Credentialing Best Practices in Long Term Care

Conn Foley, MD FACP

Chief Medical Officer
SVP Medical Services
Chairman, Department of Medicine
Medical Director

Parker Jewish Institute
CME Accreditation

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Medical Society of the State of New York (MSSNY) through the joint providership of the Academy of Medicine of Queens County and HANYS. The Academy of Medicine of Queens County is accredited by MSSNY to provide Continuing Medical Education for physicians.

The Academy of Medicine of Queens County designates this educational activity for a maximum of 1.5 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

The planners and faculty participants do not have any financial arrangements or affiliations with any commercial entities whose products, research, or services may be discussed in these materials.

This activity has been funded by an educational grant from the New York State Department of Health. No commercial funding has been accepted for the activity.
Session Objectives

By the conclusion of the program, participants will be able to:

- Identify the criteria to be used for credentialing physicians, registered nurse practitioners, and physician assistants who work in skilled nursing facilities.

- Discuss a best practice system for establishing and maintaining an organizational credentialing system.
What is Credentialing?

Implies that the facility has formally verified and documented their medical staff’s ability to provide appropriate care and services and granted them ‘privileges’ to do so, and the process is documented in a policy.

- Evidence of current license
- Relevant training and/or experience
- Current competence
- Health status
- Proof of current malpractice insurance
- Current DEA certificate
- Other information deemed appropriate
How is Credentialing Accomplished?

Transfer of credential information from another TJC healthcare organization
- verification of each item is not required

Formal internal credentialing process

- Establish a Local Governing Body
- Establish a Medical Executive Committee
- Criteria for delineating and evaluating the necessary information
- Credentials Verification Organization (CVO)
- Mechanism for communicating the granting or refusal of privileges
- Verification of authenticity and accuracy by Governing Body
- Mechanism for appointment – initial granting of clinical privileges
- Mechanism for reappointment – renewal/revision of privileges
- Policy: reappointment, at a minimum, every two years
- Uniformly and Consistently apply the established criteria – in each file
How is Credentialing Accomplished?

- Pre-application
- Application
- Primary Source Verification
- Review and Action
- Renewal and Reappointment
- Performance Expectations
How is Credentialing Accomplished?

Physician Privilege Request

- Arthritis / Rheumatology
- Cardiovascular
- Gastrointestinal
- Genitourinary
- Hematological
- Hepatic
- Metabolic / Endocrine
- Infectious Disease
- Integument
- Neurologic
- Pulmonary
- Other: e.g.: pain management
How is Credentialing Accomplished?

Physician Privilege Request

Subacute Program

- Dialysis / Renal failure
- Hyperalimentation (TPN)
- Oncology
- Psychiatric Care
- Rehabilitation
- Ventilator Care
- Wound Management
LIST OF CREDENTIALS NEEDED

( ) APPLICATION
( ) CURRENT C.V
( ) COPY OF ID (DRIVERS LICENSE, PASSPORT, ETC.)
( ) COPY OF N.Y STATE MEDICAL LICENSE
( ) COPY OF N.Y STATE REGISTRATION
( ) COPY OF ANY OUT OF STATE LICENSES
( ) DEA (IF APPLICABLE)
( ) BOARD CERTIFICATE, (IF APPLICABLE)
( ) CME'S
( ) LIFE SUPPORT (BCLS & ACLS)
( ) INFECTION CONTROL CERTIFICATE
   (CAN BE OBTAINED ONLINE AT NYSNA.ORG)
( ) MEDICAL SCHOOL DIPLOMA
( ) INTERN, RESIDENCY AND FELLOWSHIP CERTIFICATES
( ) ECFMG CERTIFICATE (FOR GRADUATES OF A FOREIGN MEDICAL COLLEGE)
( ) MALPRACTICE FACE SHEET
   (IF YOU ARE IN PRIVATE PRACTICE, PLEASE PROVIDE A FACESHEET FROM YOUR CARRIER)
( ) PHYSICAL ASSESSMENT
# Application for Initial Appointment to the Medical Staff

## 1. NAME

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Degree</th>
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Other Names Used (if applicable):

<table>
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<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Period of Time Used</th>
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</table>

## 2. BIRTH AND CITIZENSHIP

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Place of Birth</th>
<th>Citizenship (If not a U.S. citizen, check alien status below and provide requested information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[] Permanent Resident/Alien #</td>
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</table>

Authorized to work in the U.S.-Alien #

Exp. Of Authorization

Social Security #

## 3. MARITAL STATUS AND EMERGENCY CONTACT

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Spouse’s Name</th>
</tr>
</thead>
</table>

Contact in Case of Emergency:

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>City, State, Zip</th>
<th>Telephone</th>
<th>Relationship</th>
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</table>

## 4. ADDRESSES

<table>
<thead>
<tr>
<th>Current Home</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<tr>
<td>Prior Home (if current address is less than 5 years)</td>
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</table>
### 4. Addresses

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<th>Address</th>
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<td>Office</td>
<td>Address</td>
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<td>State</td>
<td>Zip</td>
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<td>Mailing (if different)</td>
<td>Address</td>
<td>City</td>
<td>State</td>
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<td>Email</td>
<td>Address</td>
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<td>NPI#</td>
<td>Address</td>
<td>City</td>
<td>State</td>
<td>Zip</td>
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### 5. Phone Numbers

<table>
<thead>
<tr>
<th>Home</th>
<th>Office</th>
<th>Cell</th>
<th>Pager</th>
<th>Other</th>
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### 6. Appointment/Privileges Being Requested In

<table>
<thead>
<tr>
<th>Department</th>
<th>Position</th>
<th>Time</th>
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<td>Per Diem</td>
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### 7. Licenses

<table>
<thead>
<tr>
<th>State</th>
<th>License #</th>
<th>Status</th>
<th>Expiration Date</th>
<th>State</th>
<th>License #</th>
<th>Status</th>
<th>Expiration Date</th>
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<td>NYS</td>
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8. CERTIFICATIONS, REGISTRATIONS, OTHER

9.1 Board Certification

<table>
<thead>
<tr>
<th>Board Specialty/Subspecialty</th>
<th>Certificate #</th>
<th>Date Certified</th>
<th>Exp. Date</th>
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If not certified answer questions a, b, c, d

- a. Are you Exam Admissible? Y __ N __
- b. When do you expect to take the exam?
- c. Have you taken the certification exam? Y __ N __
- d. If yes, how many times?

8.1 Current Life Support Certifications

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<thead>
<tr>
<th>Type</th>
<th>Certificate #</th>
<th>Expiration Date</th>
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<td>BCLS</td>
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<td>NALS</td>
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<th>Type</th>
<th>Certificate #</th>
<th>Expiration Date</th>
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<td>PALS</td>
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<td>Other</td>
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9.2 Medicaid, Medicare, UPIN

| Medicaid # | Medicare # | UPIN # |

10. EDUCATION/TRAINING

10.1 Undergraduate

<table>
<thead>
<tr>
<th>School Name</th>
<th>Address: City, State, Zip</th>
<th>Tel. #</th>
<th>Major</th>
<th>Degree Awarded</th>
<th>Dates of Attendance From</th>
<th>To</th>
<th>Program Completed?</th>
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10.2 Medical/Dental School

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<tr>
<th>School Name</th>
<th>Address: City, State, Zip</th>
<th>Tel. #</th>
<th>Major</th>
<th>Degree Awarded</th>
<th>Dates of Attendance From</th>
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<th>Program Completed?</th>
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10.3 ECFMG/Fifth Pathway

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<tr>
<th>Certificate Number</th>
<th>Date Awarded/Completed</th>
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## 10. EDUCATION/TRAINING (cont'd)

### 10.4 Post Graduate Training

<table>
<thead>
<tr>
<th>Institution</th>
<th>Address, City, State, Zip</th>
<th>Tel. #</th>
<th>Specialty</th>
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<th>Level Completed</th>
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### 10.5 All Other Professional or Graduate Education

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Address, City, State, Zip</th>
<th>Tel. #</th>
<th>Specialty</th>
<th>Dates of Attendance</th>
<th>Level Completed</th>
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### 10.6 Military Training

<table>
<thead>
<tr>
<th>Branch of Service</th>
<th>Facility/Base</th>
<th>Address, City, State, Zip</th>
<th>Tel. #</th>
<th>Department</th>
<th>Dates</th>
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Applicant Name ____________________________

Page 3 of 7
### 10. EDUCATION/TRAINING (cont’d)

#### 10.7 Languages

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<thead>
<tr>
<th>Language</th>
<th>Fluent</th>
<th>Medical</th>
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### 11. PEER REFERENCES

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Degree</th>
<th>Address</th>
<th>City, State, Zip</th>
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### 12. PROFESSIONAL ASSOCIATIONS

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<tr>
<th>Facility Name</th>
<th>Address</th>
<th>City, State, Zip</th>
<th>Dept./Service</th>
<th>Position</th>
<th>Dates</th>
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13. HOSPITAL/CLINICAL AFFILIATIONS
List all other hospitals or other healthcare entities at which you are currently or have been, within the past 10 years, a member of the Medical Staff (please attach additional pages if necessary):

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Address</th>
<th>Dept.</th>
<th>City, State, Zip</th>
<th>Tel. #</th>
<th>Position</th>
<th>Dates From</th>
<th>Dates To</th>
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14. HEALTH
Please provide a full written explanation for any “YES” responses to the following

14.1 Do you presently have a physical or mental health condition, including alcohol or drug dependence that affects or is reasonably likely to progress, within the next two years, to the point of affecting your ability to perform professional or Medical staff duties appropriately?  
   YES ☐  NO ☐

14.2 Are you currently taking medication or under any therapy for a condition, which could affect your ability to perform, professional or Medical staff duties if it were discontinued today?  
   YES ☐  NO ☐
### 15. PROFESSIONAL LIABILITY
**Please attach copy of insurance face sheet**
Current Liability Insurance Carrier

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>City, State, Zip</th>
<th>Policy #</th>
<th>Exp. Date</th>
<th>Limits</th>
<th>Status</th>
</tr>
</thead>
</table>

For any "YES" responses, please complete the attached Professional Liability Details form.

15.1 Have you ever been denied professional liability insurance, or has your coverage been canceled, or has a surcharge been imposed because of your claims experience?  
   YES [ ] NO [ ]

15.2 Have you been involved in any pending or settled malpractice claims within the past ten years?  
   YES [ ] NO [ ]

15.3 Are there any arbitration proceedings or any sanctions involving your professional practice?  
   YES [ ] NO [ ]

### 16. DISCIPLINARY ACTION
*Have you been, or are you currently subject to any of the following actions: Denial, Revocation, Suspension, Reduction/Limitation, Probation, Sanctions, Non-renewal, or Voluntary or Involuntary relinquishment to avoid adverse or disciplinary action of any of the following:*

| 16.1 Medical license in any state; other health related professional license/registration | YES [ ] NO [ ] |
| 16.2 DEA (Federal or State) Controlled Substances registration(s) | YES [ ] NO [ ] |
| 16.3 Membership/rights/prerogatives on any hospital Medical staff | YES [ ] NO [ ] |
| 16.4 Clinical privileges/competencies at any medical facility | YES [ ] NO [ ] |
| 16.5 Any institutional affiliation or authorization to provider services | YES [ ] NO [ ] |
| 16.6 Professional society membership or fellowship or Board certification | YES [ ] NO [ ] |

| 16.7 Have any criminal convictions (other than motor vehicle and juvenile violations) been brought against you, or pending investigations against you, in this state jurisdiction? | YES [ ] NO [ ] |
| 16.8 Have there been any allegations against your or have you ever been convicted or have any currently pending challenges of substance abuse or a chemical dependency in any state or jurisdiction? | YES [ ] NO [ ] |
| 16.9 Have you been sanctioned or been the subject of a focused review by a PSRO, PRO or similar agency? | YES [ ] NO [ ] |
| 16.10 Are you presently or have you been restricted or suspended from participation in any federal, state or other reimbursement program? | YES [ ] NO [ ] |
| 16.11 Have you ever voluntarily or involuntarily resigned from any health care facility in order to avoid the imposition of disciplinary measures or curtailment of clinical privileges/competencies in any way? | YES [ ] NO [ ] |
| 16.12 Have you ever been found guilty in any state/jurisdiction of any activity, which would constitute professional misconduct in the State of New York? | YES [ ] NO [ ] |
CONDITIONS OF APPLICATION

By applying for appointment to the Medical Staff at Parker Jewish Institute, I hereby:

Agree to appear for interviews relative to my application;

Authorize the facility, its Medical Staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualification, ability to work cooperatively with others and other qualifications for membership and the clinical privileges/competencies requested;

Consent to the inspection by the facility, its Medical Staff and their representatives of all documents that may be relevant to an evaluation of my qualifications and competence;

Consent to the release of any such information relevant to my application to Parker Jewish Institute, which I have applied for credentialing and privileging;

Agree to comply with the Bylaws and Rules and Regulation of this facility which I am requesting appointment;

Acknowledge that I have received or been given access to and read the Bylaws of the Medical Staff, the policies relevant to the application process generally to clinical practice at the facility; and I agree to be bound by the terms thereof in all matters relating to staff membership and clinical privileges/competencies and to the consideration of my application for appointment to the staff and for clinical privileges/competencies;

Acknowledge that the provisions of said Medical Staff Bylaws relating to the confidentiality and release from liability are express conditions to my application, for and acceptance of, staff membership and the continuation of such membership and to my exercise of clinical privileges/competencies;

Agree to meet the clinical responsibilities for provision of continuous patient care and to work within the scope of my privilege delineations.

Pledge to maintain an ethical practice and to refrain from delegating the responsibility for any aspect of the care of my patients to any practitioner not qualified to undertake that responsibility;

Certify that I am conducting my practice in accordance with the principles of professional conduct of the Medical Society of the State of New York and the current code of ethics as adopted by the American Medical Association and/or the American Dental Association. Specifically, I pledge that I will not receive from, or pay to another practitioner, either directly or indirectly, any part of a fee received from professional services;
Release from liability any and all representatives of the facility and its staff for their acts performed and statements made, in
good faith, and without malice in connection with evaluating this application and my credentials and qualifications;

Agree to inform as soon as possible, the Medical Director and Executive Director of the facility of any change made or
proposed in the status of my professional license or permit to practice, DEA registration, professional liability insurance
coverage and membership, employment or clinical privileges/competencies in other institutions/facilities/organizations
and, the status of current or initiation of new malpractice claims;

Acknowledge that any omissions, errors, fraudulent statements or intentional misrepresentation or grossly negligent
misstatements in this application are grounds for immediate termination of reappointment, denial of reappointment,
suspension of clinical privileges/competencies, or other actions as determined appropriate by the facility.

All information submitted by me in this application is true to the best of my knowledge and belief. A photo static copy of
this original statement constitutes my written authorization and request to release any and all documentation regarding this
application. Said photo static copy shall have the same force and effect as the signed original.

I hereby release from liability all representatives of Parker Jewish Institute and its staff, all persons, corporations and
organizations who provide information relative to my reappointment, for their acts performed and statements made in
good faith and without malice, concerning my professional competency, background, experience, ethics, character,
utilization practice patterns, health status and other qualifications for staff reappointment and clinical
privileges/competencies.

Printed Name of Applicant ___________________________ Date ____________

Signature of Applicant ________________________________

Applicant Name ____________________________

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AUTHORIZATION FOR THE RELEASE OF INFORMATION

I hereby authorize Parker Jewish Institute to request and obtain all of my medical, school and Personnel records (including recommendations), and other pertinent information with respect to my performance in medical school, as an intern, resident or fellow, and in connection with my prior or current associations with or privileges at all health care facilities.

I also authorize Parker Jewish Institute to consult with insurance companies who may have information bearing my competence, character and ethical qualifications. I authorize such health care facilities and insurance companies (their officers, employees, agents and representatives) to release any information to any or all of the above mentioned facilities as will have bearing on my professional competence and character and my qualifications to perform the duties of the position for which I seek appointment privileges.

In connection with the release of such information, I hereby waive all rights as to confidentiality and I release All institutions, organizations and individuals who provide, receive and use such information, in good faith and pursuant to this application and to the request of Parker Jewish Institute from liability or claim for damages in connection with that release of information. Such, institutions, organizations, and persons providing, receiving, and using such information shall also be entitled to all the protection set forth in federal state and local laws and regulations regarding the release and use of information.

A copy of this statement shall be as binding as the original.

________________________________________________________________________
Applicants Signature

________________________________________________________________________
Print or type Applicants Name

________________________________________________________________________
Date
RE: Policy #

Dear Sir/Madame:

The above-named practitioner has applied for professional staff appointment/reappointment and/or clinical privileges in the Department of Medicine at Parker Jewish Institute.

(Practitioners name) has indicated that your company provides (d) him/her with professional liability coverage. Please verify this information and provide us with his/her claims history by completing the enclosed questionnaire.

The practitioner's signed consent for the release of the requested information and a business reply envelope are also enclosed.

Thank you for your prompt response.

Sincerely,

Mary M. Legg
Mary M. Legg
Credentials Coordinator

Enclosures:  Malpractice Questionnaire
Request for Certificate of Insurance
Release/Immunity Statement
PROFESSIONAL LIABILITY INSURANCE/EXPERIENCE QUESTIONNAIRE

RE: ____________________________________________

Insurer: ________________________________________

Policy No.: ____________________________________

1. Did/Do you provide professional liability insurance under the policy referenced for the above named practitioner? YES ☐ NO ☐
   If yes, please complete questions 2, 3, and 4.

2. Type of Insurance ________________________________
   Coverage Period From: __/__/____ To: __/__/____
   Coverage amounts ____________________________

3. Have you ever cancelled or not renewed this practitioner’s insurance, or imposed a surcharge based on his/her own experience? YES ☐ NO ☐
   If yes, when and why? __________________________
   __________________________

4. Please provide claims history. If there is no claims history check this box. NONE ☐

Verification done by:

Printed Name __________________________ Signature __________________________
Title __________________________ Date __________________________

Please return completed form to:
REQUEST FOR CERTIFICATE OF INSURANCE

Carrier

Address

City, State, Zip Code

I, ____________________________, the below named insured practitioner, request the company to send a Certificate of Insurance to Parker Jewish Institute for Healthcare and Rehabilitation.

This should indicate that the policy number, the limits of professional liability insurance coverage, any special limitations and specialty classification and the effective dates of that coverage.

In addition, in the interest of making this a one-time request, this certificate should include a provision for the company to automatically notify Parker Jewish Institute of Health Care and Rehabilitation of any change in the policy, such as its expiration or cancellation, change in policy limits or added special limitations.

_____________________________  __________________
Signature of Practitioner        Date

_____________________________
Print Name

_____________________________
Policy Number

Please return certificate of insurance to
PHYSICAL ASSESSMENT

NAME: ___________________________ DATE: ___________________________

TITRES & IMMUNITY STATUS WITH RESPECT TO

RUBELLA: ________________________ LAST PPD: ________________________

RUBEOLA: ________________________ RESULT/READING: _________________

VARICELLA: _____________________ CHEST X-RAY DATE: _______________
(If positive PPD) RESULT: ____________________________

In my opinion, _______________________

LAST __________________________________________ FIRST NAME ____________ DEGREE ____________

Is physically and mentally capable of exercising the privileges concomitant with appointment to the Medical Staff of Parker Jewish Institute

DATE ___________________________ SIGNATURE OF EXAMINING PHYSICIAN

PRINT NAME __________________________

OFFICE ADDRESS __________________________

TELEPHONE __________________________
RE:
SS# XXX-XX-7132

Dear Sir/Madame:

The above-named practitioner has applied for professional staff appointment/reappointment and/or clinical privilege with *Parker Jewish Institute*. In the application he/she states that he/she was affiliated with your facility.

Based upon your personal knowledge of the applicant, we would appreciate your candid, written appraisal of him/her. Kindly complete the enclosed Affiliation Questionnaire, and in your reply, please verify any knowledge you have concerning anything that warrants our exercising caution in granting his/her request for particular clinical privileges or competencies.

Kindly verify this by completing the attached questionnaire. If you do not have adequate knowledge to answer a particular question, or to provide a rating please indicate “No Information”. The practitioner's signed consent for the release of the requested information and a business reply envelope are also enclosed.

Your candor and prompt response is appreciated.

Thank you for your assistance.

Sincerely,

*Mary M. Legg*

MARY M. LEGG

Enclosures: Release/Immunity Statement
FACILITY

RE: SS# XXX-XX-7132

DEPARTMENT: Medicine

AFFILIATION DATE:

The applicant has informed us that he/she has or had professional privilege at your facility. In connection with our evaluation of his/her application, please provide us with the following information.

1. Is/was this individual a member in good standing? YES _____ NO _____

2. Do you know of any pending professional medical conduct proceedings in New York or any other state? YES _____ NO _____

3. Do you know of any pending medical malpractice actions in New York or another state? YES _____ NO _____

4. Do you know of any judgments or settlements of a medical malpractice action in New York or any other state? YES _____ NO _____

5. Do you know of any findings of professional misconduct in New York or any other state? YES _____ NO _____

6. Do you know of any information concerning this individual that has been or should be reported by facilities pursuant to Section 2803-e of the New York Public Health Law? YES _____ NO _____

Completed By:

Print Name/Title __________ Signature __________ Date __________
RE:
SS# XXX-XX-5666

Dear Sir/Madame:

The above-named practitioner has applied for professional staff appointment/reappointment and/or clinical privilege with **Parker Jewish Institute**. In the application he/she states that he/she was affiliated with your facility.

Based upon your personal knowledge of the applicant, we would appreciate your candid, written appraisal of him/her.

Kindly complete the enclosed Affiliation Questionnaire, and in your reply, please verify any knowledge you have or anything that warrants our exercising caution in granting his/her request for particular clinical privileges or competencies.

Kindly verify this by completing the attached questionnaire. If you do not have adequate knowledge to answer particular question, or to provide a rating please indicate “No Information”. The practitioner’s signed consent for the release of the requested information and a business reply envelope are also enclosed.

Your candor and prompt response is appreciated.

Thank you for your assistance.

Sincerely,

MARY M. LEGG

Enclosures: Release/Immunity Statement
COMPETENCY ASSESSMENT FORM

Facility: ________________________________

RE: SS# XXX-XX-5666

1. Is/was the above named practitioner in good standing on the medical staff? □ Yes □ No

2. Is the above named practitioner qualified by training and experience to be approved for the privileges requested? □ Yes □ No

3. Please evaluate practitioner at his/her level of experience and background.

<table>
<thead>
<tr>
<th>Category</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Superior</th>
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</thead>
<tbody>
<tr>
<td>Medical/Clinical Knowledge</td>
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<tr>
<td>Technical Clinical Skills</td>
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<tr>
<td>Clinical Judgment</td>
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<tr>
<td>Interpersonal Skills</td>
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<td>Ethical Conduct</td>
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<td>Communication Skills</td>
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<td>Professionalism</td>
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<tr>
<td>Physical/Mental Health</td>
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<tr>
<td>Medical Record Keeping</td>
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</tbody>
</table>

4. Recommendations:
   - Recommended highly without reservation □
   - Recommended as qualified and competent □
   - Recommended with some reservation □
   - Do not recommend □

5. Please indicate, in the space below, the nature of your association with this practitioner and the time period during which you have directly observed his/her practice of Medicine: ____________________________________________

Signature: __________________________________________ Title: ________________________________

Print Name: ______________________________________ Date: ________________________________

Please return this form to Mary M. Legg, Department of Medicine at the above address.
RE:
SS# XXX-XX-5666

Dear Sir/Madame:

The above-named practitioner has applied for professional staff appointment/reappointment and/or clinical privileges at Parker Jewish Institute. His/her application lists you as a reference.

Based upon your personal knowledge of the applicant, we would appreciate your candid, written appraisal of him/her. Kindly complete the enclosed Peer Reference Questionnaire, and in your reply, please verify any knowledge you have of anything that warrants our exercising caution in granting his/her request for particular clinical privileges or competencies.

Kindly verify this by completing the attached questionnaire. If you do not have adequate knowledge to answer a particular question, or to provide a rating please indicate “No Information”. The practitioner’s signed consent for the release of the requested information and a business reply envelope are also enclosed.

Your candor and prompt response is appreciated.

Thank you for your assistance.

Sincerely,

MARY M. LEGG

Enclosures: Release/Immunity Statement
NAME OF APPLICANT:

NAME OF PEER REFERENCE

1. Do you have direct knowledge of the clinical skills and judgment as practiced by the applicant? Yes ___ No ___

2. To your knowledge, other than temporary suspensions for failure to complete medical records, have the applicant’s privileges to admit or treat patients or his/her license ever been suspended or revoked? Yes ___ No ___
   If yes, or if action considered and applicant resigned prior to implementation of such action, please specify. ____________________________

3. Please rate the applicant for each of the following attributes. Please provide an explanation for any "unsatisfactory".

<table>
<thead>
<tr>
<th>Basic medical knowledge</th>
<th>EXCELLENT</th>
<th>SATISFACTORY</th>
<th>UNSATISFACTORY</th>
<th>CANNOT COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical/Professional Judgment</td>
<td></td>
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<tr>
<td>Decisiveness</td>
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<tr>
<td>Sense of responsibility</td>
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<tr>
<td>Competence and Technical Skills</td>
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<tr>
<td>Thoroughness in patient care</td>
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<td>Ethical conduct</td>
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<tr>
<td>Emotional Stability</td>
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<tr>
<td>Cooperativeness, ability to work with others</td>
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<tr>
<td>Participation on staff and committee activities</td>
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<tr>
<td>Medical record timeliness, clarity and completeness</td>
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<tr>
<td>Relationship with patients</td>
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<tr>
<td>Relationship with peers</td>
<td></td>
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<tr>
<td>Relationship with hospital staff</td>
<td></td>
<td></td>
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<tr>
<td>Use of hospital resources necessity for admission, LOS, tests)</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
NAME OF APPLICANT:

NAME OF PEER REFERENCE:

4. Have you ever observed or been informed of any physical or mental problems, such as drugs or alcohol dependencies which could potentially impair the applicant's ability to exercise any of the requested privileges. If yes, please explain on a separate sheet. Yes ___ No ___

5. Do you have any knowledge of any unprofessional, unethical or illegal behavior. Yes ___ No ___

6. How many years have you known the applicant? ____________________________

7. Personal association was: Close _____ Casual _____ Indirect _____

8. What is your relationship to the applicant? ____________________________

9. What is your present position? ____________________________

RECOMMENDATION:

1. _____ I recommend without reservation for reappointment with all requested clinical privileges.
2. _____ I recommend for appointment. Please note reservation on attached privilege list.
3. _____ I do not recommend this applicant for appointment or clinical privileges.

We appreciate your answers to these questions in an objective and forthright manner. We do ask however, that you use the back of this page to provide candid evaluation of this applicant's abilities as you have observed them. Additionally, please feel free to offer any comments which you believe will assist us in evaluating the clinical abilities and other skills of this applicant. Your assistance is appreciated.

Name ____________________________
Signature ____________________________ Date
Title ____________________________
Facility/Institution ____________________________
Address ____________________________
City ____________________________ State __ Zip Code ____________________________
Daytime Phone Number ____________________________
### COMPETENCIES

**Ratings:**
Circle ratings that apply to performance
(1=lowest; 9=highest). Use left column for notes

<table>
<thead>
<tr>
<th>Patient Care: provides compassionate care that is effective for the promotion of health, prevention, treatment, and at the end of life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating</td>
</tr>
<tr>
<td>Medical Knowledge: demonstrates knowledge of biomedical, clinical and social sciences, and applies that knowledge effectively to patient care</td>
</tr>
<tr>
<td>Rating</td>
</tr>
<tr>
<td>Practice-Based Learning and Improvement: uses evidence and methods to investigate, evaluate, and improve his/her patient care practices</td>
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<tr>
<td>Rating</td>
</tr>
<tr>
<td>Communication and Interpersonal Skills: demonstrates these skills and maintains professional and therapeutic relationships with patients and the healthcare team</td>
</tr>
<tr>
<td>Rating</td>
</tr>
<tr>
<td>Professionalism: demonstrates behaviors that reflect an ongoing commitment to continuous professional development, ethical practice, sensitivity to diversity, and responsible attitudes</td>
</tr>
<tr>
<td>Rating</td>
</tr>
<tr>
<td>Systems-Based Practice: demonstrates both an understanding of the contexts and systems in which health care is provided and applies this knowledge to improve and optimize health care</td>
</tr>
<tr>
<td>Rating</td>
</tr>
</tbody>
</table>

### Circle descriptions that best reflect performance

#### PATIENT CARE
- Interviews and examines patients poorly; lacks technical proficiency
- Has poor judgment
- Disregards patient preference

- **Below Expectations**
  - Rating 1-3

- **Meet Expectations**
  - Rating 4-5

- **Exceed Expectations**
  - Rating 6-9

#### MEDICAL KNOWLEDGE
- Limited knowledge base
- Minimal interest in learning
- Poor understanding of complex problems

- **Below Expectations**
  - Rating 1-3

- **Meet Expectations**
  - Rating 4-5

- **Exceed Expectations**
  - Rating 6-9

#### PRACTICE-BASED LEARNING AND IMPROVEMENT
- Minimizes or ignores self-assessment
- Avoids new technology
- Ignores feedback

- **Below Expectations**
  - Rating 1-3

- **Meet Expectations**
  - Rating 4-5

- **Exceed Expectations**
  - Rating 6-9

#### INTERPERSONAL AND COMMUNICATION SKILLS
- Has poor relationships with patients/families
- Avoids educating or counseling patients
- Incomplete, illegible medical records

- **Below Expectations**
  - Rating 1-3

- **Meet Expectations**
  - Rating 4-5

- **Exceed Expectations**
  - Rating 6-9

#### PROFESSIONALISM
- Not respectful
- Not compassionate
- Dishonest
- Avoids responsibility for errors
- Not considerate of others

- **Below Expectations**
  - Rating 1-3

- **Meet Expectations**
  - Rating 4-5

- **Exceed Expectations**
  - Rating 6-9

#### SYSTEM-BASED PRACTICE
- Poor utilization of resources
- Makes no attempt to reduce errors
- Resists improvement to systems of care

- **Below Expectations**
  - Rating 1-3

- **Meet Expectations**
  - Rating 4-5

- **Exceed Expectations**
  - Rating 6-9
Dear _______________________

Enclosed you will find an application for the re-appointment to the medical staff at Parker Jewish Institute for Health Care and Rehabilitation for the appointment 2015-2017.

Please complete the enclosed application which includes:

- Physician Checklist
- Physical Assessment Form
- Appointment Application
- Consent for Release of Information for Medical Staff Appointment
- Insurance Liability Form
- Delineation of Privileges (Please initial all you are requesting)
- Authorization to Release Information form

Please make sure that all of your credentials are current,

- NYS License/registration certificate
- DEA certificate (if applicable)
- Current Infection Control Certificate
- CME credits of 25 hours of credits for the past 2 years

It is important that the completed application and all necessary documents be returned to the Medical Department at the above address no later than ____________________________.

Kindly send your completed application and any credentials that may have expired to the department of medicine at the address listed above, please make sure that the envelope states ATTN MARY LEGG, DEPARTMENT OF MEDICINE

If you have any questions, please do not hesitate to contact me directly at (718) 289-2281.

Sincerely,
COLLABORATIVE PRACTICE AGREEMENT dated as of ______________, by and between ________________ (“Nurse Practitioner”), a Nurse Practitioner and employee of Parker Jewish Institute (“Facility”) and ________________ (“Collaborating Physician”).

I. PURPOSE

The purpose of this Agreement is to establish a practice that will provide an optimum level of health care for patients by providing a mechanism for appropriate collaboration between Nurse Practitioner and Collaborating Physician.

II. PROFESSIONAL QUALIFICATIONS

The Nurse Practitioner is a registered nurse with advanced preparation from a Nurse Practitioner Program and is certified by the State of New York Education Department to use the title “Nurse Practitioner”, and to engage in the performance of primary health care services and the issuance of prescriptions (subject to Article VII, below) within identified areas of practice covered by protocols (as defined below). The Nurse Practitioner has been properly credentialed by the Parker Jewish Institute and his/her scope of practice is defined in the Delineation of Clinical Privileges which is the basis for credentialing.

III. SCOPE OF PRACTICE

The Nurse Practitioner will manage patients according to agreed-upon protocols and/or in consultation with Collaborating Physician. Any patient the Nurse Practitioner and/or Collaborating Physician feel are out of the scope of practice for the Nurse Practitioner will be referred to the Collaborating Physician based on mutual agreement between the Nurse Practitioner and Collaborating Physician. Within the Hospital/Facility setting, the Nurse Practitioner’s scope of practice will also be limited by the facility’s current job description within the Clinical Privileges Delineation attached hereto as Exhibit A.
III. SCOPE OF PRACTICE

The Nurse Practitioner will manage patients according to agreed-upon protocols and/or in consultation with Collaborating Physician. Any patient the Nurse Practitioner and/or Collaborating Physician feel are out of the scope of practice for the Nurse Practitioner will be referred to the Collaborating Physician based on mutual agreement between the Nurse Practitioner and Collaborating Physician. Within the Hospital/Facility setting, the Nurse Practitioner’s scope of practice will also be limited by the facility’s current job description within the Clinical Privileges Delineation attached hereto as Exhibit A.

IV. PROTOCOLS/REFERENCE FOR PATIENT CARE

The Nurse Practitioner and the Collaborating Physician have developed and/or adopted existing protocols agreed upon by both to serve as guidelines for the management of patients by the Nurse Practitioner. The protocols have been derived from a list of accepted medical and nursing texts and journals and a current list is attached here to as Exhibit B. It is understood that this list will be updated as needed. Such protocols shall reflect accepted standards of nursing and medical practice and include, but will not be limited to, provisions for case management including diagnosis, treatment and appropriate record keeping by the Nurse Practitioner and Collaborating Physician to be appropriate.

V. PHYSICIAN CONSULTATION

The Collaboration Physician shall be available to the Nurse Practitioner for consultation and/or referral at all times. Such availability shall include either on site or telephone access. In the absence of the Collaboration Physician, appropriate referral by the Collaborating Physician to a physician designee or other appropriate practitioner shall be made and communicated to the Nurse Practitioner; patients shall be referred to the Collaborating Physician.

At least every three months the Collaborating Physician shall randomly select a representative number of medical records of those patients who were treated by the Nurse Practitioner, and review them; documentation of the review will be by the Collaborating Physician’s signature that will appear in the patient’s medical record on the reviewed progress note. The findings of such review shall be shared with the Nurse Practitioner.
VI. RESOLUTION OF DISAGREEMENT

In the event of a disagreement between the Nurse Practitioner and the Collaborating Physician regarding a matter of diagnosis and/or treatment that is within the scope of practice of both, the Nurse Practitioner will provide a full explanation of his/her view. Such explanation shall reflect accepted standards of nursing and medical practice. The Collaborating Physician will give careful consideration to this explanation before making a final determination of the issue.

VII. PRESCRIPTIVE PRIVILEGES

The Nurse Practitioner must be certified in the State of New York to prescribe medications within his/her specialty area. Under this practice agreement the Nurse Practitioner may prescribe medications only for patients he/she sees at Parker Jewish Institute.

VIII. TERM OF CONTRACT

A. Term: The term of the Agreement shall one be one year, commencing on the date of this agreement. This agreement shall renew itself on a yearly basis unless otherwise terminated.

B. Termination: This Agreement shall be terminable on a mutual agreement of the patient or by either party upon ninety (90) days’ prior written notice to the other party. This agreement may also be terminated for cause by either party upon ten (10) days’ prior written notice if the cause is not resolved to the satisfaction of the notifying party within such ten (10) day period. This agreement may also be terminated immediately in the case of imminent harm to patient care. This agreement will terminate automatically upon termination of employment with Parker Jewish Institute.

IX. PATIENT RECORDS

The patient record or files involved in the Nurse Practitioner’s practice are the property of the facility and shall remain so upon the termination of this agreement.
IX. PATIENT RECORDS

The patient record or files involved in the Nurse Practitioner’s practice are the property of the facility and shall remain so upon the termination of this agreement.

X. MALPRACTICE INSURANCE COVERAGE

Pursuant to the agreement between Parker Jewish Institute and the named Nurse Practitioner, malpractice insurance will be provided by Parker Jewish Institute.

XI. ALTERATION OF THIS AGREEMENT

This agreement shall be reviewed annually, or more frequently as necessary, and any alterations or amendments will be made in writing and signed by both parties.

Having read and understood the full content of this document, the parties hereto agree to be bound by the terms.

Nurse Practitioners Signature

Date

Collaborating Physician’s Signature

Date
Initial Appointment Process

- Written policies and procedures
- Facility specific written performance expectations and essential functions
- Does each applicant submit:
  - written request for appointment
  - statement – physical and mental health status
  - lack of impairment – chemical dependency/substance abuse
  - history of loss of license and/or felony convictions
  - history of loss or limitation of privileges or disciplinary action
  - evidence of good standing to participate in federal/state health care programs
  - attestation of correctness and completeness of application
  - authorization to release information from all primary sources
- Obtain and verify from primary sources;
  - graduation from medical school, completion of residency, board certification
  - current, valid NYS license
  - valid DEA certificate
  - clinical privileges in good standing at community/transfer hospitals
  - work history
  - references from appropriate persons at current/prior practice settings
  - current, adequate malpractice insurance
  - good standing to participate in all federal/state health care insurance programs
- Procedure for notification of initial application and of periodic renewal
**Additional Components to be Considered**

- Governing body/administration approve all credentialing policies/procedures
- Bylaws/P&P: roles, responsibilities, functions, relationships, authorities of:
  Governing Body, Administrator, Medical Director, Medical Executive committee
  Credentials Committee, Corporate Medical Director, Medical Staff Members
- Is credentialing process ongoing
- Same credentialing procedure for all practitioners
- Credentialing criteria applied consistently
- Criteria objective and rational for quality-of-care, business, compliance concerns
- Process applications within reasonable time frames, or as specified
- Written procedure on obtaining missing or additional required information
- Written procedure on closing a file for failure to submit complete information
- What body is responsible for verifying credentials. Role of CVO
- Credentialing for temporary privileges
- Credentials Committee makes all recommendations on appointment and privileges
Additional Components to be Considered

• Credentialing impact on: resident care, compliance, medical staff, nursing home

• Right to practice granted only to qualified individuals

• Fair written procedure for reconsideration of adverse decisions

• New appointees are oriented to their roles and responsibilities

• Reappointment activity summary/profile for all reappointments

• Provide updates when expectations or regulations change

• Policies and Procedures that address:
  • impaired practitioner
  • sexual harassment
  • unavailability or non-responsiveness
  • noncompliance with regulations
  • reporting of elder abuse
  • conflict resolution mechanism for credentialing/performance dispute
Additional Components to be Considered

- Reduce, suspend, or terminate clinical privileges as necessary
- Report disciplinary actions to appropriate authorities
- Reconsideration process for those who have been disciplined
- Practitioners informed of reconsideration procedure
- Credential files stored in a secure location
- Credential files are easily accessible
- P&P controlling confidentiality of credentialing information
- P&P regarding access to and release of credentials information
QUESTIONS