

ARTESIA GENERAL HOSPITAL

NAME: _____

PRIVILEGE REQUEST: ENT

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 COMMITTEES OF THE MEDICAL STAFF.

PRIV. REQ. PRIV. GRANTED

- () () Adenoidectomy
- () () Bronchoscopy
- () () Laryngoscopy
- () () Otoscopy
- () () Tracheoscopy
- () () Excision of lesions, local (Brachial, thyroglossal, cyst, polyps, etc.)
- () () Major lesions
- () () Laryngotomy
- () () Myringotomy and tympanoplasty
- () () Tracheostomy
- () () Mastoidectomy: simple
- () () Radical
- () () Rhinoplasty
- () () _____
- () () _____

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 _____

Chief of 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



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 #



BYLAWS ACKNOWLEDGEMENT 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

Physician Signature