



# ARTESIA GENERAL HOSPITAL

A FACILITY OF COMMUNITY HEALTH CORPORATION

Name: \_\_\_\_\_ Urology Privilege Request

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

Requested      Granted

_____	_____	Renal diseases
_____	_____	Uro-Radiological procedures- including IVPs, retrograde pyelograms and cystograms
_____	_____	Endoscopic examination and surgery
_____	_____	Minor urologic surgery
_____	_____	Major urologic surgery
_____	_____	Associated elective additional general surgery, ie. incidental appendectomy, lymph node biopsy
_____	_____	May utilize thoracic abdominal incisions
_____	_____	Inguinal node dissections in association with GU cancer
_____	_____	Consultation, admission and treatment of patients with urologic conditions (in accordance with Medical Staff category assignment)
_____	_____	Pediatric urologic surgery
_____	_____	Surgical correction of urinary incontinence
_____	_____	Laparoscopic procedures, pelvic lymphadenectomy, varicocele, incontinence procedures (Note: Requires documentation of training and/or experience)
_____	_____	Other:
_____	_____	Other:

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

**For Committee Use Only**

**RECOMMENDED**                       **NOT RECOMMENDED**

Specific Privileges denied:       Yes       No  
If yes, please comment:

Chairman, Medical Executive Committee: \_\_\_\_\_ Date: \_\_\_\_\_

Chief of Staff: \_\_\_\_\_ Date: \_\_\_\_\_

Chairman, Governing Board: \_\_\_\_\_ 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