

Sleep Lab Studies Physician Privileges

Requested Staff Category: Active Consulting Locum Tenens Courtesy Allied Health

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. Must be ABIM Board certification in Sleep Medicine or scheduled to sit for the sleep medicine examination.

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 Privileges to evaluate, diagnose, provide consultation to, and treat patients of all ages except where specifically excluded from practice, presenting with conditions or disorders of sleep, e.g. sleep-disordered breathing, circadian rhythm disorders, insomnia, parasomnias, narcolepsy, restless leg syndrome.

Requested	Granted	Privilege
		Core Privileges include:
		Polysomnography (PSG) (including sleep stage scoring)
		Multiple sleep latency testing (MSLT)
		Actigraphy
		Sleep log interpretation
		Home/Ambulatory testing
		Maintenance of wakefulness testing (MWT)
		Oximetry
		Monitoring with Interpretation of EEG, ECG, EOG, Leg EMG+ O2 saturation, leg movements, thoracic and abdominal movements
		CPAP/BiPAP titration

Other Privileges:

Other privileges requested for which you have current clinical competency may be listed below. Documentation of training and/or experience must be provided for any special privileges requested. 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 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 certify to the best of my knowledge, I am qualified and have professional liability insurance coverage for practice within the scope of privileges requested.

Printed Name

Signature

Date

Reviewed By: _____

Title: _____



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