Medical Staff Services

UPSTATE UNIVERSITY HOSPITAL

OBSERVER PRIVILEGES

Requests for observer privileges from departments within the hospital are processed through the Medical Staff Services. Privileges granted may be for observing in departments, or the Operating Room. Privileges for OR observer through Medical Staff Services are granted only for a scrubbed observer. All non-scrubbed observers must make arrangements with the OR supervisor. An observer has no privileges for direct patient care. Observers are responsible for their own malpractice coverage in case of a lawsuit.

The attached application must be completed and returned at least two weeks prior to the scheduled observation period. The application may be faxed [(315) 464-8524] or e-mailed [medstaff@upstate.edu] to Medical Staff Services.

The Certificate of Health must be filled out completely and **signed by the physician of the physician** and faxed directly to Employee Health (315 464-5471). The form **should not** be signed by the physician who is requesting privileges. Employee Health must be told to contact Medical Staff Services as soon as the physician is cleared. All Employee Health clearance should be between the department and/or the physician directly. Medical Staff Services may not intercede or act as middleman.

Only upon the completion of the above information may privileges be granted for the requested observation.

Last revised 7/2011

Medical Staff Services

UPSTATE UNIVERSITY HOSPITAL

Received _____

SUNY UPSTATE MEDICAL UNIVERSITY
VISITING HEALTH PROVIDER (OBSERVER)

I. *IDENTIFYING INFORMATION* Dates of observation: _____ To: _____ Department: _____ Downtown or Community?

_____
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

II. *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 _____

III. *PROFESSIONAL LIABILITY INSURANCE INFORMATION (Is this section applicable? ☐ No ☐ Yes)*

_____
Current Insurance Carrier Expiration Date

_____
Agent (if any) Policy Limits

IV. MISCELLANEOUS INFORMATION: *To be completed only by the undersigned*

Are you now or were you subject to (provide full details for positive answers in space provided below):

	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, 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 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. 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 any of the above is yes, please explain: _____

_____

VII 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. I understand and acknowledge that observer status does not allow any direct patient care.

_____ _____

Signature of Applicant Date

IV. *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

Last revised 07/2011

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