

# SOUTHWEST IDAHO ADVANCED CARE HOSPITAL

## DELINEATION OF PRIVILEGES

### CORE COMPETENCY: Surgery

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

**Education**  MD  DO  Other (list) \_\_\_\_\_

**Training** Post graduate training in one of the following (check at least one):

<input type="checkbox"/> General Surgery	<input type="checkbox"/> Vascular Surgery
<input type="checkbox"/> Thoracic/Cardiovascular Surgery	<input type="checkbox"/> Colon & Rectal Surgery
<input type="checkbox"/> Gynecological Surgery	<input type="checkbox"/> Neurosurgery
<input type="checkbox"/> Oral & Maxillofacial Surgery	<input type="checkbox"/> Plastic Surgery
<input type="checkbox"/> Other (list) _____	

**Experience** Years of experience in post training:

0 – 5 years

6 – 10 years

11 and greater years

**Care** Admit, evaluate, treat, and diagnose adolescents and adults for most illnesses and injuries

**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

	Requested	Complete by MEC		
		Granted	Granted with FPPE*	Not Granted^
Laceration Repair (all levels)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Sharp Debridement	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
I&D Abscess	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Fine Needle Biopsy (superficial)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Central Line Insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moderate Sedation	<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"/>
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.

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Printed Name

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Signature

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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