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# CHECKLIST OF REQUIRED DOCUMENTATION FOR MEDICAL STAFF APPLICANTS TO RETURN

1. **Completed New Mexico Standard Credentialing Application (this MUST be completed to start the process)**
   - The application can be downloaded and auto-fill from the New Mexico HSC Insurance site: https://ecredspractitioner.nmhsc.com/.
   - The release must be signed & dated within the past 6 months.
   - **For any affirmative responses in Section 8 'Disclosure Questions', please provide a detailed explanation and appropriate supporting documentation.**

2. **Completed Hospital Addendum**
   - Pages 2-12 must be returned.
   - Attach a clear & recent photo attached to page 2 of the Hospital addendum (i.e. passport photo or other photo with a solid background. This photo will be used for your hospital ID badge.)

3. **Completed Delineation of Privileges Form** *(you must check the corresponding boxes or handwrite your requested privileges or the form will be invalid)*
   - Provide case logs and / or training evidence as necessary for requested ADVANCED procedures. Please note that advanced procedures WILL NOT be considered if the appropriate documentation for training and current case logs are not provided.

4. **Send TCRH Current Copies of the following documents:** *If applicable, payor credentialing can not begin without these documents*
   - License Certificates (Medical License, DEA, DPS)
   - Education Certificates (Medical Degree, Internship, Residency, Fellowship)
   - PPD Test Result (Copy of skin test read, blood test, or chest x-ray; If skin test, must have been read within past 12 months)
   - COVID & FLU vaccination record
   - Vaccination Record
     - MMR, Varicella, Hep B, Tdap or applicable titers
   - Case Logs (if applicable for requested privileges)
   - CME's or a signed attestation of completion
   - Photo – for badge (avoid busy backgrounds; a selfie is fine)
   - Curriculum Vitae
   - Board Certification Certificate (if applicable)
     - Proof of fellowship if board eligible
   - BLS ACLS/PALS card (BLS required ACLS preferred)
   - Malpractice liability insurance certificate ($200,000 / $600,000 minimum liability coverage)
   - Copy of current Driver's License, Military ID, or Passport

5. **Application Fees are Currently Not Required**

***NOTE:*** *APPLICATION FEES ARE WAIVED FOR ALL APPLICATIONS –*
*Medical Executive Committee may choose in future to apply fees for initial and* reappointment

**Please return your completed application packet via email to:**

**credentialing@3crossesrh.com**

*If you have any questions, please contact the Medical Staff Department at 575-800-3764*

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**Attach Current Photo Here**
**Or email a JPEG**

**Print Applicant's Name and Professional Suffix (MD, DO, DPM, DDS)**

_____

**Specialty**

_____

**Requested Staff Status- Circle below**
***(See below for definitions)***

ACTIVE COURTESY

* ACTIVE: REQUIRED TO TAKE EMERGENCY DEPARTMENT CALL AS DEFINED BY THE DEPARTMENT. Consists of practitioners who have offices located in county and surrounding areas and can respond to patient needs and / or the facility within fifteen minutes (15) by phone and presence within (30) minutes in order to provide continuous care to their patients. Active staff members will have performed twenty-four (24) Patient Care Contacts per Medical Staff Year. Patient Care Contacts fewer than specified number will annually or at time of reappointment will be reviewed for transfer from Active Category to another Category of Medical Staff Membership. Active staff members assume the functions and responsibilities of membership including, when appropriate, emergency service care, disaster plan assignment, and consultation assignments.

** COURTESY: Consists of practitioners who have offices located in county and surrounding areas and can respond to patient needs and / or the facility within fifteen minutes (15) by phone and presence within (30) minutes in order to provide continuous care to their patients. Courtesy staff members will have performed fewer than twenty-four (24) Patient care contacts per Medical Staff Year in the Hospital. Patient Care Contacts of more than the specified number of patients in a year by any member will require that the member be appointed to the active staff category. Courtesy staff members shall be members of the active or associate staff of another Hospital in which their regular participation in quality/performance management activities is documented and their performance is evaluated. Courtesy staff applicants and members shall provide satisfactory evidence to the Credentials Committee of such membership, participation, and evaluation. Courtesy staff members are not eligible to vote on Medical Staff or departmental matters or hold Medical Staff office.

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# HOSPITAL ADDENDUM

**TO THE STANDARDIZED CREDENTIALING APPLICATION**

This form and any and all attachments thereto are privileged, and confidential peer review communications prepared at the discretion of the Governing Board for medical peer review purposes under the authority granted to the Governing Board in the Medical Staff Bylaws and related documents and under the state and federal laws that make such communications confidential. The voluntary disclosure of this document or any information contained therein to any third party who is not a party to the committee proceedings, other than to counsel, is strictly prohibited.

## **SECTION ONE -** PERSONAL INFORMATION

| LAST NAME: | FIRST NAME: | SPECALITY: |
|---|---|---|
| Primary Office Phone #: | Primary Office Fax #: | |
| Applicant Pager #: | Applicant Cell Phone #: | |
| Applicant E-mail: | | |
| Credentials Contact Name: | | |
| Credentials Contact Phone # | Credentials Contact Fax # | |
| Credentials Contact E-mail: | | |
| Practitioner NPI # | Practitioner UPIN # | |

## **SECTION TWO-** HEALTH STATUS

**Please ✓ one answer to each question below. Indicate affirmative answers on a separate sheet of paper.**

1. What is your recent health status? □ GOOD □ FAIR □ POOR
2. Do you have any mental and / or physical health problems? that would affect your clinical judgment and / or motor skills? □ Yes □ No
3. Are you taking any medications that would affect your clinical? judgment and / or motor skills? □ Yes □ No
4. Do have any alcohol and / or drug dependency issues? □ Yes □ No
5. Please provide type & date of your last Tuberculin (PPD) test. **<u>*Please attach a copy of test report. *</u>**

   □ Skin Test (Must be within past 12 months) □ Chest X-Ray (Must be within past 3 years)

   Date: _____/_____/_____

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| **SECTION THREE** - CONTINUING EDUCATION |
|---|
| Have you met the minimum continuing education requirements for renewal of your license in the past two years? □ Yes □ No<br><br>I hereby certify I have completed the required continuing medical education. If audited, I will be able to provide documentation of the seminars or courses I attended. I recognize that failure to produce documentation upon request will jeopardize my membership on the Medical Staff.<br><br>_____ _____/_____/_____<br>**PHYSICIAN SIGNATURE** **DATE** |

## APPLICATION ACKNOWLEDGEMENT

I acknowledge that the information given in or attached to this addendum is complete, accurate and fairly represents the current level of my training, experience, capability and competency to exercise the clinical privileges requested. I understand and agree that as a condition to making this application, any misrepresentation or misstatement in, or omission from, this application, whether intentional or not, shall be grounds to deny or discontinue processing and will not entitle applicant to a fair hearing.

Photocopies of this agreement shall be as binding as the original.

_____ _____
**PHYSICIAN APPLICANT NAME (PLEASE PRINT)** **PHYSICIAN INITIALS**

_____ _____/_____/_____
**PHYSICIAN SIGNATURE** **DATE**

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# CONTACT INFORMATION FOR PEER REFERENCES

**References must from individuals other than family or affiliated by marriage who must have personal knowledge of the applicant's recent professional performance, ethical character, current competence, health status (subject to any necessary reasonable accommodation to the extent required by law), and the ability to work cooperatively with others. **

** A maximum of one (1) person from the same group practice may be used as a peer reference. The peers do not have to be of the same specialty but should hold the same or higher degree of study. **

**The peers must have observed the practitioner within the past 3 years**

**(1) Peer Reference:** _____

Address: _____

City/State: _____

Zip: _____

Phone Number: _____

Fax Number: _____

**(2) Peer Reference:** _____

Address: _____

City/State: _____

Zip: _____

Phone Number: _____

Fax Number: _____

**(3) Peer Reference:** _____

Address: _____

City/State: _____

Zip: _____

Phone Number: _____

Fax Number: _____

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# BACKGROUND VERIFICATION AUTHORIZATION

As a provider of medical services, Three Crosses Regional Hospital (TCRH) requests your permission to conduct an investigation on your background which may include procurement of information regarding your state licensure, medical education, residencies, malpractice history, criminal history, employment history and background. As part of its investigation, TCRH may obtain consumer reports from consumer reporting agencies. Under the Fair Credit Reporting Act (FCRA), TCRH is required to obtain your written authorization prior to procuring such consumer reports. Please indicate your consent by signing below.

Please note: Credit histories are not part of the background check performed on Physicians and Allied Health Professionals. The term "consumer report" applies to any type of information collected and compiled by a third party, but in this case, does not and will not include credit histories.

By my signature below, I hereby authorize Three Crosses Regional Hospital to conduct an investigation, as necessary, of my state licensure, medical education, residencies, malpractice history, criminal history, employment history and background, which may include, but may not be limited to, procuring consumer reports from consumer reporting agencies.

_____

**APPLICANT NAME (PLEASE PRINT)**

_____ _____/_____/_____

**APPLICANT SIGNATURE** **DATE**

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**APPLICANT NAME (PLEASE PRINT)**

**MEDICAL STAFF**
**BYLAWS AND RULES & REGULATIONS ACKNOWLEDGMENT**

I have received and read a copy of the Medical Staff Bylaws and Rules & Regulations of Three Crosses Regional Hospital and agree to abide by the Bylaws and Rules & Regulations at all times.

**Signature** **Date**

**POLICY: MANAGEMENT OF THE DISRUPTIVE PRACTITIONER**
**ACKNOWLEDGMENT**

I have received and read a copy of the policy regarding management of the disruptive practitioner and agree to abide by this policy at all times.

**Signature** **Date**

**POLICY: MANAGEMENT OF THE PHYSICIAN HEALTH AND WELLBEING**
**ACKNOWLEDGMENT**

I have received and read a copy of the policy regarding management of impaired physician and well-being committee and agree to abide by this policy at all times.

**Signature** **Date**

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_____

**APPLICANT NAME (PLEASE PRINT)**

**POLICY: COMPLIANCE PLAN ACKNOWLEDGEMENT**

I, _____, hereby acknowledge that I have been made aware of the Compliance Program and its purpose and intent and have access to each policy and other relevant documents relating to the Compliance Program. I understand that my participation in the Compliance Program or lack thereof is critical to the overall success of **Three Crosses Regional Hospital** and its strategic goals. It is further understood that I will abide by all policies and procedures set forth in the Compliance Program.

Finally, it is understood that any violation of compliance policies and procedures may adversely affect my medical staff privileges.

_____ _____

**Signature** **Date**

**POLICY: STANDARDS OF CONDUCT ACKNOWLEDGEMENT**

I acknowledge that I have received my personal copy of the Hospital's Standards of Conduct. I understand that I am responsible for knowing and following them. I also understand that I am responsible for reporting any violations of the Standards of Conduct to the appropriate management representative, Human Resources, the Compliance Officer or the Compliance Hotline at (855) 900-8274.

_____ _____

**Signature** **Date**

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# MEDICAL STAFF CALL COVERAGE AGREEMENT

**APPLICANT NAME:**_____

**SPECIALTY:** _____

The Medical Staff Bylaws state that each member of the Medical Staff must arrange for patient coverage in the event that the physician is unavailable for the medical management of a patient. Please complete this form in order to document the name and acknowledgment of a currently credentialed physician who will provide coverage in this event.

THIS FROM MUST BE COMPLETED AND SIGNED BY A PHYSICIAN WHO IS CURRENTLY A MEMBER OF THE MEDICAL STAFF AND PRACTICES IN THE SPECIALTY/SUBSPECIALTY IN WHICH YOU HAVE REQUESTED PRIVILEGES.

_____
COVERING PHYSICIAN NAME *(PLEASE PRINT OR TYPE)*

_____
COVERING SPECIALTY/SUBSPECIALTY

_____
COVERING PHYSICIAN OFFICE PHONE #

_____
COVERING PHYSICIAN OFFICE FAX #

*I agree to provide patient coverage for the above named physician at Three Crosses Regional Hospital in the event that such physician is unavailable for the medical management of his / her patient.*

_____ _____/_____/_____
**COVERING PHYSICIAN SIGNATURE** **DATE**

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# CENTERS FOR MEDICARE / MEDICAID ATTESTATION

As a prerequisite for submission of claims to Medicare, Medicaid and Champus, all hospitals are required to have on file a current, signed acknowledgement statement from the attending physician indicating the physician has received the notice below:

> "Notice to all Physicians: Medicare, Medicaid and Champus payments to hospitals are based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal or state funds, may be subject to fine, imprisonment or civil penalty under applicable federal or state laws"

All physicians with privileges at Three Crosses Regional Hospital are required to acknowledge receipt of the above-noted statement by signing this form. Please return this form to Medical Staff Services.

**Each physician must sign the acknowledgement statement using his or her legal signature.**

**Initials are not acceptable.**

_____

**PHYSICIAN APPLICANT NAME (PLEASE PRINT)**

_____

**PHYSICIAN SIGNATURE *(AS SIGNED ON PHYSICIAN ORDERS)***

_____/_____/_____

**DATE**

***A copy of this form will be provided for the state audit purposes when requested.***

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**APPLICANT NAME (PLEASE PRINT)**

**ELECTRONIC PATIENT RECORD SYSTEM (EPRS) CONFIDENTIALITY STATEMENT**

By signing below, I acknowledge and understand:

The information contained in the medical record imaging system is considered part of the medical record, is confidential and must not be discussed with anyone. Of necessity, I am exposed to privileged information daily and it is my duty to protect this information. Therefore, I will not discuss information contained in the system or the medical record with anyone except in the course of completion of work and I will not give anyone access to the security level assigned to me by the system administrator. This shall include other practitioners, employees of the hospital, or anyone outside the hospital. I understand that breach of this policy regarding confidentiality is grounds for immediate suspension of my privileges.

**Signature** **Date**

**ELECTRONIC SIGNATURE NOTIFICATION**

This is to inform you of my intent to electronically authenticate transcribed interpretations of dictated reports, as well as any entries, written orders, or instructions through the use of a unique, confidential PIN number assigned specifically to me.

I am the only person to whom this code is assigned. Thus, I am responsible for all entries that I record into the computer system. I will neither delegate my assigned code to any other person, nor allow any other person to use it for authentication of such transcribed reports or entries.

**Signature** **Date**

**HEALTH INFORMATION MANAGEMENT**

The Kansas Department of Health requires the following: "The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries."

To ensure compliance, Health Information Management must have your signature and signed initials on file.

**Signature *(AS SIGNED ON PHYSICIAN ORDERS)*** **Signed Initials**

***This form will be forwarded to Health Information Management for their records.***

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# DEA CERTIFICATE

Three Crosses Regional Hospital requires physician DEA numbers and signatures on record in the Pharmacy. This is in compliance with State and Federal regulations for dispensing controlled substance orders to inpatients, outpatients, and emergency room patients.

**Please complete the information below and return with your application packet.**

_____

**PRINTED NAME**

_____

**PHYSICIAN SIGNATURE (AS SIGNED ON ORDERS)**

_____

**DEA REGISTRATION NUMBER**
**(NUMBER ON DEA REGISTRATION FORM)**

***This form will be forwarded to the Pharmacy for their records.***