

Dear Applying Practitioner:

This file contains the credentialing and privileging application for Medical Staff membership and / or privileges at Upstate University Hospital. Please completely fill out all pages included, providing direct contact information where possible, and return the application to Medical Staff Services. Incomplete applications will not be processed, and referencing your CV in lieu of completing the application will not be accepted.

Copies of the following documents must be sent to the Medical Staff Services office prior to granting of privileges or medical staff membership:

- 1) New York State signed license registration
  - a) Affidavit of Agreement is required for physicians with a three-year limited license.
- 2) Other state license(s) provider has been issued.
- 3) Current DEA registration with a New York State address, if applicable to the position.
- 4) Malpractice Insurance face sheet, listing Upstate University Hospital as a certificate holder, indicating no less than 1.3M per occurrence and 3.9M aggregate liability coverage.
- 5) Excess malpractice liability insurance cover sheet, if applicable.
- 6) Current curriculum vitae or resume (*dates must be in month / year format*).
- 7) Copies of all updated certification required for the position and privileges you are applying for (may include CPR, BLS, ACLS, PALS, and Infection Control).
  - a) Infection Control self-study packets and Post-tests are available at [http://www.upstate.edu/medstaff/forms/inf\\_control.php](http://www.upstate.edu/medstaff/forms/inf_control.php).
- 8) ECFMG certificate (if applicable).
- 9) Written explanation for any discontinuation or lapse in time.
- 10) Delineation of Privilege form(s) for your specific department / specialty (Physicians: [http://www.upstate.edu/medstaff/forms/main\\_dop\\_page.php](http://www.upstate.edu/medstaff/forms/main_dop_page.php). Health Professionals: [http://www.upstate.edu/medstaff/forms/hp\\_main\\_dop\\_page.php](http://www.upstate.edu/medstaff/forms/hp_main_dop_page.php)).
- 11) There is a nonrefundable fee of \$250.00, *made payable to Upstate University Hospital*, for all medical staff (physician, dentist, or podiatrist) applicants.

**It is imperative that your complete application is returned to Medical Staff Services no less than three months prior to your requested appointment date. 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.**

- The full application process will take approximately eight weeks and may require significantly more time if your educational institutions, post graduate programs, or prior affiliations are defunct or located outside the United States, or if you have had disciplinary action.
- Temporary privileges are not granted except in rare instances of urgent patient-care need.
- The credentialing process does not begin until approval is received from the Department Chief of Service.
- All applicants must submit Medical Information forms. Go to <http://www.upstate.edu/medstaff/forms/physician.php>, print the Medical Information forms, and send the form and all required documents at one time as indicated on the cover sheet.

If you have questions regarding your application, the required documents, or the credentialing and privileging process, please do not hesitate to contact Medical Staff Services at (315) 464-5733 or (315) 492-5551.

Thank you.

APPLICATION  
MEDICAL STAFF APPOINTMENT AND CLINICAL PRIVILEGES  
SYRACUSE HOSPITALS

(CROUSE HOSPITAL (CH) ST. JOSEPH'S HOSPITAL HEALTH CENTER (SJHHC) UNIVERSITY HOSPITAL (UH) )

I am applying for privileges as described below:

CROUSE HOSPITAL	_____	_____Active _____Courtesy _____Consulting _____Associate
	Department/Service	
ST. JOSEPH'S HOSPITAL HEALTH CENTER	_____	_____Active _____Courtesy _____Consulting _____Associate
	Department/Service	
UNIVERSITY HOSPITAL *	_____	_____Active _____Affiliate _____Other (Please list): _____
	Department/Service	

\* Includes Upstate University Hospital Campus (U-UH), Upstate University Hospital at Community General Campus (U-UHCG), and Upstate Outpatient Surgery Center campus (UOSC).

Please circle all campuses you would like to practice at:      U-UH                  U-UHCG                  UOSC  
Which campus will be your primary campus at University Hospital?:      U-UH                  U-UHCG                  UOSC

Please indicate which hospital is your primary (for Excess Malpractice purposes): \_\_\_\_\_CH \_\_\_\_\_SJHHC \_\_\_\_\_UH

I. IDENTIFYING INFORMATION

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

II. GENERAL PROFESSIONAL INFORMATION

_____					
Specialty/Subspecialty					
_____					
Associates/Partners					
_____					
Hospital Coverage (other than names listed above)					
_____					
Practice/Group Name					
_____					
Office Address	City	State	Zip Code	Telephone	Fax
_____	_____	_____	_____	_____	_____
2nd Office Address	City	State	Zip Code	Telephone	Fax
_____	_____	_____	_____	_____	_____

NAME \_\_\_\_\_

**III. MILITARY SERVICE INFORMATION**

\_\_\_\_\_  
Dates of Service \_\_\_\_\_ Branch \_\_\_\_\_

\_\_\_\_\_  
Address \_\_\_\_\_ Telephone \_\_\_\_\_ Fax Number \_\_\_\_\_

**IV. 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 \_\_\_\_\_

**V. PRE-MEDICAL EDUCATION**

\_\_\_\_\_  
College or University \_\_\_\_\_ Degree \_\_\_\_\_ Date of Graduation \_\_\_\_\_

\_\_\_\_\_  
Address \_\_\_\_\_ Telephone \_\_\_\_\_ Fax Number \_\_\_\_\_

\_\_\_\_\_  
College or University \_\_\_\_\_ Degree \_\_\_\_\_ Date of Graduation \_\_\_\_\_

\_\_\_\_\_  
Address \_\_\_\_\_ Telephone \_\_\_\_\_ Fax Number \_\_\_\_\_

**VI. MEDICAL EDUCATION**

\_\_\_\_\_  
Medical School \_\_\_\_\_ Degree \_\_\_\_\_ Date of Graduation \_\_\_\_\_

\_\_\_\_\_  
Address \_\_\_\_\_ Telephone \_\_\_\_\_ Fax Number \_\_\_\_\_

**VII. EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES**

ECFMG Number (If applicable) \_\_\_\_\_

**VIII. POST GRADUATE EDUCATION**

\_\_\_\_\_  
Program \_\_\_\_\_ Address \_\_\_\_\_ Telephone/Fax Number \_\_\_\_\_ Dates (Month/Year) \_\_\_\_\_  
Completed satisfactorily? \_\_\_ Yes \_\_\_ No

\_\_\_\_\_  
Program \_\_\_\_\_ Address \_\_\_\_\_ Telephone/Fax Number \_\_\_\_\_ Dates (Month/Year) \_\_\_\_\_  
Completed satisfactorily? \_\_\_ Yes \_\_\_ No

\_\_\_\_\_  
Program \_\_\_\_\_ Address \_\_\_\_\_ Telephone/Fax Number \_\_\_\_\_ Dates (Month/Year) \_\_\_\_\_  
Completed satisfactorily? \_\_\_ Yes \_\_\_ No

**Does this represent an approved program, of sufficient duration, to fulfil that portion of the requirements to take boards in your specialty? (circle) Yes No**

NAME \_\_\_\_\_

**IX. FELLOWSHIPS**

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

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

Does this represent an approved program, of sufficient duration, to fulfil that portion of the requirements to take boards in your specialty?  
(circle) Yes No

**X. BOARD CERTIFICATION AND RECERTIFICATION**

1. Certified by: \_\_\_\_\_ Date: \_\_\_\_\_

Certificate No: \_\_\_\_\_ Date: \_\_\_\_\_

Last Recertification: \_\_\_\_\_ Date: \_\_\_\_\_

Certificate Number: \_\_\_\_\_ Date: \_\_\_\_\_

2. Certified by: \_\_\_\_\_ Date: \_\_\_\_\_

Certificate No: \_\_\_\_\_ Date: \_\_\_\_\_

Last Recertification: \_\_\_\_\_ Date: \_\_\_\_\_

Certificate Number: \_\_\_\_\_ Date: \_\_\_\_\_

**XI. LICENSES HELD**

\_\_\_\_\_ MD DO DDS DMD Other \_\_\_\_\_

Number of current and valid NYS License Registration – Circle appropriate license

Other state medical or dental licenses, past and present

\_\_\_\_\_  
State License Number Degree

\_\_\_\_\_  
State License Number Degree

Drug Enforcement Admin. (DEA) Registration Number \_\_\_\_\_

**XII. PROFESSIONAL SOCIETY MEMBERSHIPS**

\_\_\_\_\_  
Society

\_\_\_\_\_  
Society

\_\_\_\_\_  
Society

NAME \_\_\_\_\_

**XIII. CURRENT ACADEMIC APPOINTMENTS**

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Title	Institution
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Title	Institution
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**XIV. PAST PRACTICES or PROFESSIONAL EMPLOYMENT**

List in chronological order on the enclosed sheet. Include any military experience. This differs from hospital affiliations, unless you were employed by the hospital.

**XV. HOSPITAL AFFILIATIONS (all past and present)**

List in chronological order; do NOT include residency.

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Hospital	Address	Email	Telephone/Fax Number	Dates (Month/Year)
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Hospital	Address	Email	Telephone/Fax Number	Dates (Month/Year)
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Hospital	Address	Email	Telephone/Fax Number	Dates (Month/Year)
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Hospital	Address	Email	Telephone/Fax Number	Dates (Month/Year)
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Hospital	Address	Email	Telephone/Fax Number	Dates (Month/Year)
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**XVI. PROFESSIONAL LIABILITY INSURANCE INFORMATION**

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Current Insurance Carrier	Agent (if any)	Policy Number	Expiration Date
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Policy Limits	Address	Telephone	Fax Number
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*List all previous professional liability insurance carriers.*

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

PAST PRACTICES AND/OR PROFESSIONAL EMPLOYMENT

WE WILL BE CONTACTING YOUR CURRENT SUPERVISOR.

Name:

Contact information:

Account for all time from end of residency to present in chronological order - past to present

AFFILIATION NAME, ADDRESS, TELEPHONE & FAX NUMBER	DEPARTMENT AND STATUS	DATES (month/year)	REASON FOR LEAVING
NAME			
ADDRESS			
TELEPHONE      FAX NUMBER      EMAIL			
NAME			
ADDRESS			
TELEPHONE      FAX NUMBER      EMAIL			
NAME			
ADDRESS			
TELEPHONE      FAX NUMBER      EMAIL			
NAME			
ADDRESS			
TELEPHONE      FAX NUMBER      EMAIL			
NAME			
ADDRESS			
TELEPHONE      FAX NUMBER      EMAIL			
NAME			
ADDRESS			
TELEPHONE      FAX NUMBER      EMAIL			
NAME			
ADDRESS			
TELEPHONE      FAX NUMBER      EMAIL			

**XVII. CONTINUING MEDICAL EDUCATION**

On a separate sheet of paper list:

(A) All post graduate activities which you have attended or for which you have received credit in the past two years

or

(B) If you have reported your continuing medical education activities to an authorized association, please list:

- the name of the authorized association;
- the date when you reported your hours;
- the number of category I hours reported;
- the number of category II hours reported that relate to the staff privileges you are requesting.

(C) Include American Medical Association Physician Recognition Award and inclusive dates if appropriate.

**XVIII. PROFESSIONAL REFERENCES**

Please submit the names of three individuals we may contact for letters of recommendation for your appointment. These letters will be weighed by the extent of direct clinical observation and other work with the applicant. List below the names, addresses, relationships and the dates of association with each.

1.	Name	Relationship	Dates
	Address		
	Telephone	Fax Number	Email Address
2.	Name	Relationship	Dates
	Address		
	Telephone	Fax Number	Email Address
3.	Name	Relationship	Dates
	Address		
	Telephone	Fax Number	Email Address

**XIX. BIBLIOGRAPHY**

On a separate sheet, furnish a list of scientific papers or essays, articles, and books published and papers presented at scientific meetings (include reprints).

**XX. 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, pending criminal proceedings, or arrests for felonies or misdemeanors?                                                                                                                                              | _____      | _____     |
| 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 answer "yes" to any of the questions above, please provide the full details on a separate sheet.**

**XXI. 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.

(For those applying or re-applying to University Hospital) 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 \_\_\_\_\_

**XXII. AUTHORIZATION FOR RELEASE OF GENERAL INFORMATION**

I hereby make application for the appointment to the Medical Staff of  
(check as many as apply)

- Crouse Hospital
- St. Joseph's Hospital Health Center
- University Hospital

hereinafter referred to as "Hospital", and for clinical privileges as requested herein.

I acknowledge that I have received (and had an opportunity to read) the By-Laws and Rules and Regulations of the Medical Staff (and the Code of Ethics and Religious Directives for Catholic Health Services – St. Joseph's Hospital Health Center only). I have been advised that the By-Laws of the Hospital are available for my review in the office of the Administrator of the Hospital, and that I am familiar with the principles and standards of The Joint Commission and/or Det Norske Veritas Healthcare, Inc. (DNV) accreditation organizations and the applicable sections of the New York State Hospital Code pertaining to hospital medical staffs, and the principles, standards and ethics of the National, State and local professional associations that apply to and govern my specialty and/or profession. I agree to be bound by the terms of the aforementioned if I am granted membership or clinical privileges, and I further agree to abide by such Hospital and Medical Staff Bylaws, Rules and Regulations as may be from time-to-time enacted. I further agree to be bound by the terms of such Bylaws, Rules and Regulations even if I am not granted membership or clinical privileges in all matters relating to the consideration of my application to the Medical Staff. Further, I agree to maintain an ethical practice, to provide for continuous care of my patients, to refrain from fee splitting or other inducements relating to patient referral, to refrain from delegating the responsibility for diagnosis of care of hospital patients to a practitioner who is not qualified to undertake this responsibility and who is not adequately supervised, to seek consultation whenever necessary and to refrain from providing "ghost" surgical or medical services.

I have not requested privileges for any procedures for which I am not qualified. Furthermore, I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have requested privileges. I shall not attend patients unless able to do so with skill and safety and shall not exceed my professional competence unless an emergency exists and no better resources are available.

I understand and agree that I, as an applicant for Medical Staff Membership, 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. I fully understand that any significant misstatements in, or omissions from, this application constitute cause for denial of appointment or cause for summary dismissal from the Medical Staff. I hereby agree that if an adverse ruling is made with respect to my Medical Staff Membership or clinical privileges now or in the future, I will exhaust the administrative remedies afforded by the Medical Staff Bylaws before resorting to legal or other actions. All information submitted by me in this application and its enclosures is true to the best of my knowledge and belief.

I hereby further authorize and consent to the release of information by the Hospital, or its Medical Staff, to other hospitals, medical associations, government agencies 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 I hereby release from liability this Hospital and its staff for so doing.

By applying for appointment to the Hospital Medical Staff, I hereby signify my willingness to appear for interviews in regard to my application, authorize the Hospital, its medical staff and their representatives to consult with administrators and members of medical staffs of other hospital, other health care facilities or institutions with which I have been associated and with others, including past and present malpractice insurance 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 and its representatives upon authorization and release as required, of all records, and documents, including medical records at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested, as well as, my moral and ethical qualifications for staff membership.

I hereby signify my willingness to document, upon appropriate request, the current status of my mental and physical health including submission to laboratory testing and mental and physical examination by laboratories and physicians designated by the requesting body, with waiver of admissibility of results.

I hereby release from liability all representatives of the Hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the Hospital, or its Medical Staff, in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information by my signature below.

I hereby affirm under the penalties of perjury as follows: that I am the applicant named herein; that I have read the foregoing Authorization and know the contents thereof. I accept the stipulations and obligations and authorize the releases therein contained.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

*Authorization for Release of Malpractice Information*

In accordance with the Hospital Bylaws of the Medical Staff, I hereby authorize my current and/or previous insurance companies to release to the Hospital a certificate of my malpractice insurance coverage. The certificate shall detail the amount of coverage, a certification that the insurance will not be canceled until at least twenty days have elapsed after notification to the Hospital, and any conditions attached to the coverage.

I agree not to cancel or change the insurance policy without first giving the Hospital a twenty day notice of my intent to cancel.

I hereby give authorization to disclose to the Hospital the history of any malpractice actions, judgments, or settlements which I have experienced while covered by my current and/or previous insurance companies. Such history shall indicate the date of any actions, outcome, monies reserved, and the status of such actions.

I further authorize the release of information regarding successful past or current challenge, reduction, suspension, loss or denial of malpractice coverage by any company with which I have had or have contact.

Signature

Date

Company

Address

Telephone/Fax Numbers

Company

Address

Telephone/Fax Numbers

**NOTE: AN ORIGINAL OF THIS PAGE MUST BE RETURNED TO THE MEDICAL STAFF OFFICE WITH SIGNATURE**



## ***PHYSICIAN ACKNOWLEDGEMENT***

In accordance with 42 C.F.R. 412.46 and 32 C.F.R. 199.15, a Physician Acknowledgment must be completed before the physician admits his / her first patient. University Hospital requires this document to be kept in the Credentialing/Quality file for each physician who has admitting privileges. The Physician Acknowledgment remains in effect as long as the physician has admitting privileges at the hospital.

### **Notice to Physician:**

**Medicare /CHAMPUS payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures 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.**

I have read and understand the above stated Notice to Physician, and signed below using my full legal signature \*.

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Legal Signature

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Date

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Printed Name

\* Must be hand signed and hand dated (initials are not acceptable unless they are part of the legal signature used in the medical records). The use of name or date stamps is prohibited on this Physician Acknowledgment

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.

---

Signature

---

Date

---

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 also, 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)