



# Artesia General Hospital

## Geriatric Psychiatry Physician Privileges

**Requested Staff Category:**     Active             Consulting             Locum Tenens             Courtesy             Allied Health

**Active:** Regularly admit patients or regularly involved in patient care & medical staff functions. **Consulting:** Member in good standing at another CMS or TJC accredited agency, non-voting staff member & cannot admit. **Courtesy:** Admits <13 patients/year & non-voting staff member. **Locum Tenens:** Assumes duties for the identified provider for whom they are covering (including ED Call) & limited to 90 days of coverage during a 12 month period. **Allied Health:** Licensed NP, CNS, PA, CRNA, RNFA, or Podiatrist & cannot admit.

**Life Threatening Emergency:** At the time of a clinical emergency, any practitioner may render whatever care he/she believes to be indicated.

**Basic Education:** MD or DO; Current NM License

**Minimal Formal Training:** Successful completion of any ACGME or AOA approved residency training program in Psychiatry. Must be Board Eligible or Board Certified.

**Required Previous Experience:** The successful applicant must be able to demonstrate that he or she has provided inpatient or consultative services for at least 24 patients during the past 12 months.

**Core Privileges** Ability to admit, work-up, diagnose, and provide treatment or consultative services to geriatric patients presenting with psychiatric illnesses and disorders.

Requested	Granted	Privilege
		<b>Core Privileges include:</b>
		Admit to Geriatric Psychiatry Unit – Active Staff & Locum Tenens (for designated provider) only
		Psychiatric Consultation & Evaluation
		Psychiatric Admission Assessment
		Medical History and Physical Examination
		General Psychiatric Medical Management – Adult
		Pharmacotherapy – Medical and Psychiatric
		Individual, Group, & Family Psychotherapy
		Behavioral Seclusion/Restraint Application
		Psychiatric Consults for Acute Care and Emergency Department patients
		Emergency Department On-Call Coverage

**Additional Privileges:**

To be eligible to apply for a privilege listed below, you must meet the specified criteria, or be able to demonstrate, and/or document competence in performing any requested procedure. I understand that by making this request, I am bound by Artesia General Hospital's applicable bylaws and policies and hereby stipulate that I meet the minimum threshold criteria for this request.

Requested	Granted	Privilege

*I have requested only those privileges for which, by education, training, current experience and demonstrated performance, I am qualified to perform, and I wish to exercise these privileges at Artesia General Hospital. I understand that it is my obligation to notify the Chief of Staff of any procedure or mode of medical care in which I might engage that is not listed. I also acknowledge that my professional liability insurance extends to all privileges I have requested. I understand that in exercising any clinical privileges granted, I am constrained by hospital and medical staff bylaws, policies and rules applicable generally and any applicable to the particular situation.*

\_\_\_\_\_  
Applicant's Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**I have reviewed the requested clinical privileges and supporting documentation for the above named practitioner and recommend action on the privileges as noted above.**

**Medical Staff Signature:** \_\_\_\_\_

**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