

Dear Health Professional:

Please completely fill out all pages included in the credentialing and privileging application; incomplete applications will not be processed.

***It is imperative that your complete application is returned to the Medical Staff Office in sufficient time to complete the full credentialing process prior to your anticipated start date.***

- The full credentialing and privileging process will take eight to twelve weeks and may require significantly more time if your educational institutions, post graduate programs, or prior affiliations are defunct.
- Temporary privileges are not granted except in rare instances of urgent patient-care need.
- The credentialing process does not begin until the health professional's application is received.

Return the application and delineation of privilege form(s), along with copies of the following required documents, to the Medical Staff Office at University Hospital:

- New York State signed license registration
- Other state license(s) provider has been issued.
- Current DEA registration, if applicable to the position.
- Current Infection Control Certificate - self-study packets and Post-tests are available at <http://www.upstate.edu/uha/medstaff/edu> .
- BLS, ACLS, or PALS Certification
- Written explanation for any discontinuation or lapse in time.

The History & Physical form must be returned directly to the Employee Health office with all required attachments.

***The applicant shall have the burden of providing adequate information for proper evaluation of his/her competence, character, ethics and other qualifications in accordance with the requirements of Section 2805k of the Public Health Law.***

- After two attempts by the Medical Staff Office to obtain the necessary verifications, if verification has not been received, responsibility for obtaining the appropriate documentation for verification will be placed upon the applying practitioner.
- All questions on the credentialing and privileging application must be answered completely. **Referencing your CV is not acceptable.**

If you have questions, please do not hesitate to contact the Medical Staff Office at (315) 464-5733. Thank you.

Received \_\_\_\_\_

**APPLICATION FOR APPOINTMENT  
FOR HEALTH PROFESSIONAL**

Indicate the campus(es) for which privileges are being sought:

- Upstate University Hospital  
 Upstate University Hospital at Community General  
 Upstate Outpatient Surgery Center

Primary Campus (check *one*):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Degree/Certification (indicate below):

- \_\_\_\_\_ Nurse Practitioner                      \_\_\_\_\_ Physician Assistant                      \_\_\_\_\_ Psychologist  
 \_\_\_\_\_ Certified Registered Nurse Anesthetist                      \_\_\_\_\_ Certified Nurse Midwife                      \_\_\_\_\_ Chiropractor

Department/Service: \_\_\_\_\_

Please note: You **MAY NOT** function in your hired capacity for patient care until privileges are granted through Medical Staff Services.

**I. PERSONAL INFORMATION**

_____	_____	_____	_____	_____
Last Name	Maiden Name	First Name	Initial	
_____	_____	_____	_____	_____
Home Address	City	State	Zip Code	E-mail Address
_____	_____	_____	_____	_____
Home Telephone Number	Cell Phone Number	Marital Status	Spouse's Name	
_____	_____	_____	_____	
Date of Birth	Place of Birth	Citizenship	Social Security Number	
_____	_____	_____	_____	
NPI Number _____				

**II. EDUCATION**

_____	_____	_____
Undergraduate College or University	Degree	Date of Graduation
_____	_____	_____
Address	Telephone	Fax Number
_____	_____	_____
Graduate College or University	Degree	Date of Graduation
_____	_____	_____
Address	Telephone	Fax Number
_____	_____	_____
Postgraduate College or University	Degree	Date of Graduation
_____	_____	_____
Address	Telephone	Fax Number

NAME \_\_\_\_\_

**III. LICENSE / REGISTRATION / CERTIFICATION**

License Type	State	Expiration	License Number
License Type	State	Expiration	License Number
DEA Registration		Expiration	Registration Number
Other Type	State	Expiration	Number

**IV. PROFESSIONAL SOCIETY MEMBERSHIPS / FELLOWSHIPS**

Society \_\_\_\_\_

Society \_\_\_\_\_

**V. CURRENT ACADEMIC APPOINTMENTS**

Title \_\_\_\_\_ Institution \_\_\_\_\_

Title \_\_\_\_\_ Institution \_\_\_\_\_

**VI. PAST PRACTICES / PROFESSIONAL EMPLOYMENT** Account for all time from end of education to present in chronological order - past to present. List in chronological order. Include any military experience. This differs from hospital affiliations, unless you were employed by the hospital.

AFFILIATION NAME, ADDRESS, TELEPHONE & FAX NUMBER	DEPARTMENT AND STATUS	DATES (MM/DD/YYYY)	REASON FOR LEAVING
NAME			
ADDRESS			
TELEPHONE FAX NUMBER			
NAME			
ADDRESS			
TELEPHONE FAX NUMBER			
NAME			
ADDRESS			
TELEPHONE FAX NUMBER			

**VII. HOSPITAL AFFILIATIONS (all past and present)** List in chronological order.

Hospital \_\_\_\_\_ Address \_\_\_\_\_ Telephone/Fax Number \_\_\_\_\_ Dates \_\_\_\_\_

Hospital \_\_\_\_\_ Address \_\_\_\_\_ Telephone/Fax Number \_\_\_\_\_ Dates \_\_\_\_\_

Hospital \_\_\_\_\_ Address \_\_\_\_\_ Telephone/Fax Number \_\_\_\_\_ Dates \_\_\_\_\_

**VIII. PROFESSIONAL LIABILITY(MALPRACTICE) INSURANCE INFORMATION**

Current Insurance Carrier	Agent (if any)	Policy Number	Expiration Date
Policy Limits	Address	Telephone	Fax Number

*List all previous professional liability insurance carriers:*

Name / Policy Number	Address	Telephone/Fax Number	Dates
Name / Policy Number	Address	Telephone/Fax Number	Dates
Name / Policy Number	Address	Telephone/Fax Number	Dates

**IX. BOARD CERTIFICATION AND RECERTIFICATION**

Certified by: \_\_\_\_\_ Date: \_\_\_\_\_  
 Last Recertification: \_\_\_\_\_ Date: \_\_\_\_\_  
 Certificate Number: \_\_\_\_\_

**X. HEALTH INFORMATION**

I hereby affirm that I am physically and mentally able to carry out the responsibilities of medical staff membership and exercise the privileges requested.

Yes \_\_\_\_\_ No \_\_\_\_\_

**XI. PEER RECOMMENDATIONS**

Please submit the information for **five individuals** we may contact for peer recommendations. A peer ideally should be another individual from the same discipline (i.e.: NP, PA, DC, CRNA, etc.). However, in situations where there is no nurse practitioner, physician's assistant, psychologist, etc., who can provide a peer reference it is acceptable for a physician with essentially equal qualifications, who is familiar with the health professional's performance, to provide the recommendation.

1.	Name	Relationship	Dates	E-mail
	Address	Telephone		Fax Number
2.	Name	Relationship	Dates	E-mail
	Address	Telephone		Fax Number
3.	Name	Relationship	Dates	E-mail
	Address	Telephone		Fax Number
4.	Name	Relationship	Dates	E-mail
	Address	Telephone		Fax Number
5.	Name	Relationship	Dates	E-mail
	Address	Telephone		Fax Number

**XII. MISCELLANEOUS INFORMATION**

*Are you now or were you subject to (provide full details for positive answers on a separate sheet.):*

	<u>YES</u>	<u>NO</u>
1. Previously successful or currently pending limitation, suspension, revocation, voluntary or involuntary surrender of license or registration to practice in any jurisdiction?	_____	_____
2. Previously successful or currently pending limitation, suspension, revocation, voluntary or involuntary surrender of Drug Enforcement Administration (DEA) registration?	_____	_____
3. Limitation, suspension, probation, revocation, denial, non-renewal, voluntary or involuntary surrender of employment, appointment, privileges or training at any hospital or health care related institution?	_____	_____
4. Withdrawal of your application for appointment, reappointment, or clinical privileges or resignation from a medical staff <u>before</u> a potentially adverse decision was made by a hospital's or health care facility's governing board?	_____	_____
5. Formal investigation, corrective action, or discipline by any hospital or health care related institution for any reason, including patient complaints?	_____	_____
6. Pending professional malpractice claims or actions, medical conduct proceedings or licensing board actions in any jurisdiction?	_____	_____
7. Any judgment, settlement, or findings of medical malpractice or any findings of professional misconduct in any jurisdiction.	_____	_____
8. Suspension, sanction or other restriction in participation in any private, Federal or State insurance program (e.g. Medicare)?	_____	_____
9. Current police or agency investigation, substantiated charges or convictions for sexual harassment, sexual abuse, child abuse, elder abuse, findings pertinent to violations of patient's rights, or other human rights violations?	_____	_____
10. Criminal convictions or pending criminal proceedings for felonies or misdemeanor?	_____	_____
11. Malpractice premium "rating", surcharge, malpractice insurance cancellation, denial or non-renewal?	_____	_____
12. Resignation, withdrawal or termination of your position with a professional association or health maintenance organization for reasons related to clinical, quality or patient care issues?	_____	_____
13. Do you currently have any physical or mental condition (including but not limited to habitual use of or dependence on drugs or alcohol) that impairs or could impair your ability to practice medicine?	_____	_____

**If you answered "yes" to any of the above questions, please provide the full details on a separate sheet.**

**XIII. AFFIRMATION OF INFORMATION**

The undersigned hereby affirms under the penalties of perjury as follows: that he/she is the applicant named herein; that he/she has read the foregoing application and knows the contents thereof; that the same is complete, true and accurate to his/her own knowledge and belief.

I have read The Upstate Pledge: A Code of Conduct and Mutual Respect. By submitting my application, I agree to adhere to acceptable conduct as outlined by the Upstate Pledge, and abide by all requirements of behavior and civility therein.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT FOR RELEASE OF INFORMATION FOR  
HEALTH PROFESSIONAL  
REAPPOINTMENT**

**AS A LICENSED/REGISTERED HEALTH PRACTITIONER** I understand and agree that I, as an applicant for reappointment to the health professional staff as a Licensed/Registered Practitioner have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. All information submitted by me in this application is true to the best of my knowledge and belief.

In making this application for appointment and / or reappointment to the health professional staff of the University Hospital, I acknowledge that I have received and read the Bylaws, Rules and Regulations of the Medical Staff of this hospital, and further, that I am familiar with the principals and standards of the Joint Commission on Accreditation of Hospitals and the principles, standards and ethics of national, state and local associations that apply to and govern my specialty and/or profession, and I agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for reappointment to the health professional staff as a Licensed/Registered Practitioner, and I further agree to abide by such hospital, staff and University rules and regulations as may from time to time be enacted. Moreover, I pledge that I will not receive from or pay to another physician or health care worker, either directly or indirectly, any part of a fee received for professional services.

I have not requested privileges for any procedures for which I am not qualified.

By applying for reappointment to the health professional staff as a Licensed/Registered Practitioner, I hereby authorize the Hospital, its medical staff, or their representatives, to consult with administrations and members of medical staffs of other hospitals or health care institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the Hospital, its medical staff, or their representatives, of all records and documents, including medical records at other hospitals or health care institutions, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges, and I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by this Hospital, or its medical staff, to other hospitals, medical associations and other interested persons on request regarding any information the hospital and the medical staff may have concerning me as long as such release of information is done in good faith and without malice, and in conformance with Federal and State laws, and I hereby release from liability the University Hospital and its medical staff for so doing.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

AUTHORIZATION FOR REVIEW OF  
MANAGED CARE CREDENTIALING FILE

I Hereby authorize the Medical Staff Services of University Hospital to permit authorized representatives of any Managed Care Organization, Medical Service Organization or other authorized entity with which the SUNY Upstate Medical University, University Hospital or U.M.A.S. has an agreement to review my complete managed care credentials file as kept in the ordinary course of business of the Medical Staff Services. I grant this consent to access my Managed Care credentials file for the purpose of permitting such MCO, MSO or other authorized entity to evaluate my professional qualifications and competence to execute the practice privileges I apply for and/or request.

I understand that my Managed Care credentials file does not include quality assurance information which remains privileged under the Public Health Law, and shall not be disclosed pursuant to this authorization. Additionally, I understand that no copying of my Managed Care credentials file or any portion thereof will be permitted pursuant to this authorization.

In accordance with the access and review authority authorized herein, I hereby release U.M.A.S., SUNY Upstate Medical University, University Hospital its officers and employees from any and all liability in connection with or resulting from their conduct in performing any credentialing activities or otherwise, so long as such conduct is undertaken in good faith and without malice with regard to any information provided pursuant to this authorization.

This authorization shall remain in effect unless and until withdrawn by me in writing, and provided to Medical Staff Services of University Hospital. I understand that this authorization has no force or effect on those obligations of University Hospital mandated by Public Health Law Section 2805-k regarding "Investigations prior to granting or renewing privileges."

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\*\*Please return to Medical Staff Services, Room  
1100 University Hospital

*Medical Staff Services*

**UPSTATE**  
UNIVERSITY HOSPITAL

## ***ELECTRONIC SIGNATURE ATTESTATION***

I agree to abide by all Upstate privacy and security policies and procedures and applicable state and federal laws, rules and regulations. I agree that the unique access codes provided to permit my access to all electronic systems will not be shared with any other individual and shall be kept strictly secure and confidential. I acknowledge that all electronic transactions are logged and are subject to periodic review and that violation of laws or policies may result in termination of access and/or other sanctions. I acknowledge and certify that by affixing my electronic signature to sign and authenticate electronic documents and entries it is my intentional method of authenticating the information and has the same effect as my legal handwritten signature.

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Signature

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Date

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Printed Name

*Please return by fax to: 315-464-8524*

## Respecting the Confidentiality of Health Information: The Stakes are High! February 2011

Name of Education: Respecting the Confidentiality of Health Information

Oracle Tracker Code: CONFIDHEALTH

### FAST FACTS

1. Before looking at patient information ask yourself "Do I need to know this to do my job?" and if not, don't look at **anything**.
2. Look at and share only the minimal amount of confidential information necessary to do your job.
3. Respect the privacy rights of employees who come here for care by affording their information the utmost confidentiality it deserves.
4. Always log off computer screens when leaving your workstation.
5. Take measures to protect your computer passwords so that they are not misused. They are unique identifiers associated with you, and you bear responsibility for their use.
6. All employees are expected to promptly report any privacy concerns to your supervisor or the Institutional Privacy Officer.
7. Periodic audits are conducted to look at employees who access confidential health information. The burden of proof rests with the employee to explain their reason for access.
8. The consequences for snooping are just as severe as inappropriately using or sharing confidential health information in an unauthorized manner and include the following:
  - Criminal and monetary penalties imposed by state and federal agencies ranging from one to ten years prison time and \$50,000 to \$500,00 in fines.
  - Charges of professional misconduct and loss of licensure by the NYS Education Department.
  - **Termination of employment or affiliation by SUNY Upstate.**

Remember, protecting and safeguarding confidential health information is a team effort and the responsibility of every employee.

All employees are expected to respect the trust placed in us to be sure that confidential health information is **not accessed or** misused in any way.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**Please return by fax to (315) 464-8524.**

**Request form for UUHCG System Access for Member or Employee  
of CGH-Affiliated Medical Practice**

Because some members and employees of UUHCG-affiliated medical Practices request access to UUHCG computer systems in order to support patient care, CGH grants this access on an individual basis upon request of the Practice and approval by UUHCG's Department of Medical Staff Services. Each individual User approved is issued a unique User ID and password.

Before permission is granted to access UUHCG systems, Practice must agree to the following:

1. User must stay in compliance with all hospital policies, as well as State and Federal regulations including (but not limited to) HIPPA regulations.
2. User IDs and passwords assigned to the User will be used by that User only. User IDs and passwords cannot be shared. User IDs and password must be kept confidential. User IDs and passwords will not be posted on or near the PC, the monitor, keyboard, under the keyboard, under the mouse pad etc.
3. The User will respond promptly to UUHCG network audits.
4. All software on the PC(s) being used to access the hospital network will be licensed and Practice will be in compliance with the terms and conditions of those licenses. PCs connecting to CGH Systems will have all updates from Microsoft for the OS and applications. Practice will use and maintain a regularly-updated Antivirus product and firewall product.
5. User agrees to comply with any additions security policies or changes to the UUHCG security policy that may be required in the future.
6. User is responsible for educating him/herself about UUHCG network security policies, and is expected to contact the Physicians' System Assistance Line at (315) 492-5050 if in doubt about what defines compliance with network security policies.
7. Any deviation by User from UUHCG Network Security Policies will result in the revocation of network access for that User *and potentially for all members and employees of the Practice.*
8. Practice is legally responsible for all use of UUHCG systems by members and employees of the Practice, including any misuse of UUCG systems or information contained therein. Misuse includes accessing the UUHCG systems for any purpose other than facilitating the healthcare needs of patients or business needs of the Practice.
9. The Practice will ***promptly*** notify UUHCG Medical Staff Services if the User's status within the Practice changes. If the User leaves the Practice, the Practice will inform UUHCG ***immediately*** in order to ensure Practice and UUHCG are both in compliance with all related regulatory requirements and both are protected from potential liability risks.
10. If you have more than one sign-on to the UUHCG system (i.e. you have a role inside the hospital and a role outside the hospital) each sign-on will have a set of rights appropriate for the role. You must always use the sign-on that relates to the role or job you are working in at that moment. You may not use a sign-on issued to you for use in another role.

<b>User's Name:</b> _____ <b>User's Signature &amp; Date:</b> _____ <b>User's email address:</b> _____ <b>User's cell phone:</b> _____ <b>Approving Physician's Name:</b> _____ <b>Approving Physician Signature &amp; Date:</b> _____	<b>User's role (please circle one or more):</b>  MD • NP • PA • NMW • RN • LPN • COA (Clinical Office Assistant • Billing Clerk  <b>Practice Name:</b> _____
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When this form is signed by User and Employer and delivered to Medical Staff Services, the Associate Medical Director of Medical Staff Services will review the request for access and forward it to the Information Services Department upon approval.

**Medical Staff Services Office Use Only:**

**Associate Medical Director Initials:** \_\_\_\_\_ **ISR Number:** \_\_\_\_\_

The New York State Education Law requires that all prescriptions must carry the stamped or imprinted name of the prescriber who signs the prescription. Community pharmacies as well as University Hospital's Outpatient Pharmacy will reject any prescriptions that are not imprinted. Therefore, *one* hand stamp will be provided free of charge to you. In the space below, please legibly **PRINT** your name in the manner you sign your prescriptions (I.e.: If your legal signature is John Q. Smith, print your name the same below, but if you sign legal documents as J. Quincy Smith, please print this below. These stamps are a LEGAL signature, and should be written as such, in printed form).

Please also specify M.D., D.O., N.P., or P.A., as appropriate.

Please use these hand stamps in your medical records to improve legibility.

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**Printed** Signature (as your legal signature is written)

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Department

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Print your legal name  
(if different from your legal signature above)