

SOUTHWEST IDAHO ADVANCED CARE HOSPITAL

DELINEATION OF PRIVILEGES

CORE COMPETENCY: Physical Medicine and Rehabilitation

Applicant Name _____

Education MD DO Other (list) _____

Training Post graduate training in one of the following (check at least one):
 Physical Medicine and Rehabilitation
 Orthopedics
 Neurology
 Other (list) _____

Experience Years of experience in rehabilitation post training:
 0 – 5 years
 6 – 10 years
 11 and greater years

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

Staff Privileges Requested: Active Staff - Plan to regularly care for 4 or more patients each calendar year or will be actively involved in medical staff functions.
 Consulting Staff – Plan to not use the hospital as a principle practice hospital or care for three or less patients each calendar year.

Delineated Privileges Requested

	Complete by Applicant		Complete by MEC		
	Requested	Granted	Granted with FPPE*	Not Granted^	
Trigger Point Injections	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Casting, Splint, & Bracing	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Injection Joint, Tendon, or Bursa	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Simple Laceration	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Lumbar Puncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<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 per Medical Director Recommendation
- FPPE as follows:
 - No FPPE
 - FPPE with Monitoring (list):
 - FPPE with Supervision (list):

^ Not Granted Reason(s):

Recommend: Active Staff Consulting Staff Other (list):

 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

**SOUTHWEST IDAHO
ADVANCED CARE HOSPITAL
6651 West Franklin Road
Boise, ID 83709**

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

SOUTHWEST IDAHO ADVANCED CARE 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