date stamps are not acceptable.

_____
Applicant Signature

_____ _____
Printed Name Date (do not type)

DEFINITIONS of terms used in this Designation and Authorization for Release and Redisclosure of information.

"Health Care Entity" is the Health Care Entity on the front of this form.

The "Health Care Entity's Authorized Representatives" include any management or quality assurance companies hired by the Health Care Entity or HSC; the Health Care Entity's Board, staffs, committees, CEO, administrator medical director or other employees of the Health Care Entity whose performance of duties requires access to information about my qualifications; consultants whose contract with the Health Care Entity requires access to information about my qualifications; any independent credentialing services including HSC; and the Health Care Entity's attorneys and insurers.

"Credentials and Privileges" means all information regarding my qualifications, my standing with the Health Care Entity, and my right to provide healthcare services at or through the Healthcare Entity. It also includes any limitations imposed upon my right to provide healthcare services and any final disciplinary action taken by the Health Care Entity with regard to my provision of healthcare services at or through the Healthcare Entity.

"Credentialing Verification Service" is the service operated by Hospital Services Corporation. HSC may be required as a condition of certification by the National Committee for Quality Assurance (NCQA) to permit audits of HSC's system. The person providing this Release acknowledges that these audits are conducted solely for the purpose of certifying the credentialing verification service, and all information utilized by the NCQA is treated as confidential.

"Claimant" means any person, guardian, or personal representative who is asserting an administrative or legal claim against the person providing this release based in whole or in part upon allegations that the person providing this release has violated any state or federal law or regulation or has committed medical malpractice.

"Medical Staff or Provider Panel" is to be interpreted broadly to include any group of healthcare providers howsoever designated, who are authorized to provide healthcare services to patients, insureds, beneficiaries, members, or enrollees of a healthcare plan.

"Third Parties who have a need to know" include, but are not limited to governmental agencies and boards; organizations, associations, partnerships, corporations; other hospitals and clinics; managed care organizations, Independent Practice Associations ("IPA's"), Managed Service Organizations ("MSO's"), Physician Hospital Organizations ("PHO's"), Preferred Provider Organizations ("PPO's"), Health Maintenance Organizations ("HMO's"), medical foundations, insurance underwriters, employer or employee sponsored ERISA health plans, health care alliances, or others with whom I am negotiating a health care provider agreement, presently have a health care provider agreement or with whom the Health Care Entity identified on the front page of this authorization (or the Health Care Entity's Authorized Representatives) is negotiating a health care provider agreement or has health care provider agreement in which I have or will acquire an interest.

"Common Recredentials Program" has been developed to allow this application to be utilized for multiple requesting customers to both expedite processing and reduce provider paperwork.

NORTHERN COLORADO REHABILITATION HOSPITAL

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 of 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

(Signed copy to be maintained in HR file) 10/14/09