CHI Saint Joseph Health

Dear Provider:

Enclosed is the requested application for Medical Staff Membership at CHI Saint Joseph Health. You may request a copy of the Medical Staff Bylaws, Rules and Regulations, and Policies from the Medical Staff Office.

The application must be completed and submitted along with all supporting documentation before it will be processed. Failure to complete the requested application materials may result in the application being withdrawn from consideration.

The hospital may refuse to complete processing of an application if the applicant does not meet the Governing Board's approved minimum eligibility criteria for membership and privileges. These minimum eligibility criteria for applicants include:

- Demonstration that he/she has successfully graduated from an approved school of medicine, osteopathy, dentistry, or podiatry.
- Having a current license that is not subject to any restrictions or conditions that would limit practicing as a physician, podiatrist or dentist as required for the practice of his/her profession within Kentucky.
- Having a record that is free from current Medicare/Medicaid/CHAMPUS sanctions and is not on a Medicare exclusion list or OIG sanction list.
- Having a record that is free of any criminal conviction, meaning conviction of and/or pleas of guilty or no contest to any felony or misdemeanors in which the underlying allegations involve the practice of a health care profession; Federal Health Program Fraud or Abuse; third party reimbursement; the use of alcohol or controlled substances; or crimes of moral turpitude.
- A physician applicant (i.e., MD or DO) must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA), and be currently board certified **or** be able to demonstrate active pursuit of board certification as defined by the appropriate board and be board-certified within seven years of initial staff appointment by the American Board of Medical Specialties or the American Osteopathic Association in the specialty of application.
- Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation.
- Oral and maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or board admissible by the American Board of Oral and Maxillofacial Surgery within seven years**.**
- A podiatric physician (DPM) must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric

Medical Education of the American Podiatric Medical Association (APMA) and be board certified or board admissible by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine within seven years**.**

Requests for membership and privileges will be assessed according to the criteria set forth in the Medical Staff Bylaws.

Material misstatements, false statements, inaccurate or incomplete applications, and omissions or misleading statements are grounds for denial of an application, without a hearing under the Fair Hearing Plan. Failure to provide any information requested by the Credentials Committee, Medical Executive Committee or Governing Board during the application process will render an application incomplete.

By submitting this application, you agree to fulfill all medical responsibilities outlined in the Bylaws and as outlined in the Medical Staff category you have requested. In addition, the medical staff leadership wants to ensure that you are fully aware of the expectations that physicians have of each other as members of our medical staff as outlined in the attached document.

All applications must be accompanied by a signed "Acknowledgement."

In order for the application to be considered at the next Credentials Committee meeting, the completed application and all supporting documentation must be received no later than thirty days from receipt of the application. The application will be considered if it is complete and all necessary Medical Staff verifications, including receipt of reference questionnaires, have been conducted.

Sincerely,

CHI Saint Joseph Health Medical Staff Office

CHI Saint Joseph Health

PHYSICIAN
Required Documents List

Instructions: One (1) photocopy of each of the following supporting documents MUST accompany the application for Medical Staff membership in order for it to be considered complete. Please check each item listed below and submit this form, along with your completed application, to the Medical Staff Office so it can be processed in a timely manner. If you have any questions regarding this form or other requested application materials, please contact your local Medical Staff Office for assistance.

NAME: _____

☐	Current State License
☐	Current DEA Certificate (for each state of practice)
☐	Kentucky All Schedule Prescription Electronic Reporting (KASPER) Proof of Registration
☐	Proof of Current Professional Liability Insurance (Face Sheet)
☐	Medical School Diploma
☐	Board Certification
☐	Curriculum Vitae (Note: All time periods from receipt of degree to present must be accounted for.)
☐	ACLS/ATLS/NALS/PALS/etc. and/or Moderate Sedation Certification (If required on DoP)
☐	ECFMG Certificate (If applicable)
☐	Official Photo Identification (Passport OR Driver's License/Birth Certificate)
☐	COVID Vaccination Record Card
☐	Documentation of influenza vaccine receipt or a valid reason for declination (October - March ONLY)
☐	Evidence of completion of tuberculin (Tb) skin test, CXR, and/or blood assay for *Mycobacterium tuberculosis* (e.g., Quantiferon-TB Gold, T-SPOT, etc.) within the past 12 months
☐	Medical Staff Membership Application Fee (If applicable)
☐	Personal Health Status Explanation Sheet [This document is ONLY required if any questions in Section XI of the KAPER form regarding personal health status were marked as 'Yes'.]
☐	Delineation of Privileges Form (Must be requested from the Medical Staff Office at each practice location)

Expectations of Practitioners and Advanced Practice Clinicians Granted Privileges at CHI Saint Joseph Health Facilities

This document describes the expectations that Practitioners have of each other and of APCS as members of the Medical Staff and/or who have otherwise been granted Clinical Privileges at the Hospital. The expectations described below reflect current Medical Staff Bylaws and policies. This document is designed to bring together the most important issues found in those documents and key concepts reflecting our Medical Staff's culture and vision.

Medical Staff leaders will work to improve individual and aggregate Practitioner and APC performance through non-punitive approaches and providing appropriate positive and constructive feedback that allows each Practitioner/APC the opportunity to grow and develop in his or her capabilities to provide outstanding patient care and valuable contributions to our Hospital.

Patient Care: Practitioners and APCs are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease and at the end of life as evidenced by the following:

1. Achieve patient outcomes that consistently meet or exceed generally accepted Medical Staff standards as defined by comparative data and targets, medical literature, and results of peer review activities.
2. Provide appropriate patient care that consistently meet or exceed generally accepted Medical Staff standards as defined by comparative data and targets, medical literature and results of peer review activities.
3. With respect to Practitioners, to assure that each patient is evaluated by a Practitioner as often as necessary but at least daily and document findings in the medical record at that time.
4. With respect to APCs, to assure that each APC's supervising/collaborating Practitioner reviews and co-signs medical record entries consistent with Medical Staff and APC policies.
5. Cooperate with Hospital efforts to implement methods to systematically enhance disease prevention.
6. Provide for patient comfort, including prompt and effective management of acute and chronic pain according to medically appropriate standards.
7. Discuss end of life issues when appropriate to a patient's condition, including advance directives and patient and family support, and honor patient desires.

Medical Knowledge: Practitioners/APCs are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others as evidenced by the following:

1. Use evidence-based guidelines when available, as recommended by the appropriate specialty, in selecting the most effective and appropriate approaches to diagnosis and treatment.

Practice Based Learning and Improvement: Practitioners/APCs are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care as evidenced by the following:

1. Review individual and specialty data for all dimensions of performance and utilize this data to for self-improvement to continuously improve patient care.
2. Respond in the spirit of continuous improvement when contacted regarding concerns about patient care.
3. Use information technology to manage information, access on-line medical information; and support his/her education.

Interpersonal and Communication Skills: Practitioners/APCs are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams as evidenced by the following:

1. Communicate clearly with other Practitioners, APCs, caregivers, patients, and their families through appropriate oral and written methods to ensure accurate transfer of information.
2. Maintain medical records consistent with the Medical Staff bylaws and policies including but not limited

to medical record entry legibility, and timely completion of History and Physical examination reports, operative reports, procedure notes, discharge summaries, and signature requirements as well as the use of appropriate abbreviations.

3. Request inpatient consultations by providing adequate communication with the consultant including a clear reason for consultation and, for urgent or emergent requests, make direct Practitioner-to-Practitioner contact.
4. Support the Medical Staff's efforts to maintain patient satisfaction rates for Practitioners/APCs.
5. Address disagreements in a constructive, respectful manner away from patients or other non-involved caregivers.

Professionalism: Practitioners/APCs are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society as evidenced by the following:

1. Act in a professional, respectful manner at all times to enhance a spirit of cooperation and mutual respect and trust among members of the patient care team.
2. Refrain from unprofessional conduct as set forth in the Professional Conduct Policy including but not limited to impulsive, disruptive, sexually harassing or disrespectful conduct or documentation in the medical record that does not directly relate to the patient clinical status or plan of care or that is otherwise derogatory or inflammatory.
3. Respond promptly to nursing requests for patient care needs.
4. As to Practitioners, respond promptly to consultation requests.
5. Respect patient rights by discussing unanticipated adverse outcomes with patients and/or appropriate family members, by not discussing patient care information and issues in public settings, and by wearing appropriate identification when seeing or attending patients.
6. As to Practitioners, participate in emergency room call coverage as determined by the Medical Executive Committee.
7. Follow ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent and business practices.
8. Utilize sensitivity and responsiveness to patients' culture, age, gender, and disabilities.
9. Make positive contributions to the Medical Staff by participating actively in Medical Staff functions and serving when requested and by responding in a timely manner when provided information on Medical Staff matters requesting Practitioner/APC input.
10. In the spirit of early assistance, help to identify issues affecting the physical and mental health of fellow Practitioners/APCs.

Systems Based Practice: Practitioners/APCs are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize healthcare as evidenced by the following:

1. Ensure timely and continuous care of patients by clear identification of covering Practitioners/APCs and by availability through appropriate and timely electronic communication systems.
2. Strive to provide quality patient care that is cost effective by cooperating with efforts to appropriately manage the use of valuable patient care resources according to comparative data and current professional standards.
3. Cooperate with guidelines for appropriate hospital admission, level of care transfer, and timely discharge to outpatient management when medically appropriate.
4. Participate in the Hospital's efforts and policies to maintain a patient safety culture, reduce medical errors and meet national patient safety goals.
5. Follow nationally recognized recommendations regarding infection control procedures and precautions when participating in patient care.
6. Advocate for quality patient care and assist patients in dealing with system complexities.

By my signature below I am indicating that I have read, understand, and agree to adhere to practices that fulfill the expectations of the organized Medical Staff.

Name (Print): _____

Signature: _____

Date: _____

SAINT JOSEPH HOSPITAL/SAINT JOSEPH EAST/SAINT JOSEPH BEREA

EMERGENCY PREPAREDNESS PLANS

Security SJH: ext. 1852 Security SJE: ext. 5954 SJB: ext. 0

FIRE

Code: RED
R - Rescue individuals from the area
A - Pull alarm and call 1111
C - Contain the fire
E - Extinguish/Evacuate

To use a fire extinguisher:
P - Pull
A - Aim
S - Squeeze
S - Sweep

TORNADO

Stay where you are when the code is called.
Move patient/visitors to hallway
For immobile patient, close drape/blinds; cover patient with blankets, unplug unnecessary equipment, close door
Close blinds in hallway or cover with blankets

CARDIAC ARREST (Adult or Pediatric)

Code: BLUE
Start CPR if qualified or call for help
Dial 1111 @ SJE & SJH, Dial 66 @ SJB and give room number to hospital operator

BOMB THREAT

Code: BLACK
Remain calm; do not transfer call
Obtain all information, i.e. who, what, where, why
Write down all information
Call hospital operator at 1111 @ SJE & SJH, Dial 66 @ SJB.

UNCONTROLLED PATIENT

Code: GREY
Dial 1111 at SJE & SJH, Dial 66 @ SJB; call Code Grey
Code Grey team; follow instructions of team

INFANT OR CHILD MISSING

Code: PINK
Detain any individual with an infant or child from leaving the area.
Call Security to interview anyone attempting to leave hospital with infant or child.

ANTEPARTUM EMERGENCY

Code: GREEN (@ SJE)
Appropriate individuals will respond to the antepartum unit.

HAZARDOUS MATERIALS INCIDENT

Code: ORANGE
Keep all staff and patients away from the situation.
Call hospital operator at 1111 @ SJE & SJH, call 66 @ SJB.
Appropriate resources will “contain” the material.

WEAPONS WITH IMMINENT THREAT TO PATIENT OR STAFF

Code: SILVER
Call hospital operator at 1111 @ SJE & SJH, Dial 66 @ SJB.
Remove everyone from the immediate vicinity.
Only an individual trained in surrender of weapons approaches the individual.

I have read the above safety preparedness plans, understand and agree to comply as outlined.

_____
Print Name

_____ _____
Signature **Date**

Please return with your application.

CHI Saint Joseph Health

Physician & Advanced Practice/Allied Health Professional Membership Category Selection & Application Fee

Instructions: Please select the membership category that you wish to apply for, and provide payment for the amount listed along with your completed application materials to the Medical Staff Office. Application fees may vary at each facility. Consult with your local Medical Staff Office credentialing expert if you have additional questions regarding membership category selection.

NAME: _____ DEGREE / CREDENTIALS: _____

MEMBERSHIP CATEGORY SELECTION	APPLICATION FEES BY FACILITY	
ACTIVE Active members are practitioners who meet the basic qualifications for Medical Staff membership set forth in the bylaws; regularly admit or participate in the care of patients at the hospital; have completed the provisional period; and comply with all other required obligations.	Flaget Memorial Hospital: Saint Joseph Berea: Saint Joseph East: Saint Joseph Hospital: Saint Joseph Jessamine: Saint Joseph London: Saint Joseph Mount Sterling:	$100 $ --- $ --- $ --- $ --- $250 $ ---
ADVANCED PRACTICE PROVIDER (APP) Advanced Practice Providers (APPs) are individuals who are licensed or certified to practice in a health care profession independently or under the supervision/collaboration of a Medical Staff member (e.g., APRN, PA, CRNA, Certified Nurse Midwife, Psychologist, etc.).	Flaget Memorial Hospital: Saint Joseph Berea: Saint Joseph East: Saint Joseph Hospital: Saint Joseph Jessamine: Saint Joseph London: Saint Joseph Mount Sterling:	$20 $ --- $ --- $ --- $ --- $75 $ ---
AFFILIATE Affiliate members are practitioners who are not otherwise eligible to become Active, Courtesy, Consulting, Honorary, or Locum Tenens members of the Medical Staff or choose not to pursue Active status who meet the basic qualifications for Medical Staff appointment set forth in the bylaws and who do not admit or actively participate in the care of patients at the hospital because their professional practice is solely ambulatory in nature (e.g., internists, family practitioners, and pediatricians who have a primary office practice).	Flaget Memorial Hospital: Saint Joseph Berea: Saint Joseph East: Saint Joseph Hospital: Saint Joseph Jessamine: Saint Joseph London: Saint Joseph Mount Sterling:	$100 $ --- $ --- $ --- $ --- $500 $ ---

ALLIED HEALTH PROFESSIONAL (AHP) Allied Health Professionals (AHPs) are health care providers who are not practitioners or APPs but who are licensed, certified, or otherwise trained to furnish health care services under the supervision of a practitioner.	Flaget Memorial Hospital: Saint Joseph Berea: Saint Joseph East: Saint Joseph Hospital: Saint Joseph Jessamine: Saint Joseph London: Saint Joseph Mount Sterling:	$20 $ --- $ --- $ --- $ --- $ --- $ ---
CONSULTING Consulting members are practitioners who are not otherwise Active, Courtesy, Locum Tenens, or Honorary members of the medical staff who meet the basic qualifications for Medical Staff appointment set forth in the bylaw, and they possess specialized skills for a specific project or consultation required by the Hospital or a Member	Flaget Memorial Hospital: Saint Joseph Berea: Saint Joseph East: Saint Joseph Hospital: Saint Joseph Jessamine: Saint Joseph London: Saint Joseph Mount Sterling:	$200 $ --- $ --- $ --- $ --- $ --- $ ---
COURTESY Courtesy members are practitioners who meet the basic qualifications for Medical Staff appointment set forth in the bylaws; have satisfactorily completed at least one year on the provisional staff; and are members in good standing of the active staff of another accredited hospital licensed by the state of the hospital's man facility.	Flaget Memorial Hospital: Saint Joseph Berea: Saint Joseph East: Saint Joseph Hospital: Saint Joseph Jessamine: Saint Joseph London: Saint Joseph Mount Sterling:	$200 $ --- $ --- $ --- $ --- $ --- $ ---
HONORARY Honorary members are practitioners who are retired from active practice or are of outstanding reputation which the Medical Staff office wishes to honor. The Honorary category is restricted to those individuals recommended by the MEC and approved by the Board.	Flaget Memorial Hospital: Saint Joseph Berea: Saint Joseph East: Saint Joseph Hospital: Saint Joseph Jessamine: Saint Joseph London: Saint Joseph Mount Sterling:	$200 $ --- $ --- $ --- $ --- $ --- $ ---
X **LOCUM TENENS** Locum Tenens are practitioners who meet the basic qualifications for Medical Staff appointment set forth in the bylaws; who admit patients or are otherwise involved in the care and supervision of patients in the hospital; and typically maintain a permanent residence outside of the community served by the hospital; however, in order to ensure the provision of continuous care to their patients, they are located in the vicinity of the Hospital during the term of their assignment, as required by the rules and regulations.	Flaget Memorial Hospital: Saint Joseph Berea: Saint Joseph East: Saint Joseph Hospital: Saint Joseph Jessamine: Saint Joseph London: Saint Joseph Mount Sterling:	$ --- $ --- $ --- $ --- $ --- $75 $ ---

CHI Saint Joseph Health

Intended Practice Plan

1. I intend to establish (or join) a practice in the following community: _____

2. I will be practicing as a solo / group member practitioner (Circle One).

   If practicing with a group, list the name of the group: Lexington Clinic/CHI Saint Joseph Hospitals Emergency Medicine

3. I will admit my patients in need of hospitalization to CHI Saint Joseph Hospitals (Facility Name)

   ☑ Yes ☐ No

4. I will not be admitting patients; however, I will be referring patients to N/A when they are in need of acute services.

   ☐ Yes ☐ No

5. Answer the following question ONLY if you will perform procedures:

   a. Will you perform procedures at the location where the application is being submitted?

      ☑ Yes ☐ No

   b. If yes, approximately how many procedures per month do you expect to perform?

      Approximate Number of Procedures: _____

6. I will perform consultations at the request of other physicians at N/A.

   ☐ Yes ☐ No

   If no, please provide a brief explanation: _____

   _____

   *Please be advised that certain specialties may be deemed "essential" services, requiring coordination among physicians within those specialties to provide 24/7 on-call coverage and in-hospital consultations in accordance with facility-specific on-call policies, Medical Staff Bylaws, Rules & Regulations, and/or other contractual agreements.

CHI Saint Joseph Health

7. I will provide continuous coverage for my patients during periods of my absence by:

   CHI Saint Joseph Hospitals ER Providers on Staff

8. I will provide unattached Emergency Department call and in-house consultations by:

   N/A

9. Are you requesting medical staff appointment solely to secure participation with health maintenance or managed care organizations?

   ☐ Yes ☑ No

10. I agree to treat employees, patients, visitors, and other physicians/caregivers who work at CHI Saint Joseph Health in a dignified, professional, and courteous manner.

    ☑ Yes ☐ No

11. I agree to complete my patient records in the timeframes required by the organization.

    ☑ Yes ☐ No

12. I agree to participate in relevant clinical practice guidelines when such guidelines have been determined by the Medical Executive Committee to positively influence patient outcomes and aid in the provision of safe and effective patient care.

    ☑ Yes ☐ No

13. I **own** / **do not own** (circle one) a significant interest, either personally or corporately, in a healthcare organization that competes with a CHI Saint Joseph Health facility.

    ☐ Yes ☐ No

I understand that my answers to the above questions will be considered by the facility to which I am applying and appointment, if offered, will be contingent upon adherence to this practice plan.

PRINTED NAME: _____ **DATE:** _____

SIGNATURE: _____

CHI Saint Joseph Health

Preferred Contact Numbers

Name: _____

9AM – 5PM	Preferred Contact Number	Specify Office, Cell, Home, or Other
1st Preference	(_____) _____ - _____	
2nd Preference	(_____) _____ - _____	
3rd Preference	(_____) _____ - _____	
5PM – 9AM	**Preferred Contact Number**	**Specify Office, Cell, Home, or Other**
1st Preference	(_____) _____ - _____	
2nd Preference	(_____) _____ - _____	
3rd Preference	(_____) _____ - _____	

*Please be advised that your preferred contact numbers will be displayed in the order that you specify for use by nursing staff and other members of the health care team in order to contact you for patient care needs.

Conflicts of Interest Questionnaire

1. Have you had an employment, advisory, or consulting relationship with a non-CHI entity that does or seeks to do business with CHI or a CHI Entity for which you received monetary compensation?

Yes ☐ No ☐

2. Have you or any immediate family member(s) had any financial or ownership interest or served as an officer, trustee, director, consultant, or contractor:
    a. In a competing organization of CHI or a CHI Entity,
    b. In a supplier of goods or services to CHI or a CHI Entity,
    c. In any non-CHI Entity that does or seeks to do business with CHI or a CHI Entity,
    d. To any non-CHI Entity that transacts business with or provides grants or other charitable assistance to CHI or a CHI Entity via a contract or other similar arrangement?
    e. In a company that sponsors your CHI research, or relates to your institutional responsibilities at CHI?

Yes ☐ No ☐

3. Have you or any immediate family member(s) accepted any gifts, entertainment, loans, favors, or other monetary or non-monetary compensation with a value greater than $100 from any person or Entity (including Group Purchasing Organizations and pharmaceutical, medical supply, or medical device companies) doing business or seeking to do business with CHI or a CHI Entity? This excludes any salary and benefits received from CHI or CHI Entity. **NOTE: Compensation includes payment for speaking fees, gifts, stock options and dividends, research grants, entertainment, consulting fees, travel, and license fees.**

Yes ☐ No ☐

4. Have you or any immediate family member(s) been involved in a business opportunity that:

    a. CHI has a reasonable interest in;
    b. CHI is financially able to undertake;
    c. Is in line with CHI's current business operations?

Yes ☐ No ☐

5. Have you conducted, overseen, or approved research at any CHI facility, or are you involved in any research utilizing CHI facility patients, personnel, services, or any other CHI resources as any of the following:
    a. Investigator, Principal, Co-, Sub-
    b. Research Coordinator
    c. Research Nurse
    d. Research Manager
    e. Research Assistant
    f. Research Administrator/Operations Personnel (i.e., Research Manager, Regulatory Coordinator)

g. IRB Member

Yes ☐ No ☐

6. The following question asks about any publicly-traded company related to your research activities or institutional responsibilities at CHI/CHI Entity. Have you (or your spouse or dependent children) received any of the following with a combined value of $5,000 or more?
   a. Compensation or remuneration received from the Entity (including payments for services, salary, consulting fees, honoraria, paid authorship), or
   b. Equity interest (any stock, stock option, or other ownership interest, as determined through reference to public prices or other reasonable measures of fair market value).

Yes ☐ No ☐

7. The following question asks about any non-publicly traded Entity (e.g., privately owned company) related to your research activities or institutional responsibilities at CHI/CHI Entity: Have you (or your spouse or dependent children) received any of the following financial interests?
   a. Compensation or remuneration received from the Entity in aggregate of $5,000 (including any payments for services, salary, consulting fees, honoraria, paid authorship), or
   b. Any equity interest (stock, stock option, or other ownership interest, regardless of value).

Yes ☐ No ☐

8. Have you received any travel reimbursement or sponsored travel, or has any travel been paid on your behalf by a company related to your research or institutional responsibilities at CHI/CHI Entity, whether or not you know the amount (including transportation, lodging, and meal expenses)?

Yes ☐ No ☐

9. Have you (or your spouse or dependent children) received any royalty or other income related to intellectual property rights and interests (e.g., patents, copyrights) that could reasonably relate to your CHI research or your CHI institutional responsibilities?

Yes ☐ No ☐

Conflicts of Interest Questionnaire

Attestation

I acknowledge that:

- I have completed all questions required by my role(s) with CHI.
- I have access to CHI's Conflicts of Interest Policy or, if not, I have had the opportunity to request and review such policy in connection with the completion of this Conflicts of Interest disclosure.
- I agree to promptly notify my direct supervisor or other appropriate person, as outlined in the Policy, and update my Conflicts of Interest disclosure should my circumstances change in a way that may create a conflict of interest.
- I will cooperate in the development of a conflict of interest management plan and comply with any reasonable conditions or restrictions for identified conflicts.

I certify that the information I have provided about financial, ownership, or managerial interests in this disclosure questionnaire is true, accurate, and complete as of the date of submission.

Printed Name _____

Signature _____

Date _____

CHI Saint Joseph Health

Confidentiality Agreement

Catholic Health Initiatives, its affiliates and subsidiaries (CHI), treat information about CHI's business and about individuals such as the patient or resident and their families, employees as confidential and take precautions to protect the privacy, confidentiality, and security of this information.

CHI confidential information means any information regardless of the format that it is in (for example, paper, electronic, oral conversations, films) about a patient, resident, employee, student, physician, professional staff, or CHI business and financial operations that is not available to the public. Confidential information includes, but is not limited to, protected health information, billing, payroll, employment records, employee benefits, trademark, copyright, intellectual property, technical ideas and inventions, written published works, contracts, supplier lists and prices, price schedules, business practices, marketing, or strategy, confidential information of third parties for business purposes, or information that is only intended for internal use.

During the course of your employment or association with CHI, you may have access to CHI confidential information. In order to access confidential information you must read the following statements and conditions and indicate your intent to comply.

1. I will look at and use only the confidential information I need to perform my job duties such as to provide health care for a patient, resident or other individuals, or to perform CHI business related job duties.

2. I will not look at confidential information that I do not need to perform my job for my own personal benefit or profit, for the personal benefit or profit of others, or to satisfy personal curiosity, or to disclose or divulge confidential information to others.

3. I will not share confidential information with anyone who is not authorized by CHI to have access to it. If my responsibilities include disclosing confidential information with outside parties such as healthcare providers, contractors, consultants, or insurance companies, I will follow CHI policies and procedures for these types of disclosures.

4. I will take reasonable precautions and follow CHI policies and procedures for safeguarding confidential information to prevent the unauthorized use or disclosure of confidential information.

5. I will ensure that confidential information that I no longer need will be returned and maintained in the appropriate CHI department or location, or in accordance with CHI policies and procedures.

6. I understand that passwords, verification codes, or electronic signature codes assigned to me are the equivalent to my personal signature; and

    - I will only use my password, verification or electronic signature code, in accordance with CHI policies and procedures;

    - I will not use the password, verification or electronic signature code of other CHI employees or individuals authorized by CHI to have such password, verification or electronic signature code;

    - I am responsible and accountable for all entries made and retrievals accessed using my password, verification or electronic signature code regardless of whether it is used by me or by another individual; and

    - I will not use my password, verification or electronic signature code after my employment or affiliation with CHI ends.

7. I understand that CHI issues user identification and secure passwords to access confidential information that is maintained electronically and that CHI periodically monitors access and use of confidential information to determine my compliance with CHI policies and procedures and the terms of this Agreement.

8. If I become aware that another individual has access to or is using my password, verification or electronic signature code or is using his or another individual's password, electronic signature or verification code improperly, I will immediately notify my direct supervisor or the CHI Privacy Officer.

9. I understand and agree to abide by the obligations of this Confidentiality Agreement and associated CHI policies and procedures related to privacy, information security, information technology and confidentiality. I understand that CHI may take disciplinary action if I do not abide by this Confidentiality Agreement and the CHI policies and procedures, including termination of my employment, contract, or association with CHI.

10. I understand that my obligation to maintain the confidentiality of CHI's confidential information extends beyond termination of my employment or association with CHI, and I agree that I will not disclose or use CHI confidential information for any purpose after my employment or association ends.

11. I understand that CHI is entitled to take legal action against me if I do not follow this Confidentiality Agreement and CHI's confidential information is used or disclosed inappropriately, including obtaining money damages.

12. I understand that agreeing to comply with CHI policies and procedures to protect confidential information is not an employment contract. I understand that these policies and procedures may be revised or amended at any time and I will be made aware of the updated policies and procedures.

Acceptable Use of CHI IT Assets Agreement

During the course of your employment with Catholic Health Initiatives, or its affiliates and subsidiaries (CHI) you may need to have access to information systems, applications, and information technology network infrastructure (CHI IT Assets) to obtain and use CHI information for your job duties. In order to obtain and maintain access privileges to CHI IT Assets you must read the following statements and conditions and indicate your intent to comply with CHI policies and procedures and this Acceptable Use Agreement.

1. I have read the CHI Acceptable Use Policy. If I have any questions about my use of CHI IT Assets I am to ask my immediate supervisor and/or the ITS Help Desk for assistance. I may access the Acceptable Use Policy by going to Inside CHI or clicking on CHI IT Security Policies and Standards.

2. I understand that CHI maintains ownership of CHI IT Assets and the CHI Information contained on these IT Assets. CHI Information includes information that I may create, access, or obtain on behalf of CHI.

3. I understand that CHI will monitor my access, use, and transmission of information on CHI IT Assets. I do not have, and should not expect any personal privacy rights when using CHI IT Assets.

4. I am not permitted to install or remove any software on CHI IT Assets. If I need specific software for specific job duties, I will obtain approval from my immediate supervisor and request services from ITS Help Desk to install or remove such software.

5. I am responsible for complying with software licensing, copyright, and patent requirements, and the laws which protect these rights. I understand that I am not permitted to download, reconfigure, or reverse engineer any software that CHI uses with its IT Assets.

6. I am responsible for handling CHI Information to prevent unauthorized use or disclosure of CHI Information, and unauthorized access, and use of CHI IT Assets. This includes, but is not limited to taking additional physical precautions to protect IT Assets such as logging out and turning off my computer when not in use, physical protection of IT Assets to prevent theft or loss, such as with mobile devices and laptops, protecting my password from other individuals who may use it inappropriately, and regularly changing my password and making the password complex and difficult to break. I will follow the password requirements set forth in the CHI IT Security Acceptable Use Policy.

7. I am responsible for securing CHI Information when used and disclosed electronically, such as using encryption when sending Confidential Information.

8. I am responsible for knowing and following the acceptable uses of Internet, email, Instant Messaging, file transfer, and proper data storage as set forth in the CHI Acceptable Use policy.

9. I am responsible for protecting CHI IT Assets, including my company computer, from viruses and the introduction of malware. If I have any questions or concerns about unknown emails or internet web sites, I will contact the ITS Help Desk for assistance.

10. I will report all security incidents to the ITS Help Desk regardless of how insignificant I may think the incidents are.

11. I understand and agree to abide by the obligations of this Acceptable Use of CHI IT Assets Agreement and associated CHI policies and procedures while using CHI IT Assets. I understand that CHI may take disciplinary action if I do not abide by this agreement and the CHI policies and procedures, including up to termination of my employment, contract, or association with CHI.

12. I understand that agreeing to comply with CHI Acceptable Use Policy and related policies and procedures is not an employment contract. I understand that these policies and procedures may be revised or amended at any time and I will be made aware of the updated policies and procedures.

I understand that I may access a copy of the **Privacy and Security Standards** by going to the Inside CHI Web site or through these links:

Privacy Standards: http://collab.catholichealth.net/gm/folder-1.11.142497

Security Standards:
http://home.catholichealth.net/portal/site/chihome/menuitem.9330395afff7999de89df0ef43abafa0/?vgnextoid=742b43e4a0610210VgnVCM10000093bcfa0aRCRD&vgnextfmt=default

By my signature below I am indicating that I have read, understand, and agree to adhere to the conditions of this Confidentiality Agreement for continued employment or affiliation with **Catholic Health Initiatives.**

Name (print): _____ ID Number (optional):_____

Signature: _____ Position: _____

EXHIBIT B

ELECTRONIC HEALTH RECORD
ACCESS USER AND CONFIDENTIALITY AGREEMENT
WITH [_____] ("HOSPITAL")

This Agreement must be completed and signed by each individual requesting access to Hospital Electronic Health Records. The Agreement must be completed and returned to the Hospital Information Technology Department before access will be granted.

Organization Name and Address: Lexington Clinic

1221 South Broadway, Lexington, KY 40504

Site Administrator (Please print): Gary Lake

Name of individual requesting access (please print): _____

Job Title: Physician

Any previous names used: _____

Direct Work Phone*(required): 859-258-4000

Home or Mobile Phone*(required): _____

Home Address (cannot be organizational address)*(required): _____

_____

(Cannot be clinic address, home address is required to allow access to medical records.)

Are you a Provider? ☑ Yes ☐ No

Degree: _____

Specialty: _____

NPI: _____

User Attestations

As a user, I attest I:

1. Am an employee or contractor of the healthcare organization named above.
2. Am aware of and agree to comply with state and federal Privacy and Security Rules, including HIPAA.
3. Understand that the use of this IT asset, including associated files or records is strictly limited to activities directly related and appropriate to my job responsibilities.
4. Understand that the use of my identification (ID) and password by anyone other than me is prohibited. If I suspect my account may be compromised, I will report it immediately to (Insert Facility) by calling (Insert Phone Number).
5. Acknowledge that I will only access patient health information (PHI) of patients who are being treated by the above-named organization for legitimate treatment purposes, payment activities, and/or bona fide healthcare operations.

6. Understand that I have no right or expectation of privacy in my use of this IT Asset. I further consent to (Insert Facility) monitoring my use of this system.
7. Will notify (Insert Facility) immediately at (insert phone number) of any actual or potential breach of confidentiality or data loss associated with this access.
8. User agrees that any access to Hospital's internal network or other Information Technology assets is subject to CommonSpirit's Data Asset Usage Policy (IT A-002) governing acceptable use of its IT resources, available upon request.

I understand:

- (Insert Facility) is in no way responsible for my or my organization's compliance with HIPAA or any other applicable state or federal regulations.
- Failure to comply with federal or state regulations, including HIPAA privacy and/or security rules, will result in immediate loss of access for me and potentially for my organization. Additional sanctions may be assessed based on severity of violations with federal or state regulations.

_____ _____

User Signature Date

_____ _____

Witness Signature Date

Continuing Medical Education (CME) Attestation Form

By signing this form, I declare that I have received the required number of CME credit hours necessary to maintain active medical licensure and to ensure that I remain proficient in the areas of medical practice directly related to my specialty and the clinical privileges for which I am applying. I also understand that the required number of CME credit hours is directly related to my specialty, in accordance with the Kentucky Board of Medical Licensure and all applicable administrative regulations (See 201 KAR 9:310). Furthermore, I will maintain documentation of this education and provide evidence of successful completion of approved CME credit hours to the Medical Staff Office upon request.

PRINTED NAME: _____ **DATE:** _____

SIGNATURE: _____

Electronic Signature Authentication Confidentiality Agreement

I certify that my password represents my signature and as such carries all the ethical and legal implications of a written signature. I will not disclose my electronic signature password to any other person or permit another to use it. I understand that patient information is confidential and agree to follow CHI Saint Joseph Health's policies and procedures as well as the rules and regulations of the Medical Staff pertaining to patient confidentiality. I understand that failure to maintain patient confidentiality as well as the confidentiality of my electronic signature password will result in the forfeiture of my rights to use the electronic signature function.

PRINTED NAME: _____

SIGNATURE: _____ **DATE SIGNED**: _____

CommonSpirit

FAIR CREDIT REPORTING ACT INVESTIGATIVE CONSUMER REPORT DISCLOSURE

In connection with your application for Medical Staff membership and privileges in addition to your ongoing Medical Staff membership and privileges with CommonSpirit Health (the "Company"), we may obtain "investigative consumer report(s)" that include information as to your character, general reputation, personal characteristics, and mode of living, whichever are applicable.

If the Company obtains an investigative consumer report, you have the right to request disclosure of the nature and scope of the report which may involve personal interviews with sources such as your neighbors, friends, or associates. Upon your written request to the Company, you are entitled to receive additional disclosures regarding the nature and scope of the investigation and a summary of your rights under the Fair Credit Reporting Act (FCRA). You may also obtain a summary of your rights under the FCRA at *https://files.consumerfinance.gov/f/documents/bcfp_consumer-rights-summary_2018-09.docx*.

AUTHORIZATION TO OBTAIN CONSUMER REPORTS

I hereby authorize CommonSpirit Health (the "Company"), now or at any time while I am in a relationship with the Company, to obtain consumer report(s), or investigative consumer report(s), about me. This authorization does not authorize the release of medical information.

I represent that the information provided in or attached to this authorization is complete and accurate. I fully understand that a condition of the application process is that any misrepresentation, misstatement or omission from the authorization or application, whether intentional or not, is cause for denial of this application and may result in the denial of appointment and clinical privileges. Upon discovery of such misrepresentation, misstatement or omission, CommonSpirit Health may take immediate corrective action, including, but not limited to, denial of my application or request for privileges and revocation of my appointment and clinical privileges without access to fair hearing processes.

_____ _____

Applicant's Signature Today's Date

_____

Applicant's Name Printed

CommonSpirit

APPLICANT DETAILS

In order to facilitate your Background screening, please provide the following information. If additional space is needed please provide it on a separate sheet.

List all home addresses you have had in the past seven years:

1) _____

_____

2) _____

_____

3) _____

_____

4) _____

_____

List all employment/education addresses you have had in the past seven years:

1) _____

_____

2) _____

_____

3) _____

_____

4) _____

_____

5) _____

_____

6) _____

_____

CommonSpirit

STATE-SPECIFIC CHOICES, DISCLOSURES AND NOTIFICATIONS

State-specific consumer choices:

- California – If you are a California resident or applying in the State of California, in addition to this disclosure/authorization, please review the "California Disclosure Concerning Investigative Consumer Reports Obtained for Employment Purposes", the California Applicants---Investigative Consumer Report Acknowledgment and Authorization, and, if applicable, disclosures related to obtaining credit reports for employment purposes.

- Minnesota – If you are a Minnesota resident or applying at a location within the State of Minnesota, you have a right to obtain a copy of the consumer report by checking this box. ☐

- Oklahoma – If you are an Oklahoma resident or applying at a location within the State of Oklahoma, you have a right to obtain a copy of the consumer report by checking this box. ☐

Additional Notices Required by State Law (if applicable).

- Maryland – If you are a Maryland resident or applying for employment at a location within the State of Maryland, you have the right to request additional disclosures from the Company regarding the nature and the scope of the requested investigation.

- Massachusetts – If you are a Massachusetts resident or applying for employment at a location within the State of Massachusetts, you have the right to request a copy of the investigative consumer report from the consumer reporting agency. The requested investigation on you will cover *[insert description of the precise nature and scope of the requested investigation]*. The consumer report obtained as part of this application for employment may contain public record information that is reported to *[name and address of the Company]*.

- Minnesota – If you are a Minnesota resident or applying for employment at a location within the State of Minnesota, you have the right to request additional disclosures from the consumer reporting agency regarding the nature and scope of the consumer report.

- New Jersey – If you are a New Jersey resident or applying for employment at a location within the State of New Jersey, you have the right to request a copy of the report from the consumer reporting agency. The requested investigation on you will cover *[insert description of the precise nature and scope of the requested investigation]*.

- New York – If you are a New York resident or applying for employment at a location within the State of New York, you have the right to send a written request to the Company for information on whether or not an investigative consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made.

- Rhode Island – If you are a Rhode Island resident or applying for employment at a location within the State of Rhode Island, the Company may request a credit report from a consumer reporting agency in connection with your application.

- Washington – If you are a Washington resident or applying for employment at a location within the State of Washington, you have the right to request from the Company additional disclosures of the nature and scope of the investigation requested and a written summary of consumer rights prepared under the laws of the State of Washington.

CommonSpirit

CALIFORNIA DISCLOSURE
CONCERNING INVESTIGATIVE CONSUMER REPORTS OBTAINED FOR EMPLOYMENT PURPOSES

In connection with your application for Medical Staff membership and privileges ("Company"), the Company may obtain an investigative consumer report about you, as defined in the California Investigative Consumer Reporting Agencies Act, Cal. Civ. Code §1786 *et seq.* for employment purposes, which may include information as to your character, general reputation, personal characteristics, and mode of living. The requested investigation on you may include, but not limited to, one or more of the following: Social Security Number trace, civil court records, public records, education history verification, employment history verification, motor vehicle driver license, accident history, professional credentials, residential address history, nationwide wanted person check, and/or sex offender registry check.

The report will be provided by CARCO Group, Inc. also known as Cisive, 5000 Corporate Court, Suite 203, Holtsville, New York 11742, a consumer reporting agency; telephone number 1-800-645-4556; website, www.cisive.com.

Information You May Request If An Investigative Consumer Report Is Obtained (Summary of Cal. Civ. Code § 1786.22)

If the Company obtains an investigative consumer report on you, you may inspect or obtain a copy of your file and certain other information that is maintained by Cisive. In addition to making your file available for your inspection, Cisive will identify the recipients of any investigative consumer report on you that Cisive has furnished for employment, insurance, or any other purpose within the three-year period preceding your request, and the dates, original payees, and amounts of any checks or charges upon which any adverse characterization of you that may be included in your file is based.

During normal business hours and on reasonable notice, Cisive will make your file and other information available to you as follows:

(1) In person, if you appear in person and furnish proper identification. A copy of your file will also be available to you for a fee not to exceed the costs of duplication.

(2) By certified mail, if you make a written request, with proper identification, for copies to be sent to a specified addressee but, in complying with such a request, Cisive will not be liable for disclosures to third parties that may be caused by mishandling of mail after such mailings leave Cisive.

(3) Cisive will provide a summary of all information contained in your file which Cisive is required to provide to you, by telephone, if, with proper identification, you have made a written request for telephone disclosure, and you have prepaid, or had charged directly to you, any toll charge for the telephone call.

"Proper identification" as used above means that information generally deemed sufficient to identify a person, including documents such as a valid driver's license, social security account number, military identification card, and credit cards. You may be accompanied by one other person of your choosing who shall furnish reasonable identification. Cisive may require you to furnish a written statement granting Cisive permission to discuss your file in such person's presence.

Cisive will provide trained personnel to explain to you any information Cisive provides to you, and will provide a written explanation of any coded information contained in your files.

CommonSpirit

California Applicants---Investigative Consumer Report Acknowledgment and Authorization

By signing the Authorization to Obtain Consumer Reports, I authorize CommonSpirit Health (the "Company") to obtain investigative consumer report(s) about me.

This is to confirm that I have read, and hereby acknowledge receipt of, the information set forth California Disclosure Concerning Investigative Consumer Reports Obtained for Employment Purposes concerning my rights under the laws of California.

If you would like to receive a copy of any investigative consumer report the Company obtains about you, please check the following box to indicate your desire to receive a copy of the report.

☐ Please forward to my attention at the following address a copy of the investigative consumer report.

Street: _____

City, State, Zip: _____

_____ _____

Applicant's Signature Today's Date

_____

Applicant's Name Printed

Acknowledgement of Medical Staff Bylaws, Rules and Regulations

Each applicant is provided a copy of the Medical Staff Bylaws as well as Rules and Regulations of the hospital(s) to which he/she is applying. By signing this form, I agree and acknowledge that I have read and agree to be bound by the Medical Staff Bylaws; Rules & Regulations; Corporate Responsibility Program; and policies and procedures of the hospital(s) to which I am applying, as indicated below:

- ☐ Flaget Memorial Hospital
- ☐ Saint Joseph Berea
- ☐ Saint Joseph East
- ☐ Saint Joseph Hospital
- ☐ Saint Joseph London
- ☐ Saint Joseph Mount Sterling

_____

Applicant Printed Name

_____ _____

Applicant Signature Date

5005 Maryland Way, Suite 300
Brentwood, Tennessee 37027
P: 800.342.2239 F: 615.370.1343

AUTHORIZATION AND RELEASE FORM

From: _____ Medical License Number: _____

Release Information To:

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Fax Number: _____

State Volunteer Mutual Insurance Company ("SVMIC") is the carrier of my medical professional liability insurance, and as such SVMIC maintains certain information regarding my medical practice -- specifically the history of any malpractice claims against me. I understand that this information is extremely sensitive and confidential. I acknowledge that SVMIC is protective of this information and will only release it upon my express and unambiguous consent and direction. I have decided, for reasons related to my practice, that certain information from SVMIC be provided as requested. I authorize SVMIC to provide to the above person or organization information relating to any medical professional liability claims activity against me that has been reported and covered by SVMIC, but specifically limited to: a) Claims that have resulted in paid losses (settlements), and/or b) Lawsuits (open or closed).

I HEREBY RELEASE SVMIC, ITS OFFICERS, DIRECTORS, EMPLOYEES, AND AGENTS FROM ANY CLAIMS, LIABILITIES, ACTIONS, DAMAGES, OR OTHERWISE, FOR THE RELEASE OF SUCH INFORMATION IF SUCH RELEASED INFORMATION IS DELIVERED IN GOOD FAITH AND WITHOUT MALICE. I ALSO ACKNOWLEDGE THAT MISTAKES MAY OCCUR IN THE PROVISION OF SUCH INFORMATION, AND, WITHOUT LIMITING THE FOREGOING, I SPECIFICALLY RELEASE SVMIC, ITS OFFICERS, DIRECTORS, EMPLOYEES, AND AGENTS FROM ANY CLAIMS DUE TO INCORRECT, MISDELIVERED, OR OTHERWISE INAPPLICABLE INFORMATION IF SUCH ERRORS OCCURRED IN GOOD FAITH, AND UPON DISCOVERY, SVMIC TAKES REASONABLE CORRECTIVE ACTIONS.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL SPECIFICALLY REVOKED IN WRITING.

Insured Signature: _____ Date: _____

NOTE: IF SIGNED ELECTRONICALLY, AUDIT DOCUMENT MUST BE ATTACHED TO APPLICATION.

Print Insured Name: _____

SVMIC Policy Number: _____

For Advanced Practice Providers,
Please Provide Name of Employer: _____

Revised 3.2023

CHI Saint Joseph Health

TB Risk Assessment and Screening Form

PLEASE ADDRESS ALL QUESTIONS

Employee Name: _____ Emp#: _____Dept: _____

Employee Signature: _____ Telephone #: _____

Date: _____ Date of Birth: _____ Direct Patient Care: ☐ Yes ☐ No

History of TB Skin Test, Vaccine and Treatment

History of BCG? ☐ Yes ☐ No Year: _____ **BCG – VACCINE AGAINST TUBERCULOSIS**

Drug or other allergies: _____

Prior Positive Tuberculin Skin Test (TST)? ☐ Yes ☐ No Date: _____/_____/_____ Induration: _____mm

Prior TB Treatment: ☐ Yes ☐ No Provide details below:

☐ LTBI ☐ TB Disease Year of Treatment _____ Treatment Duration: _____ Location of treatment: _____

TB Medications taken: _____

I. **Screen for TB Symptoms: (Check all that apply)**

☐ **NONE (Skip to Section II, "TB Risk Assessment")**

☐ Cough for >3 weeks: Productive: ☐ Yes ☐ No Hemoptysis: ☐ Yes ☐ No
☐ Fever of 100ºF (38ºC) for >2 weeks Evaluate these symptoms in context
☐ Unexplained Weight Loss >10 pounds
☐ Night Sweats
☐ Fatigue

II. **TB Risk Assessment: (Check all that apply)**

Country of Birth:
☐ USA ☐ Africa ☐ Central America ☐ South America ☐ Mexico ☐ Eastern Europe ☐ Caribbean ☐ Middle East
☐ Other (Specify: _____)

Travel in the past 5 years for more than 1 month:
☐ Africa ☐ Asia ☐ Central America ☐ South America ☐ Mexico ☐ Eastern Europe ☐ Caribbean ☐ Middle East
☐ Other (Specify: _____) ☐ **NONE**

☐ In the past 2 years, have lived with or had close contact of a person known or suspected to have TB Disease
☐ An employee of a high TB risk congregate setting, such as prison, jail, homeless shelter or long-term care facility.
☐ Injects drugs that your doctor did not prescribe
☐ **NONE**

III. **Assess for Developing TB Disease (Check all that apply)**

☐ Person was recently infected with Mycobacterium Tuberculosis
☐ Person has certain clinical conditions, increasing potential risk for developing TB disease, such as; Diabetes, HIV infection, Kidney disease, Pregnancy
☐ Person has a history of inadequately treated TB
☐ Person is >10% below ideal weight.
☐ Person is on immunosuppressive therapy such as: treatment for rheumatoid arthritis with drugs such as Humira, Remicaid, etc.)
☐ **NONE**

IV. **Vaccination/Titer History - if unsure check with Employee Health and ask to check your record.**

☐ COVID-19 Vaccination – 2 Vaccines – Dates if known: _____
☐ Hepatitis A – 2 Vaccines – Dates if known: _____
☐ Chicken Pox (2 Vaccines) – Dates if known: _____
☐ Or Positive Titer
☐ History of Shingles
☐ Shingles Vaccine – Dates if known: _____
☐ Measles (Rubeola) – 2 Vaccines – Dates if known: _____
☐ Or Positive Immune Titer
☐ Rubella – 2 Vaccines – Dates if known: _____
☐ Or Positive Immune Titer
☐ Mumps – 2 Vaccines – Dates if known: _____
☐ Or Positive Immune Titer
☐ Last year vaccinated with TDAP (all adults should have received one dose as an adult) – Year: _____
☐ Last year vaccinated with TD if already vaccinated with TDAP – Year: _____
☐ Hepatitis B Vaccine series – Dates if known: _____
☐ Or Positive Immune Titer
☐ Employee Health with CHI Saint Joseph Health are available and here to help with your wellness concerns. If you would like information on the CHI Wellness Program or assistance in establishing Primary Care you can contact your facility Employee Health nurse for resource information.
☐ Would you like an Employee Health Nurse to call you? ☐ Yes ☐ No

OFFICE USE ONLY

V. **Finding(s) (Check all that apply)**

☐ Person has TB Risk and has one or more TB Symptoms
☐ Person has TB Risk, no symptoms and no previous history
☐ Person has previous positive TB Test, no prior treatment
☐ Person has previous positive TB Test, Completed treatment
☐ No risk factors for TB Infection

VI. **Action(s) (Check all that apply)**

☐ Referred for CXR
☐ Referred for a Medical Evaluation
☐ Other: _____

Follow Up: _____

_____

Employee Health Nurse Review:

_____ **Date:** _____

MEDICAL STAFF
FLAGET MEMORIAL HOSPITAL
EMERGENCY MEDICINE PRIVILEGES

The delineated list of clinical privileges should be completed to reflect your pattern of practice. Privileges will be granted on the basis of training, experience, and demonstrated competence. You should, therefore, not request privileges simply because you may encounter a particular condition, but rather your request should reflect your intended practice.

BASIC EDUCATION: MD or DO

Requirements - Successfully completed Emergency Medicine Residency and/or Board Certified or Board Eligible as defined by the American Board of Emergency Medicine. Board Certified or prepared in a Primary Care Specialty and/or has sufficient experience in emergency medicine demonstrated by training and competency. Current certification in CPR and ACLS is highly recommended as is ATLS or its equivalent training.

Required previous experience: The successful applicant must be able to demonstrate that he or she has been in active practice or residency in an emergency department.

PRIVILEGES:

Privileges include being able to assess, work up, and provide initial treatment and stabilization to patients of all ages who present in the emergency department. An emergency physician is expected to provide those services necessary to ameliorate minor illnesses or injuries, provide stabilizing treatment to patients presenting with major illnesses or injuries and to assess all patients in order to determine if more definitive services are necessary.

___ Category 1 Privileges
Permits initial care and treatment of patients as required in emergency situations/disaster.
Privileges are granted for fast track in the emergency room for members of the active medical staff at Flaget Memorial Hospital with credentials in Family Practice, Internal Medicine, Pediatrics and Surgery. Fast Track includes care and treatment of minor injuries/illnesses and health maintenance.

Requirements: all members of the Medical Staff shall be granted Category 1 privileges.

___ Category 2 Privileges (Core)
Permits treatment of all manner of emergencies on an initial basis, and treatment of patients based on experience and competence. Does not permit admitting and continued care of inpatients except on an emergent basis.

The following list of procedures and techniques is not to be construed as limiting an emergency physician's ability in the Emergency Department (ED). It is presented to provide ED physicians and other members of the medical staff with a broad outline of the types of procedures and techniques expected of an ED physician.

MANAGEMENT OF LIFE THREATENING EMERGENCIES
*Airway management including endotracheal intubation, transtracheal jet ventilation and cricothyroidostomy
*Percutaneous cannulation of central vessels
*Establishment of peripheral venous access via cutdown
*Insertion of intraosseous canulas for administration of fluids and medications
*Initiation of cardiac resuscitation
*Closed chest thoracostomy (chest tube or catheter insertion)/ pericardiocentesis/pluerocentesis
*Emergency interpretation and treatment of cardiac dysrythmias
*Defibrillation and emergency cardioversion
*Transvenous and external pacemaker placement
*Initiation of treatment of shock (hypovolemic/cardiogenic/septic/neurogenic)
*Nasogastric tube placement, gastric lavage
*Lumbar Puncture
*Arterial puncture for specimen collection
*Arterial puncture for specimen collection interpretation of blood gas results
*Injection of local and regional anesthetics
*Initiation of thrombolytic therapy
*Repair of lacerations

*Manual reduction of hernias
*Emergent treatment of tension pneumothorax
*Emergent/urgent reduction of fracture
*Aspiration of joints and bursae
*Application of splints
*Nail Trephination and removal
*Incision and drainage of subcutaneous abscess, paronychia felons and bartholin cysts
*Incision and drainage of thrombosed hemorrhoids
*Venous Cutdown
*Intravenous Punctures
*Assessment and intervention in:
    -Allergic reactions
    -Burns
    -Chest pain
    -Convulsions
    -Endocrine emergencies
    -Hypertensive crisis
    -Neurologic emergencies
    -Shock
    -Toxic exposures/overdoses
    -Urologic emergencies
    -Multiple trauma
*Emergency vaginal deliveries
*Sexual assault examination and referral for counseling
*Emergency evaluation of mental status
*Control of anterior and posterior epistaxis
*Ophthalmologic examination corneal foreign body removal slit lamp examination
*Removal of foreign bodies from bodily orifices and cavities
*Pre-hospital control of patients in transport
*Initiating emergency transfer of patients following assessment and stabilization
*Simple closed reduction of extremity fractures
*Urinary bladder catheterization and suprapublic aspiration
*Emergent open chest thoracotomy

___ Category 3 Privileges (Special)

IV Conscious Sedation – (Completion of this privilege can be attained by an approved CME completion.)

PROCEDURE

_____

_____

FLAGET MEMORIAL HOSPITAL
EMERGENCY MEDICINE
PRIVILEGE DELINEATION FORM

INITIAL APPOINTMENT_____ **RE-APPOINTMENT**_____

PRIVILEGE	REQUESTED BY APPLICANT (requires checkmark to request privilege)	APPROVED
Category II Privileges (Core)	**********	*******
Endotracheal intubation, nasal/oral		
Cricothyrotomy		
Neuromuscular blockage		
Mechanical ventilation		
Percutaneous transtracheal ventilation		
Local anesthesia		
Regional nerve blocks		
Cardiac massage, open/closed		
Cardiac pacing external/transthoracic/ emergent/transvenous		
Cardioversion/defibrillation		
Cardiopulmonary resuscitation		
Electrocardiography		
Arthrocentesis		
Cystourethrogram		
Contrast injection for imaging		
Lumbar puncture		
Nasograstric or orogastric intubation		
Emergent pericardiocentesis		
Tonometry		
Slit lamp examination with/without foreign body removal		
Bladder catheterization		
Precipitous delivery of newborn		
Epistaxis control		
Central venous access		
Intraosseous infusion		
Arterial sampling for blood gas analysis		
Arterial cannulation for monitoring		
Fracture/dislocation immobilization		
Emergent/urgent closed reduction of fracture or dislocation		
Cervical immobilization		
Nail Trephination		
Injection of bursa or joint		
Needle thoracostomy		
Tube thoracostomy		
Emergency thoracostomy		
Emergent pericardiocentesis		
Foreign body removal		
Gastric lavage		
Incision and drainage of abscess		
Wound management and repair		
Initial ordering of imaging studies and evaluation of the results to the degree that a plan of action can be formulated		
Category III (Special) Privileges		
IV Conscious Sedation		
Other		

I hereby request the above indicated privileges including being able to assess, work up, and provide initial treatment to patients of all ages who present in the emergency department with any illness or injury, condition, or symptom. An emergency physician is expected to provide those services necessary to ameliorate minor illnesses or injuries, provide stabilizing treatment to patients presenting with major illnesses or injuries and to assess all patients in order to determine if more definitive services are necessary.

I understand that in making this request, I am bound by the applicable bylaws and policies of the hospital and the Ethical Code of Catholic hospitals and hereby stipulate that I meet the minimum threshold criteria for this request and have maintained and demonstrated competency for any and all core and/or special privileges requested.

Signature of applicant: _____ Date: _____

FOR USE BY MEDICAL STAFF OFFICE

Approval Dates:

Credentials Committee:_____

Medical Executive Committee:_____

Board:_____

Saint Joseph London
Emergency Medicine
Delineation of Clinical Privileges

Applicants Name:_____

Eligibility Criteria:

To be eligible to request core privileges in Emergency Medicine, an applicant must meet the following minimum threshold criteria:

Education: MD or DO

Licensure: Applicant must hold a valid license issued by the State of Kentucky

Training: Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited post-graduate training program in emergency medicine, family practice, internal medicine or general surgery.

Additional Education/Training: (The applicant must meet one of the following)

Board certification **or** active participation in the examination process leading to certification in:

- Emergency Medicine

Board certification **or** active participation in the examination process leading to certification in one of the following specialties:

- Family Practice
- Internal Medicine
- General Surgery

And must be able to demonstrate full time experience in Emergency Medicine two years out of the last four years. (Proof must be provided)

All applicants requesting membership or privileges after 11/09/06 must be board certified within five (5) years of the date of appointment.

Experience: Applicants for initial appointment must be able to demonstrate active practice in emergency medicine, family practice, internal medicine, or general surgery six out of the past twelve months. Recent residency training satisfies this requirement for Emergency Medicine.

Applicants for initial appointment may be requested to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence and other qualifications and for resolving any doubts.

Certification: ACLS and PALS

(ATLS required for physicians not certified in Emergency Medicine)

Courses must be American Heart Association Approved

And:

To be eligible to **renew core privileges** in Emergency Medicine, the applicant must meet the following Maintenance of Privilege criteria.

Current demonstrated competence and an adequate volume of experience with acceptable results in the privileges requested for the past 24 months based on results of quality assessment/improvement activities and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

Evidence of continuing medical education (at least 40 hours) Category I in the past 24 months (KBML requirement). At least 30 hours of CME must be related to Emergency Medicine. Documentation of the required STEMI course must be included. Completion of residency training program within the past twelve months will be considered equivalent.

Emergency Medicine Core Privileges:

☐ **Requested**

Assess, evaluate, diagnose, and initially treat patients of all ages who present in the ED with any symptom, illness, injury, or condition and provide services necessary to ameliorate minor illnesses or injuries; to stabilize patients with major illnesses or injuries; and to assess all patients to determine if additional care is necessary. (Privileges include administration of sedation and analgesia.) Privileges do not include long-term care of patients on an inpatient basis. No privileges to admit or perform scheduled elective procedures with the exception of procedures performed during routine emergency room follow-up visits. The core privileges in this specialty include the procedures on the procedure list below and such other procedures that are extensions of the same techniques & skills. **Applicant, please cross out individual privileges below that are not currently performed in your practice.**

- Abscess incision & drainage, including Bartholin's cyst
- Airway management and intubation
- Administration of sedation analgesia
- Administration of thrombolytic therapy for myocardial infarction, stroke
- Anoscopy
- Application of splints and plaster molds
- Arthrocentesis
- Anesthesia: intravenous (upper extremity, local, and regional)
- Bladder decompression and catheterization techniques
- Blood component transfusion therapy
- Burn management, including Escharotomy
- Cannulation, artery and vein
- Cardiac massage, open or closed
- Cardioversion (synchronized counter shock)
- Intraosseous infusion
- Laryngoscopy, direct, indirect
- Lumbar puncture
- Nail trephine techniques
- Nasal cautery/packing
- Nasogastric/orogastric intubation
- Ocular tonometry
- Paracentesis
- Pericardiocentesis, emergency only
- Peripheral venous cutdown
- Peritoneal lavage
- Preliminary interpretation of imaging studies
- Removal of foreign bodies, airway including nose, eye, ear, soft instrumentation/irrigation, skin, or subcutaneous tissue

- Central venous access: femoral, jugular, peripheral, internal, subclavian and cutdowns
- Chemical restraint of agitated patient
- Cricothyrotomy
- Defibrillation
- Delivery of newborn, emergency
- Dislocation/fracture reduction/immobilization techniques
- Electrocardiography interpretation
- External transcutanous pacemaker
- GI decontamination (emesis, lavage, charcoal)
- Hernia reduction
- Irrigation and management of caustic exposures
- Removal of IUD
- Repair of lacerations
- Resuscitation, all ages
- Splint or cast application after reduction of fracture or dislocation
- Spine immobilization
- Thoracentesis
- Thoracostomy tube insertion
- Thoracotomy, open for patient in extremis
- Tracheostomy
- Use of manual and mechanical ventilators and resuscitators
- Variceal/nonvariceal hemostasis
- Wound debridement and repair

Rapid Sequence Induction <u>is required</u> with Emergency Core Criteria:

- The applicant must provide documentation of at least 10 intubations using Rapid Sequence Induction or successful performance of individual evaluation under chief of Anesthesiology or designee.

Special Non-Core Privileges

To be eligible to apply for the special non-core privileges listed below, the applicant must demonstrate successful completion of an approved, recognized course when such exists, or acceptable supervised training in residency, fellowship or other acceptable experience, and must provide documentation of competence in performing the requested procedure consistent with criteria set forth in medical staff policies governing the exercise of specific privileges. **Evidence of current ability to perform privileges requested including documentation of procedures performed is required of all applicants for renewal of privileges.**

Emergency Ultrasound Privileges

☐ ***Privilege Requested***

<u>Required Previous Experience for Initial Appointment:</u>

Emergency Ultrasound privileges are included in core privileges for Emergency Medicine trained providers. Providers trained in all other specialties must provide evidence of successful completion of an emergency ultrasound course within the previous 12 months.

Minimum Ultrasound Course Requirements

<u>CME Information</u>

The submitted ultrasound course shall be approved by American College of Emergency Physicians (ACEP) with a minimum of 8.0 *hours of ACEP Category I credit or equivalent.*

Minimum Course Content

Additionally, the approved course shall be a basic or advanced emergency medicine ultrasound course which incorporates at least three (3) hours of hands-on ultrasound training experience with live models.

Maintenance of Privilege for Reappointment: Evidence of successful completion of an emergency ultrasound course within the previous 12 months or *documentation of performing twenty (20) ultrasound studies for the following primary applications in the previous 24 months:

- Trauma
- IUP
- Emergent Cardiac
- AAA
- Bilary
- Renal

*Acceptable documentation of case logs or attestation must be provided.

Eligibility Criteria: Moderate Sedation

To be eligible to request privileges for Moderate Sedation, an applicant must meet the following minimum threshold criteria:

Education: MD, DO, or DDS, DMD (upon completion of Oral & Maxillofacial Surgery Residency)

Licensure: Applicant must hold a valid license issued by the State of Kentucky

Training: Successful completion of a residency wherein he/she received education, training, and experience to administer and/or supervise moderate sedation **All applicants for Procedural Sedation Privileges must maintain current ACLS, or for pediatricians PALS certification through American Heart Association approved course**

Initial Applicants may obtain competency requirements by one of two pathways:

(1) Applicants for initial appointment must be able to demonstrate that he or she has provided Moderate Sedation to at least 20 patients during the past 12 months *

Or

(2) Complete the following:

a. Procedural Sedation course recommended by the Medical Staff office.
b. Completion of an airway module course provided by an Anesthesia Department designee
c. Observe 3 endotracheal intubations under Anesthesia Department supervision within 3 months

*Acceptable documentation of case logs or attestation must be provided.

To be eligible to renew privileges in Moderate Sedation, the applicant must meet the following eligibility criteria:

The applicant must be able to demonstrate that he or she has provided Moderate Sedation to at least 20 patients during the past 12 months *
Or
Complete a Procedural Sedation course recommended by the Medical Staff office.

*Acceptable documentation of case logs or attestation must be provided.

Moderate Sedation Privileges:
☐ **Requested**
Provide a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Eligibility Criteria: Deep Sedation
Privileges are limited to Emergency Department physicians, Oral Surgeons, Pulmonary, or Critical Care physicians. To be eligible to request privileges for Deep Sedation, an applicant must hold current Moderate Sedation privileges and meet the following minimum threshold criteria:

1) Current certification **or** active participation in the examination process leading to certification in Emergency Medicine or in any critical care sub-board.
2) Current ACLS (with airway management) training certificate.
Current PALS certification required for Deep Sedation in pediatric patients
AND
Provide numbers of deep sedation cases for the previous two (2) years*

0-10	11-25	26+
____	_____	____

3) For physicians with ACLS certification without airway module, privileges can be granted after successful completion of an airway module course by a designated instructor (anesthesia department designee).

*Acceptable documentation of case logs or attestation must be provided.

And:
To be eligible to **renew privileges** in Deep Sedation, the applicant must meet the same eligibility criteria listed above. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

Deep Sedation Privileges:
☐ **Requested**
Provide a drug induced depression of consciousness during which the patient cannot be easily aroused, but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is maintained.

Delineation Form Reviewed and Approved:
Credentials Committee: 07/17/2017
Medical Executive Committee: 07/25/2017
Governing Board: 08/29/2017

Physicians should indicate any requested limitations in the core privilege, if not applicable to his/her practice, training, experience or current competence.

Comments/Modifications:

Initial Credentialing FPPE Requirements

Emergency Medicine - Review 5 cases maximum with 1 case per noncore procedure requested

Procedural Sedation - 1 chart review

Practitioner Acknowledgement:
I understand that by making this request I am bound by the applicable bylaws or policies of the hospital and hereby stipulate that I meet the minimum threshold criteria for this request. I certify that I possess the training, skill, experience, and current competency for the clinical privileges requested.

Physician's signature: _____

Typed or printed name: _____

Date: _____

DEPARTMENT OF EMERGENCY MEDICINE
PRIVILEGE DELINEATION FORM for INITIAL APPOINTMENT

☐ **SAINT JOSEPH HOSPITAL**
REQUESTED STATUS
☐ Active
☐Courtesy
☐ Consulting
☐ None
☐ Residents (last 6 months of training)

☐ **SAINT JOSEPH EAST**
REQUESTED STATUS
☐ Active
☐ Courtesy
☐ Consulting
☐ None
☐ Residents (last 6 months of training)

☐ **SAINT JOSEPH BEREA**
REQUESTED STATUS
☐ ER Service Staff

PRIVILEGE	**CRITERIA FOR CATEGORY II PROCEDURES**	**REQUESTED BY APPLICANT** *(Requires checkmark to request privilege)*			**COMPETENT PER PROGRAM DIRECTOR**	**APPROVED** *(For hospital use only)*
		SJH	**SJE**	**SJB**		
Category I Privileges (Core)						
Airway Techniques including, but not limited to: Endotracheal intubation, nasal/oral, Cricothyrotomy, Mechanical ventilation, Percutaneous transtracheal ventilation.						
Sedation & Neuromuscular including, but not limited to: Neuromuscular blockade, Local anesthesia, Rapid sequence intubation, Regional nerve blocks, procedural sedation.						
Cardiac Procedures including, but not limited to: Cardiac massage-open/closed, Cardiac pacing to include one or all of the following: ☐Transvenous *(SJH/SJE ONLY)* ☐Transcutaneous ☐Cardioversion/defibrillation; ☐Cardiopulmonary resuscitation						
Diagnostic Procedures including, but not limited to:						
Arthrocentesis						
Arterial blood gases						
Culdocentesis						
Cystourethrogram *(SJH/SJE only)*						
IVP Contrast *(SJH/SJE only)*						
Lumbar puncture						
Nasograstric/oral gastric tube						
Pericardiocentesis						
Peritoneal lavage						
Proctoscopy *(SJH/SJE only)*						
Thoracentesis						
Tonometry						
Slit lamp examination						

PRIVILEGE	CRITERIA FOR CATEGORY II PROCEDURES	REQUESTED BY APPLICANT *(Requires checkmark to request privilege)*			COMPETENT PER PROGRAM DIRECTOR	APPROVED *(For hospital use only)*
		SJH	SJE	SJB		
Head/Neck including, but not limited to: Epistaxis control, Laryngoscopy, Naso/pharyngeal endoscopy						
Hemodynamic Techniques including, but not limited to: Central venous access to include jugular; subclavian; supraclavicular, Intraosseous infusion, Venous cutdown						
Genitourinary Techniques including, but not limited to: Bladder Catheterization to include the following: filiform catheterization in the urinary bladder; foley catheters; suprapubic catheterization.						
Obstetrical Procedures including: Precipitous delivery of newborn						
Orthopedic procedures including, but not limited to: Fracture/dislocation to include one or all of the following: ☐ Closed reduction ☐ Injection of bursa/joint spine ☐ Cervical immobilization ☐ Trephination nail *(SJH/SJE only)*						
Thoracic procedures including, but not limited to: Emergency thoractomy *(SJH/SJE only)* Needle thoracostomy, Tube thoracostomy, Pericardiocentesis						
Other Techniques						
Foreign body removal						
Gastric lavage						
Incision and drainage						
Wound management/suture techniques						

PRIVILEGE	CRITERIA FOR CATEGORY II PROCEDURES	REQUESTED BY APPLICANT *(Requires checkmark to request privilege)*			COMPETENT PER PROGRAM DIRECTOR	APPROVED *(For hospital use only)*
		SJH	SJE	SJB		
Category II Privileges (Special)						
Moderate Sedation	1. Complete the designated moderate sedation in-service training and post-test ***OR*** 2. Submit twelve (12) cases of moderate sedation for review ***AND*** 3. Current ACLS, ATLS, NRP, or PALS certification or Board Certification in Emergency Medicine. ***Note**: Members of the Emergency Department who are Board Certified in Emergency Medicine and participate in MOC, are exempt from the current ACLS recommendation, as procedural and moderate sedation are core privileges and covered in the board certification and maintenance of certification MOC processes. ***Note:** EZ Competency offers an on-line module that covers the sedation continuum, expected level of consciousness, medications, dose, and complications along with monitoring guidelines and has been selected as an acceptable in-service training source for Saint Joseph Hospital and Saint Joseph East. ***Note:** Information regarding module exam attached to criteria.					
Portable ultrasound	Completion of AMA accredited workshop OR ACGME approved Residency; completion of AMA approved program with documentation via proctoring or certificate of training, or proctoring by a medical staff member.					

Reappointment: Requires care of 3,000 patients per reappointment period.

PRIVILEGE	CRITERIA FOR CATEGORY II PROCEDURES	REQUESTED BY APPLICANT *(Requires checkmark to request privilege)*			COMPETENT PER PROGRAM DIRECTOR	APPROVED *(For hospital use only)*
		SJH	SJE	SJB		

I hereby request the above-indicated privileges including being able to assess, work up, and provide initial treatment to patients of all ages who present in the emergency department with any illness or injury, condition, or symptom. An emergency physician is expected to provide those services necessary to ameliorate minor illnesses or injuries, provide stabilizing treatment to patients presenting with major illnesses or injuries and to assess all patients in order to determine if more definitive services are necessary.

I understand that in making this request, I am bound by the applicable bylaws and policies and the Ethical Code of Catholic Hospitals and hereby stipulate that I meet the minimum threshold criteria for this request and have maintained and demonstrated competency for any and all core and/or special privileges requested.

Signature of applicant: _____ Date: _____

ATTENTION APPLICANT: DO NOT FORWARD TO YOUR PROGRAM CHAIR - RETURN TO COMMONWEALTH CREDENTIALING WITH APPLICATION

The preceding information is provided solely for confidential medical staff credentialing purposes. While I understand that it will be reviewed and considered by appropriate committees and individuals on behalf of the medical staff and that the applicant may have access to it in the event of a controversy concerning the applicant's candidacy, I expect that it will also remain private.

Program Director Signature: _____ Date: _____

Printed Name: _____ Title: _____

Institution: _____

Revised 03/2014; 07/2017

SAINT JOSEPH MOUNT STERLING
SPECIALTY OF EMERGENCY MEDICINE
PRIVILEGE DELINEATION FORM for INITIAL APPOINTMENT

☐ **SAINT JOSEPH MT. STERLING**

REQUESTED STATUS

☐ Active
☐ Courtesy
☐ Consulting

PRIVILEGE	CRITERIA FOR CATEGORY II PROCEDURES	REQUESTED BY APPLICANT *(Requires checkmark to request privilege)*			COMPETENT PER PROGRAM DIRECTOR	APPROVED *(For hospital use only)*
		SJMS				
Core Privileges						
Airway Techniques including, but not limited to: Endotracheal intubation, nasal/oral, Cricothyrotomy, Mechanical ventilation, Percutaneous transtracheal ventilation.						
Cardiac Procedures including, but not limited to: Cardiac massage, open/closed, Cardiac pacing to include one or all of the following: ☐Transcutaneous ☐Cardioversion/defibrillation; ☐Cardiopulmonary resuscitation						
DIAGNOSTIC PROCEDURES						
Arthrocentesis						
Arterial blood gas interpretation						
Cystourethrogram						
IVP Contrast administration						
Lumbar puncture						
Nasograstric/oral gastric tube insertion						
Thoracentesis						
Tonometry						
Slit lamp examination						
Head/Neck including, but not limited to: Epistaxis management, gastric tube reinsertion, Laryngoscopy,						
Hemodynamic Techniques including, but not limited to: Central venous access to include jugular; subclavian; supraclavicular; femoral; Intraosseous infusion						
Genitourinary Techniques including, but not limited to: Bladder Catheterization to include the following: foley catheters						
Obstetrical Procedures including Precipitous delivery of newborn						

PRIVILEGE	CRITERIA FOR CATEGORY II PROCEDURES	REQUESTED BY APPLICANT *(Requires checkmark to request privilege)*			COMPETENT PER PROGRAM DIRECTOR	APPROVED *(For hospital use only)*
		SJMS				
Orthopedic procedures including, but not limited to: Fracture/dislocation to include one or all of the following: ☐ Closed reduction ☐ Injection of bursa/joint spine ☐ Cervical immobilization ☐ Nail rephination						
Thoracic procedures including, but not limited to: Emergency thoractomy, Needle thoracostomy, Tube thoracostomy, Pericardiocentesis						
OTHER TECHNIQUES						
Anoscopy						
Foreign body removal; including use of C-Arm						
Gastric lavage						
Incision and drainage						
Wound management/suture techniques						
Thrombolytic administration						
Local anesthesia						
Category I Privileges (subject to approval at time of credentialing)						
Culdocentesis						
Extensor tendon repair of the hand						
Genitourinary Techniques including, but not limited to: Bladder Catheterization to include the following: Filiform catheters; suprapubic catheterization						
Naso-pharyngeal endoscopy						
Peritoneal Lavage						
Sedation & Neuromusclar including, but not limited to: Neuromuscular blockade, Regional nerve blocks, procedural sedation (Level I & II)						
Transvenous Cardiac Pacing						

PRIVILEGE	CRITERIA FOR CATEGORY II PROCEDURES	REQUESTED BY APPLICANT *(Requires checkmark to request privilege)*			COMPETENT PER PROGRAM DIRECTOR	APPROVED *(For hospital use only)*
		SJMS				
Category II Privileges (Special)						
Emergency Ultrasound 1. As an adjunct to procedures such as starting IVs or Incision and Drainage 2. As a screening exam to rule in specific findings that require immediate intervention (such as free fluid in the abdomen of a trauma victim) or indicate that more time consuming evaluation is not needed (the absence of heart motion when considering ending a code)	*Successful completion of an ACGME/AOA-approved residency training program or its equivalent in Emergency Medicine; current enrollment in the third year of an ACGME/AOA-approved Emergency Medicine residency program; otherwise qualifying to practice emergency medicine at this facility and completion of a course in emergency ultrasound certified for at least twenty (20) hours of Category 1 CME*					
Rapid Sequence Intubation and Procedural Sedation	*Board Certification in Emergency Medicine; current enrollment in the third year of an ACGME/AOA-approved Emergency Medicine residency program; otherwise qualifying to practice emergency medicine at this facility and completion of a course in difficult airway management certified for at least sixteen (16) hours of Category I CME.*					

PRIVILEGE	CRITERIA FOR CATEGORY II PROCEDURES	REQUESTED BY APPLICANT *(Requires checkmark to request privilege)*			COMPETENT PER PROGRAM DIRECTOR	APPROVED *(For hospital use only)*
		SJMS				
Moderate Sedation	1) Complete the designated moderate sedation in-service training and post-test ***OR*** 2) Submit twelve (12) cases of moderate sedation for review ***AND*** 3) Current ACLS, ATLS, NRP, or PALS certification or Board Certification in Emergency Medicine. **Note:** EZ Competency offers an on-line module that covers the sedation continuum, expected level of consciousness, medications, dose, and complications along with monitoring guidelines and has been selected as an acceptable in-service training source for Saint Joseph Mount Sterling. ***Note:** Information regarding module exam attached to criteria.					

Reappointment: Requires care of 2,000 patients per reappointment period.

I hereby request the above-indicated privileges including being able to assess, work up, and provide initial treatment to patients of all ages who present in the emergency department with any illness or injury, condition, or symptom. An emergency physician is expected to provide those services necessary to ameliorate minor illnesses or injuries, provide stabilizing treatment to patients presenting with major illnesses or injuries and to assess all patients in order to determine if more definitive services are necessary.

I understand that in making this request, I am bound by the applicable bylaws and policies of Saint Joseph HealthCare and the Ethical Code of Catholic Hospitals and hereby stipulate that I meet the minimum threshold criteria for this request and have maintained and demonstrated competency for any and all core and/or special privileges requested.

Signature of applicant: _____ Date: _____

ATTENTION APPLICANT: DO NOT FORWARD TO YOUR PROGRAM CHAIR - RETURN TO SAINT JOSEPH MT. STERLING WITH APPLICATION

The preceding information is provided solely for confidential medical staff credentialing purposes at Saint Joseph Mount Sterling. While I understand that it will be reviewed and considered by appropriate committees and individuals on behalf of the medical staff and that the applicant may have access to it in the event of a controversy concerning the applicant's candidacy, I expect that it will also remain private.

Program Director Signature: _____ Date: _____

Printed Name: _____ Title: _____

Institution: _____

EZC EZCompetency

Session: 03:59:57
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Moderate Sedation

Description:

Moderate sedation covers the sedation continuum, expected level of consciousness, medications, dose, and complications along with monitoring guidelines.

Obectives:

The participant will be able to identify the common procedures in which moderate sedation is appropriate.
The participant will be able to explain the criteria for the proper level of sedation on the sedation continuum and be able to differentiate between the different levels of sedation.
The participant will be able to identify common medications used in moderate sedation and their effect/side effects.
The participant will be able to understand when the need to rescue a patient from deep sedation arises.
The participant will be familiar with the proper reversal agents for opioids and benzodiazepines commonly used in moderate sedation.
The participant will understand the factors that influence patient selection for moderate sedation.
The participant will be able to explain the proper monitoring of patients undergoing moderate sedation.
The participant will be familiar with the sources of guidance of practice regarding moderate sedation.

Target:

Physicians,Physician Assistants,CRNA,Nurse Pracitcioners,Nurses

EZC EZCompetency

Session: 03:59:54
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Prices and Information

Account Type	Signed Up By:	Paid By:	Price
Insitution	Institution Administrator		Free**
Institution Providers/Users	Institution Administrator	Institution	$10 per Provider per Year (No limit on number of modules)
Private Provider	Private Provider	Private Provider	$30 per module (no time limit)

**We allow 90 days to review the account. After 90 days you have to purchase a subscription or have your account removed.