

ADVANCED CARE HOSPITAL OF MONTANA

DELINEATION OF PRIVILEGES

CORE COMPETENCY: Allied Health Practitioner – Other

Applicant Name : _____

Training: Specialized Training (list): _____

Experience: Years of experience: 0-5 yrs 6-10 yrs 11 yrs and greater

Care: Evaluate, treat, and diagnose adolescents and adults for most illnesses and injuries, under the supervision of a Licensed Physician

Core Privileges Assessments/ Evaluations

Special Privileges Requested

	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"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature Applicant _____ Initials (as used in medical record) _____ Date _____

All Privileges granted to AHP must match those granted to supervising Licensed Physician.

Privileges Requested:

- Appointment – Plan to be involved in patient care, under the supervision of a Licensed Physician, and not holding membership in the Medical Staff.
- Re-Appointment – Continue involvement in patient care, under the supervision of a Licensed Physician, and not holding membership in the Medical Staff.

Certification by Supervising Licensed Physician

I hereby certify that I have reviewed and approve of the practice privileges listed above. All acts performed by the allied health practitioner will be performed under my direction. I will remain responsible for all acts performed by the practitioner. Any revision or modifications that are made to the supervising agreement between me and the practitioner will be communicated to the hospital.

Supervising Licensed Physician _____ Date _____

Focused Practitioner Practice Evaluation (FPPE)

- FPPE (initial privileges) No FPPE (re-appointments only)
- Core privileges granted with direct supervision by the supervising Licensed Physician
- Not Granted: reason(s): _____
- Recommend: Appointment with core privileges granted above
- Re-Appointment with core 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 _____

*ADVANCED CARE HOSPITAL OF MONTANA
3528 Gabel Road
Billings, MT 59102*

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

ADVANCED CARE HOSPITAL OF MONTANA

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