

ARTESIA GENERAL HOSPITAL

Name \_\_\_\_\_ Privilege Request: ORTHOPAEDIC 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 COMMITTEES OF THE MEDICAL STAFF.

PRIV. REQ.	PRIV. GRANTED	PROCEDURE
( )	( )	Treatment of closed undisplaced fractures
( )	( )	Treatment of closed displaced fractures
( )	( )	Treatment of open fractures
( )	( )	Internal Fixation of Fractures
( )	( )	Intervertebral disc excision
( )	( )	Fusion of lumbar & thoracic spine
( )	( )	Fusion of cervical spine
( )	( )	Bone grafts
( )	( )	Excision of lesion of bone
( )	( )	Arthrography
( )	( )	Arthrotomy
( )	( )	Arthrodesis
( )	( )	Arthroplasty
( )	( )	Skin grafts and flaps
( )	( )	Repair or removal of lesion or tendon, ligament or fascia (other than hand)
( )	( )	Peripheral nerve surgery
( )	( )	Myelography
( )	( )	Discography
( )	( )	Amputation of extremity
( )	( )	Manipulation of spine
( )	( )	Manipulation of peripheral joints
( )	( )	Reattachment of extremity

HAND SURGERY

( )	( )	Suture of muscle, tendon & fascia of hand
( )	( )	Transplantation of muscle and/or tendon of hand
( )	( )	Plastic operation on hand with tissue graft or prosthetic implant
( )	( )	Other plastic operations on hand
( )	( )	Reduction & fixation of fractures of hand

OTHER

( )	( )	Emergency Room back-up Call
( )	( )	_____
( )	( )	_____
( )	( )	_____

Applicant's Signature \_\_\_\_\_  
Date \_\_\_\_\_

DO NOT WRITE BELOW THIS LINE -- For Committee Use Only

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