Medical Staff Services

UPSTATE UNIVERSITY HOSPITAL

VISITING HEALTH CARE PROVIDERS: SPECIAL PRIVILEGES

The attached application contains those forms needed for special privileges at Upstate University Hospital. Medical Staff Services requires all information at least 2 weeks before arrival to allow enough time for credentialing and receipt of documentation.

The following items must be presented to Medical Staff Services (Fax: 315.464.8524 or e-mail: Medstaff@upstate.edu):

- Application (either Observer or Special privileges)**
- Proof of liability insurance coverage* (The physician will need to contact their malpractice insurance company to inform them of this visit and make sure that the physician is covered. In turn, the insurance company must provide the physician/us with a letter to that effect. If a physician comes in to proctor or perform a service and is paid for his/her services, he/she is considered an independent contractor and must provide his/her own malpractice coverage (or the clinical department may choose to supply malpractice insurance).
- Confidentiality statement, signed: (http://www.upstate.edu/medstaff/pdf/forms/conf_attest.pdf)
- 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.

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

Clinical Practice Experience (licensed physicians or health provider (not post-graduate trainees) coming to train or teach) – *no Epic access.*

Also requires:

- Letter from attending UH physician being proctored, co-signed by chief (specified time period, patient name(s), description of duties)

OR

Letter from supervising physician proctoring the incoming provider, co-signed by chief (includes description of duties)

- CV / resume - must include complete student contact information, social security number, and date of birth.
- Copy of license registration

Special Consulting Provider Status (To follow a specific patient and consult; does not include post-graduate trainees) – *no Epic access, may not be the attending physician of record*

From HEC-participating hospital (St. Joseph's or Crouse):

[1] In emergency situations where the provider is needed immediately or for only one day, orientation is not required but any longer, it must be completed.

**Health assessment, affiliation letter, and privileges shall be obtained from primary HEC-participating hospital in lieu of these items

Also requires:

- Letter from Chief at Upstate recommending special consulting provider status based on his or her personal knowledge of the applicant's experience, background, and competence

From all other hospitals:

Also requires:

- Copy of currently granted privileges and contact information for the Chief of Staff and/or Clinical Department Chair at the currently facility where privileges are maintained.
- Current CV / resume - must include complete student contact information, social security number, and date of birth.
- A letter from the Upstate University Hospital Chief of Service at the relevant campus recommending the granting of a special consulting provider status the applicant's experience, background, and competence as demonstrated by the documentation provided, and any communications with the current practice facility.

Non-Employed Procedural Team Members (NEPTM) (Health care providers, not including credentialed medical providers and post-graduate trainees, who are coming to the institution to assist a credentialed and privileged member of the Medical Staff in procedural patient care activities. Examples of non-employed procedural team members include, but are not limited to, scrub nurses, ophthalmologic technicians, dental assistants, and speech language pathologists.)

Also requires:

- Criminal Background Investigation release
  http://www.upstate.edu/medstaff/pdf/CBIrelease.pdf
  - Summary of rights can be found at
    http://www.upstate.edu/medstaff/pdf/summary_of_rights.pdf
- Letter from attending UH physician with description of duties and acknowledgment of responsibility for supervision of the provider, co-signed by Chief.
- CV / resume - must include complete student contact information, social security number, and date of birth.
- Copy of license registration or certification, if applicable
- At each reappointment of the attending UH physician, a new letter, documentation of continued licensure or certification and malpractice, as well as Safety at Work, and Right to Know mandatory education are required of each NEPTM.

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

VISITING HEALTH PROVIDER (SPECIAL PRIVILEGES)

I. *UPSTATE PROVIDER SUPERVISING OR BEING PROCTORED:*

_____

II. *VISITING PROVIDER IDENTIFYING INFORMATION:*

Last Name	Maiden Name	First Name	Middle 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		Facility 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?* ☐ *No* ☐ *Yes)*

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

Provider requesting: _____

Received date: _____

Requested 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