

DOCUMENTS REQUIRED IN **ADDITION** TO THE COMPLETED INITIAL APPLICATION:

1. Picture of applicant
2. Curriculum Vitae
3. Medicare/Medicaid Attestation
4. Statement of Continuing Education
5. Confidentiality Statement
6. TB Questionnaire
7. Statement of Applicant
8. Physician Orientation
9. Online Presentation Statement
10. Copy of all state license
11. Copy of DEA
12. Copy of CDC
13. Insurance Face Sheet
14. ACLS/CPR Certificate, if applicable
15. Delineation of privileges

MEDICARE NOTICE TO PHYSICIANS

“Medicare 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 may be subject to fine, imprisonment, or civil penalty under applicable Federal laws”

Signature

Printed Name

Date Signed

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Signature

Printed Name

Date Signed

**** Your signature will be kept in medical records, please sign as you would in a medical record chart or medical record electronic record.**

Texas Spine & Joint Hospital

Professional Staff Continuing Education Verification

Please submit documentation of your continuing education for the past year.

The following options are offered:

- 1) List the courses taken, location, date and number of CEUs or contact hours obtained. If necessary, attach additional pages(s).
- 2) Forward a copy of your own listing. Copies of certificates may be submitted, but are not required.
- 3) Certify that you have the required CEU's for the State of Texas and will provide them upon request.

Course Taken	Location	Date	CEU/Contact Hrs.

*** I hereby certify I have completed the required continuing education needed to maintain my license and/or certificate. I understand a random audit will be done at which time I will bring proof of the education listed above. The record will be maintained in my file.

Printed Name/Title

Signature/Title

Date

Texas Spine and Joint Hospital

Confidentiality Statement

The Texas Spine & Joint Hospital (TSJH) has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their personal health information. As an employee, contract employee, or visitor of TSJH, I may have access to or learn certain information, which is proprietary and confidential.

Therefore as an employee, contract employee or visitor of TSJH, and as a condition of my employment or visit, I agree to the following:

1. I will treat all information received in the course of my employment or visit with TSJH, which relates to the patients of the hospital as confidential and privileged information.
2. I understand that I am responsible for complying with the HIPAA policies and procedures, which were provided to me.
3. I will not access patient information unless I have a need to know this information in order to perform my job.
4. I will not disclose information regarding patients to any person or entity, other than as necessary to perform my job, and as permitted under the HIPAA policies.
5. I will not log onto any of the TSJH computer systems that currently exist or may exist in the future using a password other than my own.
6. I will safeguard my computer password and will not post it in a public place, such as the computer monitor or a place where it will be easily lost, such as my nametag.
7. I will not allow anyone, including other employees, to use my password to log onto the computer.
8. I will log off the computer as soon as I have finished using it.
9. When patient information must be discussed with other healthcare practitioners in the course of my work, I will use discretion to assure that such conversations cannot be overheard by others who are not involved with the patient's care.
10. I will not use e-mail to transmit patient information unless I am instructed to do so by the Privacy Officer.
11. I agree that I will not remove from TSJH any documents containing confidential information without the express permission from the Privacy Officer and my supervisor and to return any documents removed if my employment were to be terminated.
12. Upon cessation of my employment or visit at TSJH. I agree to continue to maintain the confidentiality of any information I learned while an employee and agree to turn over any keys, access cards, or any other device that would provide access to the facility or its information.

I recognize that in the course of my employment, I may have access to information, observations and data regarding the business, marketing of affairs of the company and its affiliates. Confidential information can include but is not limited to names, photographs, trade secrets, address or particular desires or business plans. I understand that any TSJH information obtained by me during the course of my presence in and with the company is the exclusive property of TSJH. I agree that I will not disclose to any person or organization or use for my own benefit any confidential business information without the company's written consent, unless (1) the confidential information becomes a generally known to and available for use by the public other than as a result of my actions or failures to act or (2) I am required by law to disclose the information.

I understand that violation of this agreement and the stated policy may result in corrective action, up to and including termination. I also acknowledge that I have had a chance to ask any question I may have about these promises.

Employee, Contract Employee or Visitor Signature

Date

Witness

Date

**Texas Spine and Joint Hospital
TB Questionnaire**

1. Have you been treated in the past for TB? Yes___No___
2. Have you ever had a positive TB Skin Test? Yes___No___
3. Do you have any of the following symptoms?
- a. Chronic cough? Yes___No___
 - b. Sputum production? Yes___No___
 - c. Night sweats? Yes___No___
 - d. Fever? Yes___No___
 - e. Involuntary weight loss? Yes___No___
 - f. Chronic fatigue Yes___No___

If yes to any above, please explain:

4. Physician review to positive answers:

5. Have you ever completed the Hepatitis B Series Yes___No___

6. Do you any history of natural rubber/latex allergy: Yes___No___

Date of last physical exam: ____/____/____

Examining Physician: _____

Physician Address: _____

Signature of Applicant:

_____ Date:_____

STATEMENT OF APPLICANT

Please read carefully before signing

I fully understand that any significant mis-statements in or omissions from this application constitute cause for denial of appointment or cause for summary revocation of privileges. All information submitted by me in the application is true to my best knowledge and belief.

In making this application, I signify my willingness to appear for interview, authorize the Hospital and the medical staff to consult with hospitals or employers with which I have been associated, as well as other persons or entities who may have information concerning my competence, character and ethical qualifications. I consent to the examination of all records that may be pertinent to the evaluation of my professional, moral and ethical qualifications and competence to carry out the clinical privileges I request. I release from any liability all representatives of the Hospital and its medical staff for their acts performed in good faith in connection with evaluation of my application and my credentials. I release from any liability all individuals and organizations who provide information to the Hospital in good faith concerning my competence, ethics, character and other qualifications pertaining to this application, including otherwise privileged or confidential information.

I understand and agree that I 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 qualification.

If approved by the Hospital and the medical staff, I agree to the following:

- 1. To engage in the practice of medicine as defined by the Medical Practice Act, State Board of Licensure, State Board of Governors, Podiatric Licensing Board, or Dental Board of Licensure.**
- 2. Adhere to the policies and procedures of the medical staff and the Hospital as they may apply to my actions of duties.**
- 3. When in the Hospital to wear proper identification indicating my name and title.**
- 4. To always maintain malpractice insurance coverage that meets or exceed the required amount as established by the facility Board of Manager**

MEDICAL STAFF ORIENTATION CHECK SHEET

PHYSICIAN NAME _____

I have read the following check sheet and understand its contents. Further information for clarification is available by request from Administration.

- 1) For each unit I have been provided with a tour so that I know the location of fire exits, fire extinguishers, restrooms, emergency equipment, and supplies needed for patient care.
- 2) All chemicals and waster encountered at the hospital are regarded as hazardous in nature and should not be handled. **Material Safety Data Sheets** are available on each unit to provide information about specific chemicals
- 3) I have been made aware and oriented to patient schedules and programs.
- 4) This facility adheres to Standard Precautions, which assumes that all patient blood, body fluids and other potentially infectious materials are contaminated. Appropriate protective equipment will be provided if I am required to handle these materials. I will wash my hands before and after patient contact and follow infection control guidelines.
- 5) I have been oriented to documentation requirements by receiving a copy of the Medical Staff Bylaws, Rules & Regulations. In addition I have been given or shown other documentation forms I will be using, such as physicians orders, progress notes, master treatment plans, etc.
- 6) I understand how to report and respond to emergency situations. Emergency codes are:

**	Code Purple	(RPA) Response Team to Patient Aggression
**	Code Blue	Medical Emergency
**	Code Red	Fire
**	Code Black	Bomb Threat
**	Code Orange	External Disaster
**	Code Pink	Abduction
**	Code Green/Weather	Severe Storm or weather.

- 7) In the event of fire I would:

R =	Rescue	Remove all patients from the area
A =	Alarm	Pull fire alarms, call "0" to report the fire
C =	Contain	Close doors to contain the fire
E =	Extinguish	Use fire Extinguishers ONLY after the above measures are taken

All fire extinguishers, at UK Good Samaritan Hospital, are located within 75 feet of where ever you are standing. The O.R. areas have water extinguishers, but most are ABC used on all but electronics in the I.T. room.

To use extinguisher:

P =	Pull pin
A =	Aim nozzle
S =	Squeeze handle
S =	Sweep flames

- 8) The Performance Improvement Program utilizes the CQI approach for improvement:
 - a. **Plan**/design the indicator/process to measure performance
 - b. **Do**/Implement a change to improve the outcome
 - c. **Check** (how did we do?) Did the action actually result in an improvement
 - d. **Act**/to maintain the gain.
- 9) I have participated in the orientation to pain management and understand the application of the hospital's policy regarding assessment and management.
- 10) I have been advised of my responsibilities for patient care hand off communication for the continuum of care.

Signature: _____ Date: _____

PHYSICIAN ORIENTATION

ONLINE PRESENTATION

To review the following policies go to www.tsjh.org and click on Physician Access

- 1. All Hazard Emergency Policy**
- 2. Medical Staff By-Laws**
- 3. Rules & Regulation**

My signature below indicates that I have read the policies listed above and agree to abide by the policies of Texas Spine & Joint Hospital.

Signature

Printed name

Date