SUNY UPSTATE MEDICAL STAFF

DISASTER CREDENTIALING PACKET

Thank you for offering to help at Upstate during the current situation! We appreciate the offer of your skills in caring for our patients. In order to expedite disaster privileges (these expire at the direction of the hospital or the declaration of the end of the disaster by the hospital), we need to ask you to complete an abbreviated credentialing process, as outlined below.

Please complete the attached documents:

- ☐ Application
- ☐ Release
- ☐ Orientation
- ☐ HIPAA/Confidentiality statement
- ☐ Health forms (must be signed by your physician and be accompanied by immunization proofs as specified on the cover document).

In addition, please provide us with **copies** of your:

- ☐ Curriculum Vitae / Resume (any format)
- ☐ driver's license
- ☐ current hospital ID
- ☐ current privileges (hospital) or written job description or equivalent (private office or other healthcare setting)
- ☐ vehicle registration (for parking setup)
- ☐ photo (for badge)

The above documents may be emailed to erwine@upstate.edu or faxed to 315-464-8524, Attn. : Beth

If you have any questions, please call Beth Erwin, Director, Medical Staff Services & Quality Project Management at 315-399-9200.

Disaster Credentialing Health Care Professional Form

PLEASE PRINT

NAME: ______________________ SS#: ______________ DOB: __________

ADDRESS: ____

CITY: ______________________ STATE: ________ ZIP CODE: __________

HOME PHONE: ________________ WORK PHONE: ________________

CELL PHONE: ________________ E-MAIL ADDRESS: ________________

PRIMARY AFFILIATED HOSPITAL/EMPLOYER & ADDRESS: ________________
____

SPECIALTY BACKGROUND (IE: pediatrics, ICU, emergency dept):________________
____

NAME OF COLLEGE/GRADUATE/MEDICAL SCHOOL or Technical School:________ ________________
____

YEAR OF GRADUATION: ______________________________

CURRENT PROFESSION: MD RN LPN NP PA RT RADTECH OTHER: ____________
LICENSE/REGISTRATION/CERTIFICATION #:________________________
STATE OF LICENSURE/REGISTRATION/CERTIFICATION: ________________
Date of Last Clinical Practice Under This License/Registration/Certification: ____________
DEA # (if applicable) ______________________________
NPI # ______________________________

Epic training: Have you previously used Epic as an Electronic Medical Record (EMR)? YES NO Dates

I certify that the information documented above is true and complete. I understand that misrepresentation or omission of facts called for may prevent or result in termination of medical staff privileges, if granted. To the best of my knowledge, I do not have any physical or mental health impairment which is of potential risk to patients or that might interfere with the performance of my duties, including habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs (including those prescribed) that may adversely alter my behavior or judgment.

______________________________ ________________
Signature of Professional Requesting Privileges Date

______________________________ ________________

Approved By (printed name/signature) ***Date***
Labor Pool Unit Leader, Medical Director or Planning Section Chief/Emergency Incident Commander

- ***Upon conclusion of the emergency, the emergency privileges granted during the emergency situation are immediately terminated.***
- ***Complete one form for each volunteer.***

UNIVERSITY HOSPITAL

EMERGENCY/DISASTER PRIVILEGES RELEASE

I ATTEST THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS CORRECT AND COMPLETE.

I hereby volunteer my medical services to University Hospital during this emergency/disaster and agree to practice as directed and to be bound by all hospital policies and rules as well as the Bylaws, rules and regulations of the Medical/Professional Staff.

I also acknowledge that my emergency/disaster privileges at University Hospital shall immediately terminate once the emergency/disaster has ended, as notified by the Hospital.

I authorize University Hospital to consult with any individual(s) or organization(s) who may have information bearing on my professional qualification, competency, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on my professional qualifications and competency to carry out the emergency/disaster privileges I am requesting. I authorize all individuals and organizations who are requested to provide such information to University Hospital or its representative.

I release from any liability all representatives of University Hospital and its Medical/Professional Staff for their acts performed in good faith and without malice in connection with their evaluation of me and my credentials. I release from any liability all individuals and organizations who provide information to University Hospital in good faith and without malice concerning my competency, ethics, character and other qualifications including otherwise privileged or confidential information.

I agree that a photocopy or facsimile of this document with my signature may be accepted by any entity from which such information is sought, with the same authority as the original and I specifically waive written notice from any such entities or individuals who may provide information based upon this authorized request.

I certify that as of this date, I have no physical, medical or mental condition that would impair rendering care to the patients or meeting medical staff responsibilities. I further attest to having no impairment due to chemical dependency/substance abuse.

______________________________ ______________________________

Signature of Applicant Date

____

Printed Name of Applicant

Appendix A
Emergency Volunteer Orientation

Upstate EM codes:

Emergency Code	Description
Code Red	Fire, smoke, or the odor of something burning.
Code Amber	Code Amber is activated when an infant/child is confirmed missing.
Code Yellow	Bomb Threat has been received or potential explosive device has been discovered.
Code Black	National Weather Service has issued a Severe Weather Watch or a Warning that potentially endangers the hospital
Code Orange	Contaminated patients are presenting to the Emergency Department from an external Hazardous Materials Spill.
Code White	Pediatric Medical Emergency.
Code Blue	Adult Medical Emergency.
Code Silver	Person with a weapon and/or an individual is being held against their will by an unarmed/armed perpetrator.
Code Grey	An adult patient is missing (Eloped, lost or abducted) from the Hospital.
Code Clear	Situation had been resolved.

Imporant Phone Numbers:

- **Incident Command:** Downtown 464-8888 Community 492-5338
- **University Police** Downtown 464-4000 Community 492-5511

Fire Safety:

Remember RACE:

- **RESCUE** or relocate endangered people to a safe place
- **ACTIVATE** the fire alarm system and call 464-5555 for the Downtown Campus. For leased properties call 9-911, and for Community Campus call 492- 5011.
  - Give fire location
  - STAY ON THE PHONE – DO NOT HANG UP
- **CONTAIN** fire by closing ALL doors and any open windows
  - DO NOT turn off oxygen unless told to – note Oxygen Shut Off valves
  - Unplug any appliances – touch the cord only – if equipment appears to be overheating/ smoking
- **EVACUATE** or extinguish
  - Evacuate the area as quickly as possible
  - Extinguish the flames with extinguisher if trained and the fire has not left its source.

Life Safety:

- INDIVIDUAL RESPONSIBILITIES
  - Wear employee identification badge at all times while on Upstate property
  - Report unauthorized persons (no ID/badge)
  - Report suspicious activities

Include a brief description of suspicious activity
Include detailed description of person
Include location

- **REPORT ACCIDENTS AND INJURIES**
    - **Involving visitors, students, and employees**

Hazardous Materials

Services to be contacted in case of a spill:

- **Blood –**
    - **Downtown Campus: Call Environmental Services at 464-6576**
    - **Community Campus: Call Environmental Services at 492-5994**
- **Chemicals –**
    - **Downtown Campus: Call Environmental Health and Safety at 464-5782**
- **Nights and weekends: Call University Police Department 464-4000**
    - **Community Campus: Call Environmental Services at 492-5994**
- **Radioactive Materials –**
    - **Downtown Campus: Call Radiation Safety at 464-6510**
    - **Community Campus: Call Radiology at 492-5015 or 492-5526**
- **Persons exposed to hazardous spills are to be directed to the Emergency Department with the applicable Safety Data sheet (SDS)**
- **Hazardous Material (HAZMAT) spills that cannot be contained require:**
    - **Remove persons from the spill danger and notify others in the area to leave.**
    - **Notify**
        - **Downtown Campus: Call Environmental Health and Safety at 464-5782**
        - **Nights and weekends: Call University Police Department at 464-4000**
        - **Community Campus: Call University Police of the incident at 492-5511 & Environmental Services at 492-5994 any time**

Hand Hygiene

- **Upstate University Hospital follows the Centers for Disease Control and Prevention Guideline for Hand Hygiene in Health-Care Settings**
- **YOU SHOULD WASH YOUR HANDS**
    - **Before and after giving care to a patient (touching patient or environment)**
    - **Before and after eating**
    - **After removing gloves**
    - **After sneezing, coughing, or using the bathroom**
- **HAND WASHING SKILL**
    - **Wet hands with warm water**
    - **Apply soap**
    - **Wash hands using friction**
    - **Wash for at least 15 seconds**
    - **Dry thoroughly**
- **ALCOHOL-BASED WATERLESS HAND SANITIZERS**
    - **Use only if hands are not visibly soiled**
    - **Push one time to get gel/foam into palm of hand**
    - **Rub both hands together using friction till dry**

- **EMPLOYEES WHO ARE REQUIRED TO WEAR GLOVES**
  - **Artificial nails are not acceptable – anything that is not your natural nail**
  - **Nail polish must be in good repair**
  - **Natural nails should be short**
  - **Refer to Hand Hygiene Policy/Procedure (Policy IC D-01/Infection Control Manual)**
- **THE BLOOD BORNE PATHOGEN STANDARD**
  - **Methods of Compliance:**
    - **Standard Precautions (hand hygiene, use of barriers)**
    - **Engineering and Work Practice Controls (e. g. safety devices, working sinks, labeling with biohazard symbol or color red to identify contamination and need for barrier use)**
  - **Personal Protective Equipment - PPE (determine exposure potential; needed barriers)**
  - **Environmental Cleaning (blood spills, decontaminating patient equipment)**
- **BLOOD-BORNE DISEASES**
  - **You can get a Blood-Borne Disease by:**
    - **Sexual contact**
    - **Women to infant during birth process and breast feeding**
    - **Sharing needles among IV drug users**
    - **Transfusions of infected blood products**
    - **Needle sticks with infected blood**
    - **Infected blood contact to mucus membranes or non-intact skin**
- **EXPOSURE TO BLOOD/BODY FLUIDS**
  - **Intact skin – (no breaks in skin)- This is not a blood/body fluid exposure**
  - **Non-intact skin – (breaks in skin)**
    - **Wash area with soap and water and report injury**
  - **Needle Sticks and other sharps injuries**
    - **Wash area with soap and water and report injury**
  - **Splashes to mucus membranes of eyes, nose, or mouth**
    - **Flush/rinse area with water and report injury**
  - **Large volume splash – report to Emergency Department for eye irrigation**
- **REPORT ALL BLOOD/ BODY FLUID EXPOSURES TO YOUR SUPERVISOR/TEAM LEADER IMMEDIATELY.**

STANDARD PRECAUTIONS

- **Infection prevention practices are used to protect both the healthcare worker and the patient**
- **Applies to all patients for handling blood & body fluids, excretions and secretions**
- **Include the use of hand hygiene and personal protective equipment (PPE)**
- **Basic Barrier Precautions includes:**
  - **Gloves**
  - **Gowns**
  - **Masks/attached visor**
  - **Protective eyewear**
  - **Use a resuscitation mask/ambu bag if your patient can't breath**
  - **Sharps and needles are placed in special containers; staff using sharps should:**

  - **Avoid using needles or sharps whenever possible**
  - **Use safety devices whenever possible (safety butterflies, safety IV catheters, safety lancets, etc.)**
  - **Use transfer devices for filling blood tubes directly**
  - **Plan for sharps disposal before starting a procedure**
  - **NEVER recap used needles**
- **Soiled or dirty linen is placed in a plastic bag for transport to laundry**
  - **Body waste is discarded into hopper or toilet: if chance of splashing, wear eye protection/masks.**
  - **If soiled with blood/body fluids, reusable equipment is surface wiped down with hospital-approved germicide wipes and then placed in dirty utility/soiled staging area for pick-up.**
  - **Spills: wipe up gross material with paper towels, and then clean area with a hospital approved germicide. Clean spills immediately.**
    - **Wear gloves**
    - **Watch for sharps**
  - **Large spill clean-up:**
    - **Flood large spills with germicide before wiping up**
    - **Downtown- Vocera "housekeeping supervisor" @ 315-464-1400**
    - **Community Campus- call Environmental Services at 315-492-5994**
  - **Empty trash carefully, holding it away from your body, never push trash down with your hand or foot**

<u>HIPAA – Health Insurance Portability and Accounting Act</u>

Access to documents, materials and information containing medical, personal and/or financial information regarding patients, employees, volunteer or Hospital matters is restricted to those who need the information to carry out their specific work assignments.

- **Unauthorized access to documents or materials and inappropriate use of, discussion of, or dissemination of such information is consider a breach of confidentiality, and as such is grounds for dismissal.**
- **Keep in mind when determining whether you should have access to patient information; use the "need to know" phrase.**

I hereby acknowledge the above conditions of Volunteering **Date:_______________**

***Volunteer's name*___________________________________ *Print*______________________**

***Witnessed By* ______________________________________ *Print*______________________**

UPSTATE MEDICAL UNIVERSITY CONFIDENTIALITY AGREEMENT

Printed Name: ______________________________ **SUNY Employee ID#:** ______________
Signature: ______________________________ **Date:** ______________________

Employee: _____ Non-Employee: _____ Nursing Service: _____ MedBest _____ Student _____

IMPORTANT: Please read all sections. If you have any questions, please ask before signing.

1. **Confidentiality of Patient Information**
   I understand and acknowledge that: (i) services provided to patients are private and confidential; (ii) to enable such services to be performed, patients provide personal information with the expectation that it will be kept confidential and used only by authorized persons as necessary; (iii) all information provided by patients or regarding services provided to patients, in whatever form such information may exist, including oral, written, printed, photographic and electronic formats (collectively, the "Confidential Information") is strictly confidential and is protected by federal and state laws and regulations that prohibit its unauthorized use or disclosure; and (iv) in the course of my employment/affiliation with Upstate Medical University ("Upstate"), I may be given access to certain Confidential Information.

2. **Disclosure, Use and Access**
   I agree that, except as authorized in connection with my assigned duties, I will not at any time use, access or disclose any Confidential Information to any person (including but not limited to co-workers, friends and family members). I understand that this obligation remains in full force during the entire term of my employment/affiliation and continues in effect after such employment/affiliation terminates.

3. **User Accounts, Passwords, and Electronic Signatures**
   I agree that: (i) any unique access codes provided to permit my access to electronic systems will not be shared with any other individual and shall be kept secure and confidential; (ii) all electronic transactions are logged and subject to periodic audit; (iii) violation of laws, policies or this agreement may result in termination of access and other sanctions; and (iv) I certify that affixing my electronic signature to sign and authenticate electronic documents and entries is my intentional method of authenticating information and has the same effect as my legal handwritten signature.

4. **Return of Confidential Information**
   Upon the termination of my employment/affiliation for any reason, or at any other time upon request, I agree to promptly return to Upstate or my employer all copies of business, administrative, and patient confidential information that is individually identifiable in my possession or control (including all printed and electronic copies), unless retention is specifically required by law, regulation or for special issues as outlined in the Upstate University Hospital Administrative Confidentiality Policy.

5. **Periodic Certification**
   I understand that I may be required to periodically certify that I have complied in all respects with this Agreement, and I agree to so certify when requested.

6. **Violations**
   I understand and acknowledge that: (i) the restrictions and obligations I have accepted under this Agreement are reasonable and necessary in order to protect the interests of patients, Upstate and my employer (if different from Upstate); and (ii) I am required to comply with laws and regulations and (iii) my failure to comply with this agreement in any respect could subject me to penalties by both Upstate as well as third parties. Penalties include but are not limited to disciplinary measures up to and including termination of employment or affiliation, and the imposition of civil or criminal penalties.

UPSTATE
UNIVERSITY HOSPITAL

EMPLOYEE/STUDENT HEALTH
Jacobsen Hall
750 East Adams Street
Syracuse, NY 13210
315-464-4260 (telephone)
315-464-5471 *(fax)*
Email: ESHealth@Upstate.edu

TO: Medical Staff Applicants
FROM: Jarrod Bagatell, MD
Director, Employee/Student Health
RE: Requirements for Medical Clearance to be credentialed

The New York State Department of Health requires: a complete medical history and physical exam, proof of immunity for rubella and rubeola, and surveillance for tuberculosis be submitted prior to granting medical staff privileges. In addition, evidence of immunity to mumps, varicella and hepatitis-B are required by Upstate policy and documentation of influenza vaccine for the current influenza season is mandated by the Hospital Executive Committee for medical staff to maintain privileges.

Requirements for Medical Clearance:

- ☐ Medical History and Physical exam within **6** months prior to anticipated start date
- ☐ Rubella IGG Antibody Titer — evidence of immunity by **ONE** of the following:
  - Rubella IGG Antibody Titer — (***copy of actual lab report is required***)
  - Documentation of one (1) MMR vaccine on or after 1st birthday
- ☐ Rubeola IGG Antibody Titer — if born on 1/1/1957 or later, evidence of immunity by **ONE** of the following:
  - Rubeola IGG Antibody Titer — (***copy of actual lab report is required***)
  - Documentation of two (**2**) MMR vaccines, one on or after 1st birthday and at least 4 weeks apart
- ☐ Mumps IGG Antibody Titer — if born on 1/1/1957 or later, evidence of immunity by **ONE** of the following:
  - Mumps IGG Antibody Titer — (***copy of actual lab report is required***)
  - Documentation of two (**2**) MMR vaccines, one on or after 1st birthday and at least 4 weeks apart
- ☐ Varicella — evidence of immunity by **ONE** of the following:
  - Varicella IGG Antibody Titer — (***copy of actual lab report is required***)
  - Documentation of two (**2**) varicella vaccines, one on or after 1st birthday and at least 4 weeks apart
- ☐ Hepatitis-B Surface Antibody Titer—is **mandatory** (***copy of actual lab report is required***)
  - Documentation of three (**3**) Hepatitis-B vaccines is also required
- ☐ Influenza vaccination date for current flu season (***documentation required***)
- ☐ Tuberculin Skin Test (PPD) — within **6** months prior to beginning assignment (prior BCG vaccination does not negate placing a PPD). IGRA (blood test) for tuberculosis is also acceptable and must be within **6** months prior to starting.
- ☐ Chest x-ray — is required if a prior tuberculin skin test has been **positive**, the x-ray must be done within **12** months prior to beginning assignment. A copy of the official x-ray report is required. You must also submit detailed documentation of the past positive PPD.

Your medical forms are reviewed only by the medical personnel of the Employee/Student Health Office. Please submit all required documents at one time by e-mail: ESHealth@upstate.edu or fax to: (315) 464-5471 or mail to the address listed above.

Documentation of Physical Examination

Name: ______________________________ Date of Exam: ______________

BP: ______/______ Temp:________ Pulse:________ Respiration:________ Weight:________ Height:________

Examination: (Must be within 6 months of application)

	Normal	Abnormal	NE	Notes: Describe abnormality with pertinent numeral before comment.
1. General Appearance	☐	☐	☐	
2. Skin	☐	☐	☐	
3. Head	☐	☐	☐	
4. Eyes	☐	☐	☐	
5. Ophthalmoscopic	☐	☐	☐	
6. Ears	☐	☐	☐	
7. Nose	☐	☐	☐	
8. Mouth/throat	☐	☐	☐	
9. Neck/thyroid	☐	☐	☐	
10. Lymphatics	☐	☐	☐	
11. Breasts	☐	☐	☐	
12. Thorax/lungs	☐	☐	☐	
13. Heart	☐	☐	☐	
14. Abdomen	☐	☐	☐	
15. Vascular system	☐	☐	☐	
16. Extremities/feet	☐	☐	☐	
17. Spine	☐	☐	☐	
18. Musculoskeletal	☐	☐	☐	
19. Neurologic	☐	☐	☐	
20. Psychiatric	☐	☐	☐	

Diagnosis and assessment of medical problems:

☐ No Medical Problems

☐ Ongoing medical problems: (Explain)

Limitations/Recommendations: (Further specialist examinations, labwork, x-ray, immunizations, etc.)

☐ No Limitations

☐ Limitations: (Explain)

After examination as required and to the best of my knowledge, I have determined that this individual is free from any health impairment that is of potential risk to patients or which might interfere with the performance of his/her duties. This included the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances, which may alter the individual's behavior or judgement.

Printed Name of Physician/Health Care Provider: ______________________ Date: ____________

Physician/Health Care Provider Signature: ______________________________

Physician/Health Care Provider Address: ______________________________

______________________________ Telephone: (   ) ____________

750 East Adams Street
Syracuse, NY 13210

Employee/Student Health

Tel 315.464.4260
Fax 315.464.5471

www.upstate.edu

State University of New York

Upstate Medical University

Medical Staff History and Physical

Last Name	First	Middle Initial	Sex	Date of Birth	Today's Date

Local Address (No. and Street)	City	State	Zip	Social Security Number

Email Address	Phone Number	Job Title	Department/Unit

Personal Health History

Have you **EVER** had, or do you have, any of the following? If YES, please specify by number and provide an explaination.

	No	Yes		No	Yes
1. Chicken pox or shingles	☐	☐	25. Broken bones	☐	☐
2. Measles	☐	☐	26. Bone or joint problems	☐	☐
3. Mumps	☐	☐	27. Arthritis/gout	☐	☐
4. Skin problems or chronic rash	☐	☐	28. Back pain/injury	☐	☐
5. Eye problems	☐	☐	29. Numbness/tingling legs or feet	☐	☐
6. Hearing loss or ear problems	☐	☐	30. Knee pain/injury	☐	☐
7. Chronic cough	☐	☐	31. Foot pain/injury	☐	☐
8. Asthma	☐	☐	32. Neck pain/injury	☐	☐
9. Shortness of breath	☐	☐	33. Loss of limb	☐	☐
10. Lung problems	☐	☐	34. Severe headaches	☐	☐
11. Tuberculosis or positive TB skin test	☐	☐	35. Dizziness or fainting	☐	☐
12. Chest pain	☐	☐	36. Epilepsy or seizures	☐	☐
13. Heart trouble/attack	☐	☐	37. Severe weakness or tiredness	☐	☐
14. Palpitations/irregular heart beat	☐	☐	38. Depression or anxiety	☐	☐
15. Heart murmur	☐	☐	39. Emotional or psychiatric problems	☐	☐
16. High blood pressure	☐	☐	40. Drug or Alcohol dependency	☐	☐
17. Stroke or paralysis	☐	☐	41. Eating disorder	☐	☐
18. Stomach or intestinal problem	☐	☐	42. Bleeding or blood disorder	☐	☐
19. Liver disease/hepatitis	☐	☐	43. Immune suppression	☐	☐
20. Kidney disease	☐	☐	44. Chronic/recurrent infection	☐	☐
21. Weight change	☐	☐	45. Tumor/cancer	☐	☐
22. Thyroid problems	☐	☐	46. Anemia	☐	☐
23. Shoulder/elbow/wrist/hand pain	☐	☐	47. Diabetes	☐	☐
24. Numbness/tingling of arms or hands	☐	☐	48. Any other illness not listed	☐	☐

NAME: ____________________

Please Check **EACH** Item, If YES, please specify by number and provide an **EXPLAINATION**.

	No	Yes
1. Are you on any medications	☐	☐
2. Do you have any allergies to medication	☐	☐
3. Do you use other drugs	☐	☐
4. Do you use alcohol	☐	☐
5. Refused as a blood donor	☐	☐
6. Do you smoke cigarettes	☐	☐
7. Have you ever been hospitalized	☐	☐
8. Have you ever had surgery	☐	☐
9. Have you ever received treatment or counseling for psychiatric or emotional illness	☐	☐
10. Do you have allergies to certain chemicals, dust, animals, or animal products (animal dander, bedding waste)	☐	☐
11. Have you ever been refused employment for health reasons	☐	☐
12. Do you have visual, hearing or other physical limitations	☐	☐
13. Are you unable to assume certain body positions	☐	☐
14. Are you unable to perform certain motions	☐	☐
15. Is there any reason you cannot fully perform all duties that your employment or volunteer work will require on any shift	☐	☐
16. Have you ever had a work related injury or illness	☐	☐
17. Have you ever had:		
a) needlestick/blood or body fluid exposure	☐	☐
b) rash or symptoms related to glove use	☐	☐

I certify that the information documented above is true and complete. I understand that misrepresentation or omission of facts called for may prevent or result in termination of medical staff privileges if granted. To the best of my knowledge, I do not have any physical or mental health impairment which is of potential risk to patients or that might interfere with the performance of my duties, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs (including those prescribed) which may adversely alter my behavior or judgement.

Printed name of Medical Professional Applicant: ____________________

Signature of Medical Professional Applicant: ____________________

Health care provider's summary and elaboration of all pertinent data. Please comment on all positive answers.

Health Care Provider: ____________________ Date: ____________