

**Touro Infirmery
Medical Staff/ AHP Application (Additional Documents)**

Applicant Name:

◆ **Medical Staff Category:** I am applying for appointment in the following category: ◆

Active Medical Staff **Courtesy Medical Staff**

Division of Medicine	Division of Surgery	Division of Maternal & Child Care
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Gynecology
<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Cardiothoracic Surgery	<input type="checkbox"/> Obstetrics
<input type="checkbox"/> Family Medicine	<input type="checkbox"/> Dentistry	<input type="checkbox"/> Pediatrics
<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> General Surgery	<input type="checkbox"/> Neonatology
<input type="checkbox"/> Neurology	<input type="checkbox"/> General Vascular Surgery	
<input type="checkbox"/> PM&R	<input type="checkbox"/> Neurosurgery	
<input type="checkbox"/> Psychiatry	<input type="checkbox"/> Ophthalmology	
<input type="checkbox"/> Radiology	<input type="checkbox"/> Orthopedics	
<input type="checkbox"/> Radiation Oncology	<input type="checkbox"/> Otolaryngology	
	<input type="checkbox"/> Pathology	
	<input type="checkbox"/> Plastic Surgery	
	<input type="checkbox"/> Podiatry	
	<input type="checkbox"/> Urology	

ON-CALL COVERAGE: The Physician(s) listed below will attend to my patients in my absence. **This physician is on the Touro Medical Staff and has privileges that would allow him/her to care for my patients.**

PHYSICIAN NAME:

TELEPHONE:

◆ **AHP Category:** I am applying for appointment in the following category: ◆

Advanced Registered Nurse Practitioner **Certified Nurse Midwife**
 Clinical Psychologist **Certified Registered Nurse Anesthetist** **Physician Assistant**

SPONSORING PHYSICIAN: The Physician listed below is my sponsoring physician. **This physician is on the Touro Medical Staff.**

PHYSICIAN NAME:

TELEPHONE:

I agree I have read the Touro Infirmery Medical Staff Bylaws and will abide by the Bylaws, Rules and Regulations, and Policies and Procedures. I also agree I have submitted the online component of the Touro Infirmery application process and have supplied all additional information requested, including documentation of CMEs and supporting information to the Professional Practice Questions on the online application. Please note, any final rulings by medical review panels must be disclosed.

Physician/ AHP Signature

Date

Physician/ AHP Name (please print)

IMPORTANT NOTICE
DOCUMENTATION STANDARDS

The Touro Infirmery Medical Staff Rules and Regulations, the Louisiana Department of Health and Hospitals, and The Joint Commission (TJC) requires that medical documentation meet the following standards:

H & P Standards:

A medical history and physical examination must be completed within no more than 24 hours of inpatient admission or prior to a surgery or procedure requiring anesthesia services. The history and physical must have been completed within 30 days prior to patient admission and updated at admission to reflect the patient's current condition.

Operative Report Standards:

Operative reports are to be dictated immediately following the procedure. An Initial Procedure Note must be completed prior to transfer of patient to next level of care. In order to assist the physician in this documentation standard, the Initial Procedure Note form is available to all physicians for immediate documentation until the dictated report is made available. Failure to provide dictated report within 24 hours will result in suspension.

Legibility Standards:

All documentation must be in ink, legible, accurate, dated, timed, and signed. The staff is urged to print if they can not write legibly.

Discharge Summary:

Must be documented within 24 hours of discharge and includes the reason for hospitalization; procedures performed; the care, treatment, and services provided; the patient's condition at discharge; and Final Diagnos(es).

Dangerous Abbreviations:

Below is a list of dangerous abbreviations (DNUs). These abbreviations are prohibited as they place patients, the organization's Joint Commission accreditation, and the hospital reputation at risk. Therefore, I will avoid using any dangerous abbreviations.

Prohibited Abbreviations – DO NOT USE

Prohibited Abbreviation	Misinterpretation	Required Term
U, u	Pharmacists could mistake as zero, four, or cc.	“Unit”
IU	Pharmacists could mistake as IV (intravenous) or 10 (ten).	“International Unit”
Q.D., QD, q.d., qd or Q.O.D., QOD, q.o.d., qod	Pharmacists could mistake the abbreviations for each other. The pharmacist could mistake the period after “Q” for “I” and mistake “O” for “I.”	“Daily” or “every other day”
Trailing zero (X.0 mg)* or Lack of leading zero (.X mg)	Pharmacists may miss the decimal point.	“X mg” do not let prescribers write a zero by itself after a decimal point “0.X mg” write a zero before a decimal point
MS MSO ₄ MgSO ₄	Pharmacists may confuse one for another. They could also mean morphine sulfate or magnesium sulfate.	“Morphine sulfate” or “magnesium sulfate”

*Exception: A “trailing zero” may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes.

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All applicants to the Touro Infirmery Medical Staff are required to sign, date, and return the following attestation:

I acknowledge that I have received and reviewed the above standards relative to medical record documentation (including H&P standards, operative standards, legibility standards, discharge summary requirements, and notification of dangerous abbreviations) and agree to abide by the requirements.

Physician/ AHP Signature

Date

Physician/ AHP Name (please print)

Touro Infirmary
Medical Staff/ AHP Application (Additional Documents)
CONFIDENTIALITY STATEMENT

I FULLY UNDERSTAND THAT ANY SIGNIFICANT OMISSIONS, MIS-STATEMENTS OR MISREPRESENTATIONS IN THIS APPLICATION, OR DURING THE APPLICATION PROCESS, CONSTITUTE CAUSE FOR DENIAL OF THIS APPLICATION, OR FOR TERMINATION OR SUSPENSION OF MY MEMBERSHIP AND/OR CLINICAL PRIVILEGES AT TOURO INFIRMARY. I AFFIRM THAT THE INFORMATION SUBMITTED IN, OR APPENDED TO, THIS APPLICATION IS COMPLETE, CURRENT, AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND IS FURNISHED IN GOOD FAITH.

In making this application for appointment to Touro Infirmary, I acknowledge that I have received the pertinent Medical Staff Bylaws, Rules and Regulations and policies and procedures (herein "Bylaws"). Further, I agree to be bound by the terms thereof, and to uphold the Bylaws if I am granted membership, and/or clinical privileges. I further agree to be bound by the terms of the Bylaws without regard to whether or not I am granted membership and/or clinical privileges in all matters relating to the consideration of my application for appointment to Touro Infirmary. I further agree to comply with all applicable federal laws and laws of the State of Louisiana, as well as government regulations, in addition to specific department and/or service rules and regulations.

I signify my willingness to appear for interviews in regard to this application, and I authorize Touro Infirmary and its/their representatives to consult with representatives of other healthcare organizations with which I have been affiliated (e.g., hospital medical staffs, medical groups, IPAs, HMOs, PPOs, other health delivery systems or entities), medical societies, professional associations, medical school faculties, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents (collectively, "other Healthcare Organizations"), and with others who may have information bearing on my competence, character, and ethical qualifications. I authorize and direct persons so consulted to provide such information to Touro Infirmary. I understand that letters of recommendation concerning me are to be written and maintained in confidence, and I waive any rights I might have to access such letters.

I agree to notify the Medical Staff Office of Touro Infirmary in writing within five (5) days of receiving any written or oral notice of any adverse action by the Medical Board of Louisiana, whether taken or pending; any adverse action taken by any other Healthcare Organization which has resulted in the filing of an 805 Report with the Medical Board of Louisiana or a report with the National Practitioner Data Bank; any revocation of DEA certificate or pending action; any new restrictions and/or any pending actions on my membership and/or clinical privileges with any other Healthcare Organizations; a conviction of any felony or misdemeanor of moral turpitude; any action or pending action against any certification under the Medicare or Medicaid programs including opt-out decision(s); or any cancellation, non-renewal or material reduction in my professional liability insurance coverage.

I hereby further consent to the disclosure, inspection and copying of information in my credentials file by and between Touro Infirmary and its representatives, and other Healthcare Organizations and its representatives, or other persons or entities who, in the opinion of Touro Infirmary and its representatives have a legitimate need for such information. I authorize and consent to the release by and between Touro Infirmary and other Healthcare Organizations and their representatives, all records and documents, including medical records, that may be material to an evaluation of my professional qualifications and competence for membership and/or clinical privileges here requested, as well as my physical and mental health, and moral and ethical qualifications for membership and/or clinical privileges. I also consent to sharing of credentialing, quality assessment and peer review between Touro Infirmary, to which I hereby apply, or where I already hold membership and/or clinical privileges. I understand that this may include sharing information received by them during this application process and during any corrective action procedures, including formal disciplinary hearings. I hereby release from liability Touro Infirmary, and other Healthcare Organizations, and their officers, directors, employees, liaisons, agents and representatives, including medical staff members, for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from liability any and all individuals and other Healthcare Organizations who provide information to, or share information with, Touro Infirmary, in good faith and without malice, concerning my professional competence, ethics, character and other qualifications for membership and/or clinical privileges.

I understand and agree that I, as an applicant for membership and/or clinical privileges, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. By my signature below, I acknowledge and agree that I will promptly and fully report all information to the Medical Staff Office of Touro Infirmary to which I am applying in the event any of the answers above change, or if any situation arises which affects my ability to treat patients, after I have signed and dated this form, while my application is pending, and, if I am granted membership and/or clinical privileges, while I maintain membership and/or clinical privileges.

I am familiar with the principles and standards of The Joint Commission (TJC), and/or the National Committee for Quality Assurance, that apply to me. In accordance with them and the Bylaws of Touro Infirmary, I promise to provide patients with continuous care that meets the professional standards established by Touro Infirmary. I pledge to adhere to the ethical standards of my profession. In addition, I specifically pledge to refrain from fee splitting and from providing ghost surgical or medical services. I agree to respect and maintain the confidentiality of all discussions and records generated in connection with peer review and quality assurance activities conducted by the committees of Touro Infirmary involved in the evaluation and

improvement of the quality of patient care. I agree to make no voluntary disclosure of such information except to persons authorized to receive it. I understand that Touro Infirmary is entitled to undertake such action as is deemed appropriate to ensure that this confidentiality is maintained, including application to a court for relief. I further understand that violation by me of this agreement could subject me to corrective action, up to and including, summary termination or suspension.

I agree that my password(s) and/or electronic signature used to access Touro Infirmary computers shall be used only by me and that I will not disclose my password(s) to any other individual (except to authorized security staff of the computer system). The use of a member's password(s) is equivalent to the electronic signature of the member. The member shall not permit any physician, resident, or other person to use his/her password(s) to access Touro Infirmary computers or computerized medical information. Any misuse may, in addition to any sanctions approved by Touro Infirmary regarding security measures, be a violation of State and federal law and may result in denial of payment under Medicare and Medicaid.

I hereby acknowledge that I am allowed access to my credentials/peer review file and that I may have copies of any documents which I submitted or which were addressed to me. In addition, I may have access to further information not submitted by me following written request by myself, and upon the approval of the Medical Board and either the Governing Board or its designated representative. I have the right to correct erroneous information obtained throughout the credentialing process to ensure an accurate evaluation on my behalf.

MEDICARE NOTICE TO PHYSICIANS: Medicare payment 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 misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject fine, imprisonment, or civil penalty under applicable federal laws.

WORKFORCE CONFIDENTIALITY AGREEMENT

Touro Infirmary, Touro Infirmary d/b/a Touro Home Health, Touro Infirmary d/b/a Touro Rehabilitation Center, and Metrolab (hereinafter "Organization") have legal and ethical responsibility to safeguard the privacy of all patients and to protect and safeguard the confidentiality of health information. Additionally, the Organization must assure the confidentiality of its patient, human resources, payroll, fiscal, research, computer systems, computer access, management information, and/or personal computer access codes (hereinafter "Confidential Information").

By signing this document, I acknowledge that I have received a copy of the Organization's Information Privacy and Security Program and related policies (attached). I have read this material and understand its contents. I furthermore agree not to directly or indirectly use or disclose Confidential Information without proper authority and specifically agree to the following:

1. In the case of my employment/assignment/medical privileges/efforts/training at the Organization, I may come into the possession of Confidential Information. I understand that such information must be maintained in the strictest confidence.
2. I agree not to use, disclose, or discuss any Confidential Information with others, including friends or family, who are not authorized or who do not have a need-to-know.
3. I agree not to access any information, or utilize equipment, other than what is required to do my job.
4. I agree not to discuss Confidential Information where others can overhear the conversation, e.g., in hallways, on elevators, in the cafeterias, on the shuttle buses, on public transportation, at restaurants or at social events. Discretion must be used when discussing Confidential Information in public areas even if a patient's name is not used, since it can raise doubts with patients and visitors about our respect for their privacy.
5. I agree not to make inquiries for other personnel who do not have proper authority or need-to-know.
6. I agree not to willingly inform other persons of my computer password or knowingly use another person's computer password instead of my own for any reason.
7. I agree not to make any unauthorized transmissions, inquiries, modifications, or purgings of data in the system. Such unauthorized transmissions include, but are not limited to, removing and/or transferring data from Organization computer systems to unauthorized locations (e.g., home).
8. I agree to log-off prior to leaving any Organization computer or terminal unattended.

I have read and agree to the terms and conditions of this agreement, and understand that any violation may result in corrective action, up to and including termination and/or suspension and loss of privileges.

Physician/ AHP Signature

Date

Physician/ AHP Name (*please print*)