*Medical Staff Services*

UPSTATE UNIVERSITY HOSPITAL

# OBSERVER PRIVILEGES[1]

Requests for observer privileges from departments within the hospital are processed through the Medical Staff Services. Observer status includes a physician or health care provider who is visiting for the purpose of observation in a specific department, or as a scrubbed[2] observer in the operating room.

Observer status may be issued for a period of six months or less. Observer status does not allow access to Upstate University Hospital's patient information systems. Observers must shred or return to the supervising attending physician, prior to leaving the premises, any documentation containing patient information that may be provided to them for the purposes of their observation.
OBSERVER STATUS DOES NOT ALLOW ANY DIRECT PATIENT CARE.

For Observer status, the following items must be presented to Medical Staff Services (Fax: 315.464.8524 or e-mail: Medstaff@upstate.edu):

- Completion of the attached Application for Observer Status by supervisor/co-signed by Chair
- Confidentiality statement, signed: (http://www.upstate.edu/medstaff/pdf/forms/conf_attest.pdf)
- While proof of malpractice insurance is not required, observers are still responsible for their own coverage should they be named in a lawsuit.
- Non –employee orientation (Parts 1 & 2): http://www.upstate.edu/hr/new_staff/orientation/non_employee_orientation.php

The following should be faxed to Employee/ Student Health services (Fax: 315.464.5471):

- Certificate of health , sections I and II, *(http://www.upstate.edu/forms/documents/F82034.pdf)*
- Documentation of Flu vaccination is required once the State Commissioner announces that the flu season has started, and throughout each flu season.

Observers who will be at at Upstate for ***more than three months*** must complete the Safety At Work (SAW) education (packet available at http://www.upstate.edu/hr/document/saw_all_staff.pdf. Packet and post-test for licensed staff available on http://www.upstate.edu/hr/new_staff/orientation/non_employee_orientation.php.

Only upon the completion of the above information, and approval by University Hospital Employee /Student Health of the Certificate of Health, may privileges be granted for the requested observation.

Post-graduate trainees enrolled in an educational exchange program with a formal written agreement in place between institutions may be eligible for observer status with prior written approval of the Graduate Medical Education office. The duration of the agreement and the duration of visits of each individual are defined in each written agreement.

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[1] This does not include the provision of patient-care services.
[2] All non-scrubbed observers must make arrangements with the OR supervisor.

## VISITING HEALTH PROVIDER (OBSERVER)

I. *DEPARTMENT BEING OBSERVED:*_____

II. *OBSERVING PROVIDER DEMOGRAPHIC INFORMATION:*

| Last Name | Maiden Name | First Name | Initial |
|---|---|---|---|

| Office Address | City | State | Zip Code |
|---|---|---|---|

| Telephone | Fax |
|---|---|

| Residence Address | City | State | Zip Code |
|---|---|---|---|

| Telephone | E-mail (optional) |
|---|---|

| Social Security Number | Date of Birth | Place of Birth | Citizenship |
|---|---|---|---|

| Degree (s) earned | Institution or Office coming from |
|---|---|

III. *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 _____

IV. *PROFESSIONAL LIABILITY INSURANCE INFORMATION (Is this section applicable?)* Yes_____No _____

| Current Insurance Carrier | Expiration Date |
|---|---|

| Agent (if any) | Policy Limits |
|---|---|

## V. *MISCELLANEOUS INFORMATION:*

Are you now or have you EVER been subject to: (provide FULL details for positive answers on a separate sheet.) Please place a check mark on each line. Lines/arrows are not acceptable.

| | *YES* | *NO* |
|---|---|---|
| 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, 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 before 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. Any judgment, settlement, or findings of medical malpractice or any findings of professional misconduct in any jurisdiction. | _____ | _____ |
| 7. Suspension, sanction or other restriction in participation in any private, Federal or State insurance program (e.g. Medicare)? | _____ | _____ |
| 8. 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? | _____ | _____ |
| 9. Criminal convictions, pending criminal proceedings, or arrests for felonies or misdemeanors? | _____ | _____ |
| 10. Malpractice premium "rating", surcharge, malpractice insurance cancellation, denial or non-renewal? | _____ | _____ |
| 11. 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? | _____ | _____ |

Do you currently: (provide FULL details for positive answers on a separate sheet.)

| | | |
|---|---|---|
| 12. Have pending professional malpractice claims or actions, medical conduct proceedings or licensing board actions in any jurisdiction? | _____ | _____ |
| 13. Have any physical or mental condition that impairs or could impair your ability to practice medicine? | _____ | _____ |
| 14. Habitually use drugs or alcohol, or have a dependence on drugs or alcohol (or have you ever had such habitual use of or dependence on drugs or alcohol) that impairs or could impair your ability to practice medicine? | _____ | _____ |

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. 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 _____

Printed name:_____

## *VI. AUTHORIZATION FOR RELEASE OF GENERAL INFORMATION*

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

*INTERNAL USE ONLY*

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Observer Name_____

Received date: _____

Requested observation dates:_____to_____

*CHIEF OF SERVICE / SUPERVISOR SIGNATURE*

I, the below signing physician, acknowledge that I am responsible for supervising the observer listed on page 1. I understand that observers are not credentialed to provide any direct patient care.

Supervisor:_____

Printed Name Signature Date

Chief of Service: _____

Printed Name Signature Date