ARTESIA GENERAL HOSPITAL

NAME: ______________________________ Privilege Request: DENTAL/ORAL SURGERY

PRIVILEGES WILL BE GRANTED ON AN INDIVIDUAL BASIS, BASED ON EXPERIENCE, TRAINING, AND DEMONSTRATED COMPETENCE. ANY CHANGES OR EXCEPTIONS ARE SUBJECT TO REVIEW AND APPROVAL BY THE APPROPRIATE COMMITTEE OF THE MEDICAL STAFF.

PRIV. REQ.	PRIV. GRANTED	PROCEDURE
( )	( )	Extra-Oral Drainage - Infection of the Oral Cavity
( )	( )	Excision of benign tumors
( )	( )	Fractures - Closed Reduction - Noncomplicated
( )	( )	Fractures - Open Reduction
( )	( )	Treatment of Sinus Pathology Secondary to Dentition
( )	( )	Sialolithotomy - Intraoral ducts only
( )	( )	Reparative Surgery - Prognathism, Retrognathism, Grafts, etc.
( )	( )	Temporomandibular Joint Surgery
( )	( )	Removal of Foreign Body(s)
( )	( )	Tooth Transplant
( )	( )	Treatment of Neurological Disease - Specify Procedures ______________________________
( )	( )	Ridge Extension Procedures
( )	( )	Complete Bony impactions
( )	( )	Oral Surgery - Intermediate
( )	( )	Alveoplasty
( )	( )	Maxillary and Mandibular Tori
( )	( )	Cystectomy - when not exceeding alveolar area not involved with contiguous structures
( )	( )	Surgical Periodontics
( )	( )	Multiple extractions
( )	( )	Implantation Prosthodontics
( )	( )	Other ______________________________

Applicant's signature: ______________________________ Date: ____________

DO NOT WRITE BELOW THIS LINE — FOR COMMITTEE USE ONLY

☐ RECOMMENDED ☐ NOT RECOMMENDED

Chairman, Credentials Committee ______________________________ Date: ____________

Chairman, Executive Committee ______________________________ Date: ____________

President, Medical Staff ______________________________ Date: ____________

Chairman, Board of Trustees ______________________________ Date: ____________

CONFIDENTIALITY STATEMENT

I, ____________________________________, understand that in performance of my duties at Artesia General Hospital, I am required to have access to and am involved in the processing of patient care data. I understand that I am obligated to maintain the confidentiality of these data at all times, both at work and off duty. I understand that a violation of these confidentiality considerations may result in disciplinary action, including termination. I further understand that I could be subject to legal action. I agree to comply with information security policies for Artesia General Hospital concerning the privacy and confidentiality consideration of patient care.

_____________________________________ _____________________

Signature Date

MEDICAL STAFF SIGNATURE AUTHENTICATION FORM

Medicare regulation 482.24, authentication of signature, requires that the medical records department maintain a current list of authenticated signature, written initials, codes and stamps, when such are used for authorship.

______________________________________ ___________________________

Physician Name and Title (PRINTED) Date

______________________________________ ___________________________

Physician Signature Physician Initials

Approved Signature Stamps or Seals:

Original: Credential File
CC: Pharmacy, Medical Records

702 N. 13th Street Artesia, NM 88210 Phone (575) 736-8127 Fax: (575) 748-8540

PHYSICIAN'S ACKNOWLEDGEMENT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) requires hospitals to obtain a signed ***Physician's Acknowledgement Statement*** from any physician who is being granted admitting privileges at that Hospital.

Your signature acknowledges that you have received the following notice [42 CFR 41246 (b)]:

Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnosis, and the major procedure 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.

______________________________ ______________________

Physician Name and Title (PRINTED) Date

______________________________ ______________________

Physician Signature UPIN/NPI #

702 N. 13th Street Artesia, NM 88210 Phone (575) 736-8127 Fax: (575) 748-8540

BYLAWS ACKNOLEDGEMENT OF RECEIPT

I, __________________________, acknowledge that I have read and understood the Medical Staff Bylaws, Rules and Regulations of Artesia General Hospital.

Furthermore, I agree to abide by all such Bylaws, Rules and Regulations, Hospital Policies and Directives during the time I remain appointed to the Medical Staff or Allied Health Professional Staff of Artesia General Hospital.

______________________________________ __________________________

Physician Name and Title (PRINTED) Date

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Physician Signature