Credentialing, Recredentialing, and Privileging

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Difference Between Credentialing and Privileging

Credentialing
involves
verification of a practitioner’s “credentials”

Privileging
involves
documentation and evaluation of the actual patient care, treatment, or services that will be provided at your facility

Why do we do it?

• To protect patients
• Risk management – negligent credentialing
• Accreditation/Regulatory requirements

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Review Of Application

- Each question should be answered legibly
- Signed and dated
- No unexplained time gaps since medical or professional school

Remember!

THE BURDEN OF PROOF IS ON THE APPLICANT

Applying Criteria for Membership and Privileges

- Criteria for granting/denying privileges must be consistently applied
Primary Source Verification

**Information received directly from the issuing source**

- Written
- Phone (name of organization, date, person contacted, questions asked, response, the name of the person receiving the response)
- Fax
- Approved web site
- Can be Internal, Centralized, Delegated

Designated Equivalent Sources

- Agencies determined to maintain specific item(s) of credential information identical to the information at the primary source
- Primary source may designate another organization as its agent in providing information to verify credentials. This other organization is then considered a designated equivalent source

Verification of Individual Elements

- Education and Training
- Experience/Work History
- Licensure
- Board Certification
- Sanctions/Disciplinary action
- Peer Recommendations
Review and Approval Process – Roles and Responsibilities

Step 1: Credentialing expert verifies credentials
Step 2: Department chair or service chief reviews and recommends
Step 3: Credentials committee reviews and recommends
Step 4: Medical executive committee reviews and recommends
Step 5: Governing body reviews and final decision

Documenting Recommendations and Actions
- Document recommendations made and actions taken in each step of the process
- Documentation included in meeting minutes or on an approval form (see sample form)
- Include the reasons for the recommendation or decision

Red Flags
- Loss of licensure/DEA
- Loss of appointment or privileges
- Frequent moves (excluding military)
- Excessive professional liability judgments or settlements
Red Flags

- Information on the application that differs from information received from respondents
- Negative responses from references
- Adverse actions by health plan due to quality of care or professional conduct
- Unexplained Gaps

Licensure Disciplinary Actions

Most common actions:
- Illegal drug use/prescribing
- Inappropriate sexual contact
- Fraud

John Anderson King, DO aka Christopher Wallace Martin

- 8/84 – DO at U of New England College of Osteopathic Medicine
- 7/84 – 6/85 – Internship Cuyahoga Falls General Hosp
- 7/85 – 10/85 – Anesthesiology residency Med College Georgia
- 1/85 – 6/85 – Anesthesiology residency Monmouth Med Center NJ
- 7/86 – 1/87 – Anesthesiology residency Western Reserve OH
- 1989 – Resigns from Walker Regional MC, Jasper, AL after privileges suspended
- 11/89 – 2/92 – OB/GYN residency Albert Einstein, Philadelphia (not completed)
- 5/93 – 5/95 – Ortho residency Hillcrest HC, OK City, OK (not completed)
- 1993 – 1997 – Ortho residency Lincoln Mental Health Center, Bronx, NY
- 1997 – 1999 – Jackson Hospital, Marianna, FL
- 2000 – 2002 – Doctors Hospital, Groves, TX
NY Medical Board – Dr. King

The Hearing Committee sustained the charge finding the physician guilty of having been disciplined by the Alabama State Board of Medical Examiners for unprofessional conduct: endangering the health of patients; gross or repeated malpractice or gross negligence, and being unable to practice medicine with reasonable skill and safety due to lack of basic medical knowledge or clinical competency.

Actual Disciplinary Actions

In Hawaii, a physician was sentenced to 1 year and 1 day in prison and ordered to pay a $10,000 fine for dispensing Oxycodone outside the course of professional medical practice and for no legitimate medical purpose. An investigation revealed that the physician was illegally prescribing Oxycodone. The physician will be deported to Canada upon completion of his prison sentence.

Actual Disciplinary Actions

Podiatrist performed routine foot care on residents in community rooms of low-income buildings then billed the Medicare program as if he performed more complex procedures. In fact, residents were only getting their nails clipped.
Actual Disciplinary Actions

Inappropriately and unnecessarily performing breast exams
Engaged in a sexual relationship with a patient for approximately thirty (30) days in 2005
License on probation for 10 years

Licensee failed to notify the Board of a change in work address, and practiced for a period of time without a valid license.
License publicly reprimanded

Pled guilty to felony offense of health care fraud.
License is Revoked with no application for reinstatement for a period of two (2) years and one (1) day.
Actual Disciplinary Actions

Licensee was decertificated by Blue Cross/Blue Shield of Kansas City for failure to adhere to the ethics of professional conduct, failure to disclose a disciplinary action from a state licensing board and failure to disclose revoked hospital privileges.

License Publicly Reprimanded.

Actual Disciplinary Actions

- Failure to appropriately account for federally-funded vaccines provided free of charge to indigent children
- While participating in the federal program, Licensee administered the free vaccines to private patients and billed patients or their insurance companies for the vaccines
- Board Action: License is Publicly Reprimanded.
- Licensee must take and complete a Board-approved course in medical ethics

Actual Disciplinary Actions

Failure to register each place of practice where she distributed controlled sub.

Licensure reprimanded
Actual Disciplinary Actions

- Physician entered into a romantic and sexual relationship with a patient
- Prescribed controlled substances to the patient during the relationship
- Entered into a financial arrangement with the patient to aid his psychiatric practice, when the patient attempted to end relationship, he struck her in the head with channel lock pliers twenty to thirty times and left her bleeding in his office

Evaluate “Red Flags” on an individual basis

Don’t be shy about asking for additional information!!
ACPE 2006 Survey Patient Trust and Safety

Is there a doctor in your community that you would avoid because you think he or she makes medical mistakes?

<table>
<thead>
<tr>
<th>Patient Responses</th>
<th>Physician Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>20% Yes</td>
<td>77% Yes</td>
</tr>
<tr>
<td>78% No</td>
<td>23% No</td>
</tr>
<tr>
<td>2% Don't know</td>
<td></td>
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</tbody>
</table>

Mongan Institute for Health Policy at Mass. General Hospital 7/2010 Study

- 64 percent agreed that physicians should always report impaired or incompetent colleagues
- 17% had direct personal knowledge of impaired colleague, but only 67% reported
“Our findings cast serious doubt on the ability of medicine to self-regulate with regard to impaired or incompetent physicians”

Questions? Comments!
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Phone (618) 624-8124
BIOGRAPHICAL SKETCH, KATHY MATZKA, CPMSM, CPCS

Kathy Matzka, CPMSM, CPCS is a speaker, consultant, and writer with over 20 years of experience in credentialing, privileging, and medical staff services. She holds certification by the National Association Medical Staff Services (NAMSS) in both Medical Staff Management and Provider Credentialing. Ms. Matzka worked for 13 years as a hospital medical staff coordinator before venturing out on her own as a consultant, writer, and speaker.

Ms. Matzka has authored a number of books related to medical staff services including The Chapter Leader's Guide to Medical Staff: Practical Insight on Joint Commission Standards, The Compliance Guide to Joint Commission Medical Staff Standards, and The Medical Staff Meeting Companion: Tools and Techniques for Effective Presentations. For the past eight years, she has been the contributing editor for The Credentials Verification Desk Reference.

She has performed extensive work with NAMSS’ Library Team developing and editing educational materials related to the field including CPCS and CPMSM Certification Exam Preparatory Courses, CPMSM and CPCS Professional Development Workshops, and NAMSS Core Curriculum. These programs are essential educational tools for both new and seasoned medical services professionals. She also serves as instructor for NAMSS.

Ms. Matzka shares her expertise by serving on the editorial advisory boards for three publications - Briefings on Credentialing, Credentialing, Peer Review Legal Insider, and Advisor for Medical and Professional Staff Services. She is a member of the advisory board of Global Health Sources, where she serves as an expert in provider credentialing, privileging, and other aspects of medical staff management.

Ms. Matzka is a highly-regarded industry speaker, and in this role has developed and presented numerous programs for professional associations, hospitals, and hospital associations on a wide range of topics including provider credentialing and privileging, medical staff meeting management, peer review, negligent credentialing, provider competency, and accreditation standards.

In her spare time, Ms. Matzka takes pleasure in spending time with her family, listening to music, singing with her church worship team, traveling, hiking, fishing, and other outdoor activities.
# Table of Contents

Documenting Competency .................................................................................................................... 1
Sample Letter for Verification of Training ................................................................................................ 1
Training Program Director’s Evaluation and Recommendation ............................................................ 2
Sample Letter: Facility Privileges and Competency Validation .............................................................. 4
CONFIDENTIAL Evaluation of Privileges and Competency Validation ................................................ 5
Sample Peer Recommendation Letter .................................................................................................... 6
Sample Peer Recommendation Form ....................................................................................................... 7
Focused Professional Practice Evaluation Plan ..................................................................................... 9
Sample Proctorship Form ....................................................................................................................... 10
Proctoring Summary Report .................................................................................................................. 11
Sample Indicators for LIP APRNs and PAs ............................................................................................ 12
Focused Professional Practice Evaluation (FPPE) Report ....................................................................... 13
Ongoing Professional Practice Evaluation (OPPE) Report ..................................................................... 14
Sample Peer Review Form .................................................................................................................... 15

Low Volume Practitioners ...................................................................................................................... 16
Admit and Follow Privilege Form .......................................................................................................... 16
Refer and Follow Privilege Form .......................................................................................................... 16

Red Flags Work Session ....................................................................................................................... 17

Expedited Credentialing Resources ...................................................................................................... 24
Application Flow Chart .......................................................................................................................... 25
Sample Medical Staff Expedited Credentialing Policy and Procedure ................................................ 26

Privileges Resources ............................................................................................................................. 28
AAFP Core Privileges Example ............................................................................................................. 28
Modified Core Example .......................................................................................................................... 42
Procedure for Determining “Core” Privileges in Each Specialty .......................................................... 46
Worksheet for Development of Core Privileges .................................................................................. 47
Work Sheet for Consideration of New Privilege .................................................................................. 49

Documenting Recommendations .......................................................................................................... 50
Sample language for medical staff minutes: .......................................................................................... 50
Sample language for Board minutes: ..................................................................................................... 50

Recommendation and Approval Form for Medical Staff Appointment and Clinical Privileges .......... 51

Notification of Internal and External Parties Regarding Practitioner Privileges .................................. 52
Sample Letter for Verification of Training

[Date]

Re: [Applicant's full name, Title]
Training: [Residency/fellowship]
Specialty: [Specialty]
Dates: [From/to]

Dear [Program Director name]:

We have received an application from the above-named provider for medical staff appointment and/or privileges. A copy of the privileges requested is attached. The applicant noted that the above-specified training took place at your institution. In order to process the application we require verification of completion of training and documentation of experience, ability, and current competence on the six areas of “General Competencies” adopted from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative.

Our policies require completion of the enclosed form. Failure to receive this form will delay consideration of the applicant’s request for privileges. Also, our policies require the physician to document competency in performing specific procedures by allowing our organization to obtain a copy of his/her procedure list from your program and the outcomes for those procedures (if outcomes are available). The applicant has authorized you to provide this information to our organization via signature on the attached Authorization and Release Form.

Enclosed is a copy of a release and immunity statement signed by the applicant consenting to this inquiry and your response. The immunity statement releases from liability any individual who provides the requested information.

Thank you for your assistance. We look forward to hearing from you.

Sincerely,

Director

Enclosures
Training Program Director’s Evaluation and Recommendation

Re: [Applicant’s full name]
Training: [Residency/fellowship]
Specialty: [Specialty]
Dates: [From/to]

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<thead>
<tr>
<th>Area of Evaluation</th>
<th>YES</th>
<th>NO</th>
<th>Unable to Evaluate</th>
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<tbody>
<tr>
<td>1. Were you the director of the program at the time of this applicant’s training?</td>
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<td>2. Was the applicant at your institution in the above program for the stated period of time?</td>
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<td>3. Was the program fully accredited throughout the applicant’s participation in it?</td>
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<td>4. Did the applicant successfully complete the program?</td>
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<td>5. Did the applicant receive satisfactory ratings for all aspects of his/her training in the program?</td>
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<td>6. Was the applicant ever subject to or considered for disciplinary action?</td>
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<td>7. Did the applicant ever attempt procedures beyond his/her assigned training protocols?</td>
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<td>8. Was the applicant’s status and/or authority to provide services ever revoked, suspended, reduced, restricted, not renewed, or was he/she placed on probationary status or reprimanded at any time or were proceedings ever initiated that could have led to any of the actions?</td>
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<td>9. Did the applicant ever voluntarily terminate his/her status in the program or restrict his/her activities in the program in lieu of formal action or to avoid an investigation?</td>
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<td>10. In reviewing the attached request for privileges, do you feel that the applicant’s training and experience included these procedures?</td>
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<td>11. In reviewing the attached request for privileges, do you feel that the applicant is currently competent to carry out these procedures?</td>
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<td>12. Are you aware of any physical or mental condition that could affect this practitioner’s ability to exercise clinical privileges in his/her specialty area, or would require an accommodation to exercise those privileges safely and competently?</td>
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Comments:

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<th>Question</th>
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© Kathy Matzka, CPMSM, CPCS
Training Program Director’s Evaluation and Recommendation

Re: [Applicant’s full name]
Training: [Residency/fellowship]
Specialty: [Specialty]
Dates: [From/to]

Please rate the applicant in each of the following areas:

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<th></th>
<th>Excellent</th>
<th>Good</th>
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<tr>
<td>Patient care/Procedural Skills</td>
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<td>Medical knowledge</td>
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<td>Practice-based learning and improvement</td>
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<td>Interpersonal and communication skills</td>
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<td>Professionalism</td>
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<td>Systems-based practice</td>
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This evaluation is based upon:

- Personal knowledge of the applicant.
- Review of file.
- Other

Overall Recommendation (check ONE):

- I recommend privileges as requested without reservation.
- I recommend privileges as requested with the following reservation(s) (use back of form, if necessary)

- I do not recommend this applicant for the following reason(s)

Signature ____________________________ Date ____________________________

Name, Position/Title (Please Print) ____________________________ Phone Number ____________________________

Please return this form within 2 weeks. Failure to receive the form will delay consideration of the applicant’s request for privileges.
Sample Letter: Facility Privileges and Competency Validation

Date

Facility Name
Facility Address

Regarding applicant: John Doe, M.D.
Specialty: General Surgery

Dear Medical Services Professional:

We have received an application from the above-named provider for medical staff appointment and privileges. A copy of the privileges requested is attached. The applicant noted that s/he currently, or has in the past, held privileges at your facility. In order to process the application we require documentation experience, ability, and current competence on the six areas of “General Competencies” adopted from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative. These competencies include assessment of patient care, interpersonal and communication skills, professionalism, medical knowledge, practice-based learning and improvement, and systems-based practice.

Our policies require completion of the enclosed form. Failure to receive this form will delay consideration of the applicant’s request for privileges. Also, our policies require the physician to document competency in performing specific procedures by allowing our organization to obtain a copy of his/her privilege form from your hospital as well as a list of the actual procedures performed in the past 12 months and the outcomes for those procedures. The applicant has authorized you to provide this information to our organization via signature on the attached Authorization and Release Form.

Sincerely,

Medical Staff Coordinator
CONFIDENTIAL Evaluation of Privileges and Competency Validation

Name of Facility Providing Information: _____________________________________________________________

Name of Practitioner for which Information is Provided: _________________________________________________

Dates on Staff: From ________________________________  To ____________________________________

Has the practitioner been subject to any disciplinary action, restrictions, modifications, or loss of privileges or medical staff appointment either voluntary or involuntary at your facility? □ Yes □ No

Are you aware of any restrictions, modifications, or loss of privileges or medical staff appointment, either voluntary or involuntary, at any another facility? □ Yes □ No

Are you aware of any physical or mental condition that could affect this practitioner’s ability to exercise clinical privileges as requested, or would require accommodation to perform privileges safely and competently? □ Yes □ No

If the answer to any of the above questions is “YES”, please explain:
_________________________________________________________________________
_________________________________________________________________________

Evaluation: Please rate the practitioner in the following areas.

• **Patient Care** is compassionate, appropriate, and effective for the treatment of health problems and promotion of health. Procedural skills are
• **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care
• **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
• **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals
• **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
• **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

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Signature ____________________________ Date ____________________________

Name, Position/Title (Please Print) ____________________________ Phone Number ____________________________

Please return this form within 2 weeks along with a copy of the applicant’s privilege list for your hospital and a list of the actual procedures performed in the past 12 months and the outcomes for those procedures.
Sample Peer Recommendation Letter

Date

Facility Name
Facility Address

Regarding applicant: John Doe, M.D.
Specialty: General Surgery

Dear _____________:

We have received an application from the above-named provider for medical staff appointment and privileges. A copy of the privileges requested is attached. The applicant has listed you as a peer who will be willing to provide a recommendation. In order to process the application we require your evaluation of the applicant’s experience, ability, and current competence in the areas of medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.

Our policies require completion of the enclosed form. Failure to receive this form will delay consideration of the applicant’s request for privileges. You may supplement the form with additional information, if you so desire. The applicant has authorized you to provide this information to our organization via signature on the attached Authorization and Release Form.

Sincerely,

Medical Staff Coordinator
**Sample Peer Recommendation Form**

CONFIDENTIAL Professional Peer Reference & Competency Validation

Page 1 of 2

Name of Applicant:________________________________________________________________________________

Name of Evaluator:____________________________________ Relationship to Applicant:________________________

How well do you know the applicant? □ not well □ casual personal acquaintance □ professional acquaintance □ very well

Do you refer your patients to the applicant? □ yes □ no. If no, list reason(s) why not __________________________________________________________

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### PLEASE RATE THE PRACTITIONER IN THE FOLLOWING AREAS

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<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Unable to evaluate</th>
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<tbody>
<tr>
<td><strong>Medical knowledge</strong> - Practitioner should have a good knowledge of established and evolving biomedical, clinical, and cognate sciences, and how to apply this knowledge to patient care. This is evidenced by completion of educational and training requirements as well as on-the-job experience, inservice training, and continuing education.</td>
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<tr>
<td><strong>Technical and clinical skills</strong> - Skill involves the capacity to perform specific privileges/procedures. It is based on both knowledge and the ability to apply the knowledge.</td>
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<td><strong>Clinical judgment</strong> - Clinical judgment refers to the observations, perceptions, impressions, recollections, intuitions, beliefs, feelings, inferences of providers. These clinical judgments are used to reach decisions, individually and/or collectively with other providers, about a patient’s diagnosis and treatment.</td>
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<tr>
<td><strong>Communication skills</strong> - The provider should create and sustain a therapeutic and ethically sound relationship with other care givers, patients, and their families. He/she should be able to communicate effectively and demonstrates caring, compassionate, and respectful behavior. This also includes effective listening skills, effective nonverbal communication, eliciting/providing information, and good writing skills</td>
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<td><strong>Interpersonal skills</strong> - Areas of evaluation include how the provider works effectively with other professional associates, including those from other disciplines, to provide patient-focused care as a member of a healthcare team.</td>
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<td><strong>Professionalism</strong> - Professionalism is demonstrated by respect, compassion, and integrity. It means being responsive and accountable to the needs of the patient, society, and the profession. It means being committed to providing high-quality patient care and continuous professional development as well as being ethical in issues related to clinical care, patient confidentiality, informed consent, and business practices.</td>
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CONFIDENTIAL Professional Peer Reference & Competency Validation
Page 2 of 2

Name of Applicant: __________________________________________________________

Name of Evaluator: ________________________________________________________

Relevant training and experience – In reviewing the attached request for privileges, do you feel that the applicant’s training and experience are adequate to carry out these procedures?

☐ No - If no, please provide an explanation _______________________________________

☐ Yes

☐ Unable to evaluate

Current competence – In reviewing the attached request for privileges, do you feel that the applicant is currently competent to carry out these procedures?

☐ No - If no, please provide an explanation _______________________________________

☐ Yes

☐ Unable to evaluate

Health Status - Are you aware of any physical or mental condition that could affect this practitioner’s ability to exercise clinical privileges in his/her specialty area, or would require an accommodation to exercise those privileges safely and competently?

☐ No

☐ Yes - If yes, please provide an explanation _______________________________________

☐ Unable to evaluate

Overall Recommendation (check ONE):

☐ I recommend privileges as requested without reservation.

☐ I recommend privileges as requested with the following reservation(s) (use back of form, if necessary)

________________________________________________________

☐ I do not recommend this applicant for the following reason(s)

________________________________________________________

________________________________________________________

________________________________________________________

________________________________________________________

Signature __________________________ Date __________________________

Name, Position/Title (Please Print) __________________________

Phone Number __________________________

Please return this form within 2 weeks. Failure to receive the form will delay consideration of the applicant’s request for privileges.
Focused Professional Practice Evaluation Plan

Practitioner Name:_______________________________________________
Medical Staff Department: _________________________________________
Practitioner Specialty:_____________________________________________

Reason(s) for Review

- Initially requested privilege(s) for current medical/professional staff (list privilege(s)) _________________
- Newly-credentialed practitioner new to staff
- Referred to peer review due to incident
- Low volume of clinical activity
- Trigger (list) _________________________________________________________________________
- Other:______________________________________________________________________________

Duration (Complete for recommended timeframe and/or volume)

- Time Specific:    Start Date: ___________________   End Date:___________________
- Volume Specific:   Designated # of Cases: __________
- Other (specify):_______________________________________________________________________

Method for Monitoring (Check all that apply)

- Chart review
  - Retrospective (name of reviewer)___________________________________________________
  - Concurrent (name of reviewer)_____________________________________________________
- Direct observation by (name of observer)______________________________________________
- Monitoring of diagnostic and treatment techniques and clinical practice patterns via QAPI program
- Proctoring by (name of proctor) _______________________________________________________
- External Review (list criteria met)_____________________________________________________
- Discussions with other individuals, involved in the care of the patient, including consulting physicians, assistants at surgery, nursing and administrative personnel
- Other (list) ___________________________________________________________________________

Additional Individual(s) Assigned for Review/Observation/Monitoring/Proctoring

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Additional Details/Specifics of Plan

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

SIGNATURE:

___________________________________________  Date: ________________________
Departmental Chair

Printed Name of Department Chair
Sample Proctorship Form

Verification of Proctored Procedure/Treatment

If a surgery or an invasive procedure is performed, the Proctor should evaluate the indication for the procedure, the technique for the procedure, how it is performed, and the preoperative, operative, and postoperative care of the patient. The Proctor may utilize the patient’s record, discussion with the physician, and actual observation as the basis for the review.

Proctored Physician: _____________________________ Date: _________________________________

Proctor: ______________________________________________________________________________

Procedure/Treatment:____________________________________________________________________

Comments: _____________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Areas of in need of Improvement:  __________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Procedure Completed Successfully: _____ Yes _____ No

________________________________________
Signature, Proctoring Physician Date

________________________________________
Signature, Proctored Physician Date

© Kathy Matzka, CPMSM, CPCS 10 | P a g e
Proctoring Summary Report

Proctored Physician: ________________________________ Date: __________________

Proctor: ____________________________________________________________________

Number of Procedures/Treatment Episodes Proctored: ____________________________

Comments: ___________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Areas in need of Improvement: ________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Proctoring Completed Successfully: _____ Yes _____ No

___________________________________________________________________________

Signature, Proctoring Physician Date

Department Chair Recommendation

☐ The applicant appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogative of the category to which the appointment was made, and that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments. It is recommended that proctoring cease.

☐ It is recommended that proctoring continue for __________________________________

(list number of procedures and/or time frame)

Comments________________________________________________________________________

________________________________________________________________________________

___________________________________________________________________________

Signature, Department Chairperson Date
## Sample Indicators for LIP APRNs and PAs

<table>
<thead>
<tr>
<th>Specialty</th>
<th>FPPE</th>
<th>OPPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Midwife</td>
<td>• Proctor for first 2 cases vaginal delivery</td>
<td>• 3rd and 4th degree lacerations following vaginal delivery</td>
</tr>
<tr>
<td></td>
<td>• Review of charts for first 5 cases</td>
<td>• Delivery unattended by provider</td>
</tr>
<tr>
<td></td>
<td>• Discussion with nurse manager of OB and NB nursery</td>
<td>• Significant birth trauma</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medical records legibility</td>
</tr>
<tr>
<td>CRNA</td>
<td>• Anesthesiologist present in OR room to proctor first 2 major surgical procedures</td>
<td>• ICU admission due to anesthesia management</td>
</tr>
<tr>
<td></td>
<td>• Discussion with OR nurse manager/OR staff</td>
<td>• Medical records legibility</td>
</tr>
<tr>
<td>Emergency Department PA</td>
<td>• ED physician closely monitor/proctor for (X) shifts</td>
<td>• Death in ED</td>
</tr>
<tr>
<td></td>
<td>• Visual monitoring of (X) procedures performed (i.e. suture of laceration, removal of foreign body, nasogastric intubation etc.)</td>
<td>• Unplanned returns within 48 hours for same complaint</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patients admitted to Med/Surg and moved to ICU within 4 hours of admission</td>
</tr>
<tr>
<td>APRN</td>
<td>Need to customize pertaining to area of practice.</td>
<td>• Refer to/consult with other health care professionals, as appropriate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Order appropriate diagnostic tests</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medication usage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medical records documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Any department-specific indicators relevant to all LIPs</td>
</tr>
</tbody>
</table>
Focused Professional Practice Evaluation (FPPE) Report
(To be included in Credentials File)

Practitioner Name:______________________________________________________

Department:____________________________________________________________

Time Period for Review: From:_____________________ To:__________________

The information from Focused Professional Practice Evaluation has been reviewed and based on this review:

☐ The practitioner is performing well or within desired expectations and it is recommended that current privileges continue and FPPE cease.

☐ Issue(s) exist or trigger(s) met requiring continuation of Focused Evaluation. The specific issue(s) is (are)_____________________________________________

________________________________________________________________
________________________________________________________________

☐ Practitioner has not had sufficient patient volume or has not met assigned FPPE requirements. Continue FPPE for ______ months.

☐ Other____________________________________________________________

_______________________________________________________________

_________________________                     _________________________
Signature, Department Chair          Date

__________________________________                     _________________________
Name Department Chair

Ongoing Professional Practice Evaluation (OPPE) Report
(To be included in Credentials File)

Practitioner Name: ______________________________________________________

Department: _____________________________________________________________

Time Period for Review: From:_____________________ To:__________________

The information from Ongoing Professional Practice Evaluation has been reviewed and based on this review:

☐ The practitioner is performing well or within desired expectations and no further action is warranted. It is recommended that current privileges continue.

☐ Issue(s) exist or trigger(s) met requiring a focused evaluation. The specific issue(s) is (are) ____________________________________________________________

                                                                                   
                                                                                   

☐ Practitioner has had no patient contact for _____ months, notify practitioner and initiate focused review.

☐ Other ________________________________________________________________

                                                                                   
                                                                                   

_________________________                     _____________________________
Signature, Department Chair      Date

____________________________
Name Department Chair
Sample Peer Review Form

WARNING - The information contained in this report is CONFIDENTIAL. Improper disclosure of the information contained herein may result in disciplinary action, as well as civil or criminal penalties.

ASSIGNED TO DOCTOR(S):________________________________________________________

COMMITTEE/DEPARTMENT REFERRED TO:__________________________________________

EVENT DATE:_______________________________________________________________

PATIENT RECORD #:__________________________________________________________

ADMISSION DATE:______________________DISCHARGE DATE:___________________________

PHYSICIAN(S) INVOLVED IN REVIEW  ______________________________________________

REASON FOR REFERRAL: ________________________________________________________

________________________________________________________________________________

SUMMARY:

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________


RESULTS OF PHYSICIAN REVIEW

☐ CARE APPROPRIATE - NO FURTHER ACTION NECESSARY  - Please provide documentation to reflect the bases for decision regarding the appropriateness of review of care/service. (Use back of page, if necessary.)

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

☐ FURTHER ACTION NECESSARY AS STATED BELOW (Use back of page if necessary)

☐ Documentation Only ☐ Counseling ☐ Disciplinary Action ☐ Refer to ______________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________


PHYSICIAN REVIEWER SIGNATURE: _____________________________DATE________________
LOW VOLUME PRACTITIONERS

Admit and Follow Privilege Form

Print Name: ___________________  ___________________ ____________________
First    Last      Degree

Admit and Follow privileges include admitting a patient to the hospital and immediately referring patients to a Hospitalist or other Medical Staff member for inpatient care, following patients during the hospital stay, reviewing the medical record of referred patients and conversing with attending physician, consultants and hospital staff concerning referred patients.

Privileges do not include ordering tests, consultations, drugs or therapies for inpatients or entries in the medical record other than admitting orders.

☐ I request Admit and Follow Privileges.

I certify that I have requested only those privileges for which I am qualified by education, training, current experience and demonstrated competence. I understand that by making these requests that I am bound by the applicable Bylaws and policies of the Medical Staff and hospital. I also attest that my professional liability insurance covers the privileges I have requested.

Refer and Follow Privilege Form

Print Name: ___________________  ___________________ ____________________
First    Last      Degree

Refer and Follow privileges include referring patients to a Hospitalist or other Medical Staff member for inpatient care, following patients during the hospital stay, reviewing the medical record of referred patients and conversing with attending physician, consultants and hospital staff concerning referred patients.

Privileges do not include ordering tests, consultations, drugs or therapies for inpatients or entries in the medical record.

☐ I request Refer and Follow Privileges.

I certify that I have requested only those privileges for which I am qualified by education, training, current experience and demonstrated competence. I understand that by making these requests that I am bound by the applicable Bylaws and policies of the Medical Staff and hospital. I also attest that my professional liability insurance covers the privileges I have requested.
RED FLAGS WORK SESSION
# SAMPLE APPLICATION FOR APPOINTMENT TO MEDICAL STAFF

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MIDDLE NAME</th>
<th>DEGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith</td>
<td>Josiah</td>
<td>Thomas</td>
<td>MD</td>
</tr>
</tbody>
</table>

**Other Name Used/Maiden Name**

**Specialty:** General and Vascular Surgery

## BOARD CERTIFICATION

List the certifying board, the specialty, the date of certification/recertification & expiration.

<table>
<thead>
<tr>
<th>Name of Board</th>
<th>Specialty</th>
<th>Certification/Recertification Date(s)</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Am Board Surgery</td>
<td>General Surgery</td>
<td>1/1/83 and 6/30/03</td>
<td>6/30/2013</td>
</tr>
</tbody>
</table>

☐ Not planning to take boards  ☐ Not eligible to take boards  ☐ Board certification in process. Date scheduled or taken ___/___/___  Specialty __________

## GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Citizenship (If foreign national – USA Status)</th>
<th>Social Security Number</th>
<th>Date of birth</th>
<th>Medicare UPIN</th>
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</thead>
<tbody>
<tr>
<td>USA</td>
<td>321-897-3876</td>
<td>12/13/49</td>
<td>A2194</td>
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</tbody>
</table>

**PRIMARY OFFICE ADDRESS:**

<table>
<thead>
<tr>
<th>Street and Suite Number</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>1110 N. 9th Street</td>
<td>St. James</td>
<td>IL</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone Number</th>
<th>FAX</th>
<th>Name of Office Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>(618) 223-8998</td>
<td>(618) 223-8990</td>
<td>Jennifer Johnston</td>
</tr>
</tbody>
</table>

**SECONDARY OFFICE ADDRESS:**

<table>
<thead>
<tr>
<th>Street and Suite Number</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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</thead>
</table>

<table>
<thead>
<tr>
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<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Office Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**HOME ADDRESS:**

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>43 Green Acres</td>
<td>Smithville</td>
<td>IL</td>
<td>98746</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Beeper Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>(618) 224-8726</td>
<td>( )</td>
</tr>
</tbody>
</table>

## LICENSES AND REGISTRATION

<table>
<thead>
<tr>
<th>State</th>
<th>License Number</th>
<th>Date Granted</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>IL</td>
<td>036-4598874</td>
<td>3/30/99</td>
<td>6/30/11</td>
</tr>
<tr>
<td>LA</td>
<td>MD 4679</td>
<td>7/5/75</td>
<td>7/1/99</td>
</tr>
<tr>
<td>MD</td>
<td>031-036-4598874</td>
<td>3/30/99</td>
<td>6/30/11</td>
</tr>
<tr>
<td>IL Cont Sub</td>
<td>AS 1234567</td>
<td>7/30/75</td>
<td>7/30/12</td>
</tr>
</tbody>
</table>

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**EDUCATION/TRAINING**

<table>
<thead>
<tr>
<th>MEDICAL SCHOOL</th>
<th>Name</th>
<th>U of Illinois</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address, City, State, Zip</td>
<td>Chicago, IL</td>
<td></td>
</tr>
<tr>
<td>Dates of Attendance</td>
<td>From: 5/71 To: 5/75</td>
<td></td>
</tr>
<tr>
<td>Degree Granted/Date</td>
<td>MD</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESIDENCY #1</th>
<th>Name</th>
<th>Earl Long Medical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address, City, State, Zip</td>
<td>Shreveport, LA</td>
<td></td>
</tr>
<tr>
<td>Dates of Attendance</td>
<td>From: 7/75 To: 6/77</td>
<td></td>
</tr>
<tr>
<td>Specialty</td>
<td>General Surgery</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESIDENCY #2</th>
<th>Name</th>
<th>LA State University</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address, City, State, Zip</td>
<td>Shreveport, LA</td>
<td></td>
</tr>
<tr>
<td>Dates of attendance</td>
<td>From: 7/77 To: 6/81</td>
<td></td>
</tr>
<tr>
<td>Specialty</td>
<td>General Surgery</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FELLOWSHIP</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address, City, State, Zip</td>
<td></td>
</tr>
<tr>
<td>Dates of attendance</td>
<td>From: To:</td>
</tr>
</tbody>
</table>

**ALTERNATE(S) - List the name of the Medical Staff appointee(s) who will serve as your alternates and/or proctors.**

**ALTERNATES:**
Don’t have one at this time. Am discussing with several surgeons on your staff.
## WORK HISTORY/HOSPITAL AFFILIATIONS, PAST AND PRESENT

List work history, starting with the present. Include office practice, teaching appointments, employers, current and past hospital affiliations. If additional space is needed, provide details on separate sheet and attach.

<table>
<thead>
<tr>
<th>Name of Organization, Hospital, or Office Practice</th>
<th>Address, City, State, Zip</th>
<th>From:</th>
<th>To:</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Jude Memorial Hospital</td>
<td>4501 St. Jude Place, Shreveport, LA</td>
<td>7/81</td>
<td>12/98</td>
<td>Surgeon</td>
</tr>
<tr>
<td>St. Stephen Catholic Hospital</td>
<td>12 Main Street, Scoville, IL, 63421</td>
<td>4/99</td>
<td>Present</td>
<td>Surgeon</td>
</tr>
</tbody>
</table>

## PERSONAL REFERENCES

List three peer references - **NOT RELATED TO YOU OR A PROSPECTIVE PARTNER** - who have personal knowledge of your current clinical ability, ethical character, and ability to work cooperatively with others. These references should have acquired their knowledge through recent observation of your professional performance and, **at least one must have had organizational responsibility for supervision of your performance. (e.g. department chair, service chief, training program director).**

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Relationship</th>
<th>City, State, Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adam West, MD</td>
<td>11 Brown</td>
<td>Colleague</td>
<td>St. Louis, MO 63108</td>
</tr>
<tr>
<td>Tina Graham, M.D.</td>
<td>University Hospital Emergency Department</td>
<td>Colleague</td>
<td>St. Louis, MO, 63106</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# PROFESSIONAL LIABILITY INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>NAME OF CURRENT CARRIER:</th>
<th>ADDRESS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ILMed, Inc.</td>
<td>1433 St. Louis Road, St. Louis MO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POLICY LIMITS</th>
<th>POLICY NUMBER:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$500,000 per occurrence</td>
<td>MR 4437</td>
</tr>
<tr>
<td>$1,000,000 aggregate</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE UNDERWRITTEN:</th>
<th>DATE OF EXPIRATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/1/03</td>
<td>6/1/11</td>
</tr>
</tbody>
</table>

### PROFESSIONAL BACKGROUND

Please answer the following questions regarding your professional background. If the answer to any question is "yes", please provide the nature and specific details on a separate sheet and attach.

1. Have you ever voluntarily or involuntarily surrendered, or had any pending or completed action involving the denial, revocation, suspension, reduction, limitation, probation, reprimand, or non-renewal of,
   a. a license or certificate to practice medicine or any profession in any state or country
   b. Drug Enforcement Agency or other controlled substance license or registration
   c. membership or fellowship in any local, state, or national professional organization
   d. specialty or subspecialty board certification or eligibility
   e. faculty membership at any medical or other professional school
   f. staff membership or clinical privileges at any hospital, clinic, or healthcare institution

2. Has any hospital, health plan, or government sponsored program ever restricted, suspended, invoked probation, or rejected or terminated your contract?

3. Have you ever been named as a defendant in a case alleging medical negligence, or has a suit for any alleged malpractice ever been brought against you?

4. Do you have any physical or mental health condition, treated or untreated, which in any way impairs your ability in terms of skill, attitude, or judgment to practice to the fullest extent of your license and qualifications or in any way poses a risk of harm to your patients?

5. Have you ever been convicted of a felony, or currently have felony charges pending?
I hereby apply for appointment to the Medical Staff of State Hospital. In making application for appointment to the Medical Staff of State Hospital, I certify that I have received, read, and agree to be bound by the Medical Staff Bylaws, Rules and Regulations and related manuals, and the current hospital policies that apply to my activities as a Medical Staff appointee and that are consistent with the Medical Staff Bylaws, Rules and Regulations and related manuals. Moreover, I specifically pledge that I will maintain an ethical practice, provide for continuous care of all my patients, refrain from fee-splitting or other inducements relating to patient referral, and refrain from providing "ghost" surgical or medical services.

I certify that there has not been any unsuccessful or currently pending challenges to licensure or registration, no loss of medical or dental organization membership, nor loss of medical staff membership or privileges at another hospital, except as noted herein. I understand that my competence and general functioning and performance with regard to my patients and my duties and obligations as a Medical Staff appointee of State Hospital, will be reviewed from time to time by my peers working within the structure of the Medical Staff in accordance with the Bylaws thereof. I hereby give my permission for, and in fact request, such review pursuant to my appointment and reappointment to the Medical Staff of State Hospital, that I will not bring legal action to prevent such review or to recover damages from those participating in such review.

By applying for Medical Staff appointment, I accept the following conditions below during the processing and consideration of my application and for the duration of my medical staff appointment regardless of whether or not I am granted Medical Staff appointment and clinical privileges:

(a) I extend absolute immunity to and release from any and all liability, State Hospital, its authorized representatives, and any third parties, as defined in subsection (c) below, for any acts, communications, reports, statements, documents, recommendations or disclosures involving me, performed, made, requested or received by any third party, including otherwise privileged or confidential information.

The foregoing shall be privileged to the fullest extent permitted by law; such privilege shall extend to the hospital and its authorized representatives, and to any third parties.

(b) I specifically authorize the hospital and its authorized representatives to consult with any third party who may have information, including otherwise privileged information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on my satisfaction of the criteria for Medical Staff appointment as well as to inspect any and all communications, reports, statements, documents, recommendations, or disclosures of said third parties relating to such questions. I also specifically authorize said third parties to release such information, including any and all peer review material from any and all hospitals wherein I have held appointments, to the hospital and its authorized representatives upon request.

The term "hospital and its authorized representatives" means State Hospital and any of the following individuals who have any responsibility for acting upon my application for Medical Staff appointment: the members of the hospital's Board and their appointed representatives, the Chief Executive Officer or his designees, other hospital employees, consultants to the hospital, the hospital's attorney(s) and his/her partners, associates or designees, and all appointees to the Medical Staff. The term "third parties" means all individuals, including appointees to the medical staffs of other hospitals or physicians or health practitioners, nurses or other government agencies, organizations, associations, insurance companies, managed care organizations, credentials verification organizations, partnerships and corporations, whether hospitals, health care facilities or not, from whom information has been requested by the hospital or its authorized representatives or who have requested such information from the hospital and its authorized representatives.

I also agree to provide any additional information as may be requested by the hospital or its authorized representatives. Failure to produce this information will prevent my application from being evaluated and acted upon. A copy of this consent and release is a binding as the original. In submitting this application for the purpose of securing appointment to the Medical Staff of State Hospital, I hereby voluntarily state that all of the information above is complete and truthful. I also voluntarily state that I have made no effort to evade telling the complete truth regarding my professional career. I understand that any incomplete or false statement will lead to automatic withdrawal of this application for appointment. Should I be appointed to the Medical Staff of State Hospital and it is subsequently found that any statement above is false I understand that my Medical Staff appointment and privileges will be automatically terminated.

SIGNATURE________________________________________DATE___________________________

PRINTED OR TYPED NAME Josiah Smith, M.D.

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Page 22
Review the application on the previous pages and list any “red flags”.

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________
EXPEDITED CREDENTIALING RESOURCES
Application Flow Chart

<table>
<thead>
<tr>
<th>Name of Applicant</th>
<th>Department</th>
<th>Application Type</th>
<th>Date Returned</th>
<th>Date Completed*</th>
<th>Days to Complete*</th>
<th>Date Chair Review</th>
<th>Days to Complete Chair Review</th>
<th>Date Credential Committee Recommendation</th>
<th>Days to Complete Credential Committee Recommendation</th>
<th>Date MEC Recommendation</th>
<th>Days to Complete MEC Review</th>
<th>Date Board Action</th>
<th>Days to Complete Board Action</th>
<th>Total Days From Completion to Action</th>
</tr>
</thead>
<tbody>
<tr>
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*A complete application is one in which the application itself is not only complete, but all primary source verification and information required by the medical staff bylaws is completed.*
Sample Medical Staff Expedited Credentialing Policy and Procedure

PURPOSE:

This policy and procedure is made to provide a more efficient mechanism for review of requests for new or renewed applications for appointment and privileges without compromising the quality of the review. “Expedited Credentialing” provides an expedited review and approval process if specific, pre-defined, Board approved criteria are met.

Expedited Credentialing is neither a right nor a privilege, and no applicant is automatically entitled to this type of processing. Candidates who do not meet the criteria for Expedited Credentialing will be processed through the usual credentialing process as specified in the Medical Staff Bylaws.

PROCEDURE:

The Credentials Committee Chair and Medical Staff Coordinator, or their designee, will review each application and its associated documentation, and categorize the application according to the following criteria:

Category One - Expedited:

Category One applications must meet all of the following criteria:

1. The application is complete and accurate with all requested information returned.
2. The application contains no unexplained or alarming gaps in time.
3. No discrepancies in information or negative or questionable information received
4. Unremarkable medical staff/employment history - no frequent moves
5. The applicant's request for clinical privileges is consistent with his/her specialty, based on experience, training, and current competency, and meets applicable criteria.
6. Medical staff appointment, staff status and/or clinical privileges have never been involuntarily resigned, denied, revoked, suspended, restricted, reduced, surrendered, or not renewed at any other health care facility.
7. The applicant has never withdrawn application for appointment, reappointment or clinical privileges or resigned from the medical staff before a decision was made by another health care facility's governing board.
8. The applicant possesses current, valid state license, professional liability insurance (in sufficient limits), and federal and/or state narcotics certificate(s), if applicable.
9. No license(s), DEA or other controlled substance authorizations, or membership in local, state or national professional societies, or board certification have ever been suspended, modified, terminated or voluntarily or involuntarily surrendered or are pending.
10. The applicant has never been named as a defendant in a criminal action and/or has never been convicted of a crime.
11. There are no significant adverse findings reported by the National Practitioner Data Bank, Healthcare Practitioner Data Bank, Federation of State Medical Boards, and/or the American Medical Association/American Osteopathic Association.
12. There are no past or pending malpractice actions, including claims, lawsuits, arbitrations, settlements, awards or judgments that show an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.
13. There are no proposed or actual exclusions and/or any pending investigations of the applicant from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid.

14. The applicant has indicated that he/she can safely and competently exercise the clinical privileges requested, with or without a reasonable accommodation.

15. The applicant’s history shows an ability to relate to others in a harmonious, collegial manner.

16. At the time of renewal of privileges, documentation of activity in the hospital and/or verification from outside healthcare entities and/or peers sufficiently verifies current competence.

17. At the time of renewal of privileges, the results of peer review activities and the quality improvement functions of the medical staff reveal no areas of concern.

**Processing Category One Applications:**

1. The Medical Staff Office receives and processes the application.
2. The appropriate department chair and the Credentials Committee Chair, or designees, review the completed and verified application.
3. The Department and Credentials Committee Chair, or designees, forward a report with findings and a recommendation to the Medical Executive Committee, which reviews the application at its next scheduled meeting.
4. The Chief of Staff forwards the Executive Committee’s recommendation to the Credentials Committee of the Governing Board, which reviews and evaluates the qualifications and competence of the practitioner applying for appointment, reappointment, or renewal or modification of clinical privileges and renders its decision.
   A positive decision by the committee results in the appointment or privileges requested. If the Board Credentials Committee’s decision is adverse to an applicant, the matter is referred back to the Medical Staff Executive Committee for further evaluation. The Board Credentials Committee reports its recommendation to the full Board.
5. The full Board considers and, if appropriate, ratifies all positive Board Credentials Committee decisions at its next regularly scheduled meeting.
6. If, at any point, any reviewer feels the application does not meet Category One criteria, the file will be considered Category Two and the usual review process (Category Two) will be followed.
7. Expedited credentialing decisions will be reported to the Credentials Committee for informational purposes.

**Category Two - Full Review:**

Applications that do not meet ALL requirements as outlined under "Category One" above will be processed and transmitted through the full review process as outlined in the Medical Staff Bylaws.
PRIVILEGES RESOURCES

AAFP Core Privileges Example

CLINICAL PRIVILEGE REQUEST
FOR FAMILY MEDICINE WITH MATERNITY CARE
SOURCE: AMERICAN ACADEMY OF FAMILY PHYSICIANS

CLINICAL PRIVILEGE REQUEST
FOR FAMILY MEDICINE WITH MATERNITY CARE

Name: ________________________________
Effective from __/__/__ to __/__/__

INTRODUCTION OF CORE PRIVILEGES

Family medicine is the medical specialty which provides continuing, comprehensive health care for the individual and family. It is a specialty in breadth that integrates the biological, clinical and behavioral sciences. The scope of family medicine encompasses all ages, both sexes, each organ system and every disease entity.

Core privileges within the department of family medicine should reflect the core curriculum and training offered in accredited family medicine residency programs. The categories and core privileges listed are based on the “Program Requirements for Graduate Medical Education in Family Medicine,” a publication by The Accreditation Council for Graduate Medical Education (ACGME) (http://www.acgme.org/acWebsite/downloads/RRC_progReq/120pr706.pdf), and the “Recommended Curriculum Guidelines for Family Medicine Residents” endorsed by the American Academy of Family Physicians (http://www.aafp.org/x16524.xml). Resources for family physicians and hospitals for special non-core privileges can be found at the AAFP website at aafp.org, including the AAFP position paper on colonoscopy found at http://www.aafp.org/online/en/home/policy/policies/c/colonoscopypositionpaper.html.

ELIGIBILITY

To be eligible to apply for core privileges in family medicine, the applicant must meet the following criteria:

- Current certification or active participation in the examination process leading to certification in family medicine by the American Board of Family Medicine or the American Osteopathic Board of Family Physicians

And/or

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited post-graduate training program in family medicine.

FAMILY MEDICINE CORE PRIVILEGES

☐ Requested Admission, evaluation, diagnosis, treatment and management of infants and children, adolescents and adults for most illnesses, disorders and injuries. Core privileges include but are not limited to:

- The care of neonates and infants, including both well-baby and ill newborns.
- Illnesses, disorders and injuries of childhood, such as pneumonia, asthma, gastrointestinal infections, dehydration and urinary tract infections.
- Illnesses, disorders and injuries of adolescence.
Sample Core Privileges form American Academy of Family Practice

- Illnesses, disorders and injuries of the adult, including but not limited to conditions of the heart, kidney, lung, musculoskeletal system, skin, eye, and nervous system, and including multi-system diseases such as diabetes mellitus, HIV/AIDS and cancer, and including the care of patients requiring admission to intensive care.
- Women’s health, including illnesses, disorders and injuries of the female reproductive and genitourinary systems.
- Pre- and post-operative evaluation and care.
- Acute and chronic diseases of the elderly, including dementias, as well as functional assessment, physiologic and psychologic aspects of senescence and end-of-life care.
- Psychiatric disorders in children and adults, emotional aspects of non-psychiatric disorders, psychopharmacology, alcoholism and other substance abuse.
- The care for patients of all ages with acute illnesses, disorders and injuries in an emergency care setting.
- Community issues, such as child abuse and neglect, domestic violence, elder abuse and neglect, disease prevention and disaster preparedness.
- Procedures such as suturing lacerations, removal of non-penetrating corneal foreign bodies, simple skin biopsies or excisions, incision and drainage of abscesses, burn care, the management of uncomplicated minor closed fractures and uncomplicated dislocations, and such other procedures that are extensions of the same techniques and skills.

Exclusions: Though considered core privileges for Family Medicine, the following privileges will be excluded for this applicant at their request.

________________________________________________________

MOTHER CORE PRIVILEGES

☐ Requested Admit, evaluate and manage pregnancy, labor and delivery, post-partum care, and other procedures related to maternity care, including medical diseases that are complicating factors in pregnancy (with consultation as appropriate). Applicant must provide documentation of at least 2 months obstetrical rotation during family practice residency with 40 patients delivered.

SPECIAL NON-CORE PRIVILEGES

To be eligible to apply for special non-core privileges, the applicant must have documented training and/or experience and current competence in performing the requested procedure(s) consistent with criteria set forth in medical staff policies governing the exercise of specific privileges. This may be accomplished by providing documentation of acceptable supervised training and experience during residency and/or fellowship training, or successful completion of an approved, recognized course when such exists.

C-Section

☐ Requested Application Criteria: Successful completion of an ACGME or AOA accredited residency training program in family medicine or obstetrics and gynecology. Required Previous Experience: A minimum of 30 Cesarean births as primary operator.
Sample Core Privileges form American Academy of Family Practice

Acknowledgement of Practitioner
I acknowledge that I have requested only those privileges for which by current competence, training and/or experience, I am qualified to perform and for which I wish to exercise at the Hospital. I understand that I am bound by the applicable bylaws or policies of the Hospital.

Signed: ________________________________ Date: ____________

Typed or printed name: ________________________________

Department Chair’s Recommendation

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ Recommend all requested privileges
☐ Recommend privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

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Notes:

Department Chair Signature: ________________________________ Date: ________
CORE PROCEDURES

The following are a few examples of procedures from the Family Medicine CORE, illustrating the depth of Family Medicine training. As with other specialties, not every applicant for privileges will choose to do all procedures within the core, and may elect to exclude those procedures from their privilege request. It remains the responsibility of the Family Medicine department chair to forward credentialing/privileging applications to the credentials committee that have been appropriately vetted at the department level.

General

- Arthrocentesis
- Incision and drainage (I & D) abscess
- Incision and drainage (I & D) hemorrhoids
- Breast cyst aspiration
- Burn care
- Excision of skin and subcutaneous lesions
- Excision of cutaneous and subcutaneous tumors and nodules
- Local anesthetic techniques
- Lumbar puncture
- Management of uncomplicated closed fractures and dislocations
- Needle biopsies
- Placement of anterior and posterior nasal hemostatic packing
- Perform skin biopsy or excision
- Peripheral nerve blocks
- Interpretation of electrocardiograms
- Management of non-penetrating corneal foreign body, nasal foreign body
- Repair of lacerations, including those requiring layer closure
- Suprapubic bladder aspiration
- Exercise Treadmill testing
- Vascular access and intubation of newborns
- Management of abnormal Pap, including colposcopy, cryotherapy and LEEP
- Insertion and removal of intrauterine devices
- Tracheal Intubation
- Circumcision
- Central venous line placement
- Paracentesis/Thoracentesis
Maternity Care

- Amniotomy
- Normal spontaneous vaginal delivery of a term vertex presentation, including ante- and postpartum care
- Dilation and curettage (D&C), including suction and postpartum
- Excision of vulvar lesions at delivery
- External and internal fetal monitoring
- Augmentation of labor
- Induction of labor
- Management of uncomplicated labor
- Manual removal of placenta, post delivery
- Operative or assisted vaginal delivery
- Oxytocin challenge test
- Post partum hemorrhage (PPH)
- Post partum endometritis
- Pudendal anesthesia
- Repair of episiotomy, including lacerations/extensions
- Repair of vaginal and cervical lacerations
- Dilation and Curettage for Incomplete Abortion

Note: Appendix A is NOT incorporated by reference into the Core document but instead is to be used by an applicant when seeking privileges when they determine it would be to their benefit. There is no expectation that every physician graduating from a Family Medicine program will have been trained/be competent in all listed procedures. It is the responsibility of the Family Medicine department chair to forward only those requests for privileges that have been appropriately reviewed and vetted at the department level. Alternatively, Appendix A does not represent the entire scope of family medicine. Utilizing Appendix A as a mechanism to restrict privileges for family physicians by interpreting the appendix as a comprehensive delineation of services offered by family physicians would be incorrect.
Family Medicine Clinical Privileges  Source: Core Privileges Published by HCPro

Name: ____________________________________________

Effective from: ___/___/____ to ___/___/____

☐ Initial appointment
☐ Reappointment

All new applicants must meet the following requirements as approved by the governing body effective ___/___/____.

If any privileges are covered by an exclusive contract or an employment contract, practitioners who are not a party to the contract are not eligible to request the privilege(s), regardless of education, training, and experience. Exclusive or employment contracts are indicated by [EC].

Applicant: Check off the “Requested” box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

[Department Chair/Chief]: Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

Other Requirements

Note that privileges granted may only be exercised at the site(s) and setting(s) that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document. Site-specific services may be defined in hospital or department policy.

This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

Qualifications for Family Medicine

☐ To be eligible to apply for core privileges in family medicine, the initial applicant must meet the following criteria:

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)– or American Osteopathic Association (AOA)–accredited residency in family medicine.

AND/OR

Current certification or active participation in the examination process [with achievement of certification within [n] years] leading to certification in family medicine by the American Board of Family Medicine or the American Osteopathic Board of Family Physicians.

Required previous experience: Applicants for initial appointment must be able to demonstrate provision of care, reflective of the scope of privileges requested, for at least 24 inpatients as the attending physician during the past 12 months or demonstrate successful completion of an ACGME- or AOA-accredited residency, clinical fellowship, or research in a clinical setting within the past 12 months.
Family Medicine Clinical Privileges  

Name: ____________________________

Effective from: ____/____/______ to ____/____/______

Reappointment requirements: To be eligible to renew core privileges in family medicine, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and an adequate volume of experience (\[n\] inpatients) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

### Core Privileges

**FAMILY MEDICINE CORE PRIVILEGES**

☐☐ ☐☐ Requested  

Admit, evaluate, diagnose, treat, and provide consultation to adolescent and adult patients with illnesses, diseases, and functional disorders of the circulatory, respiratory, endocrine, metabolic, musculoskeletal, hematopoietic, gastroenteric, and genitourinary systems. [May provide care to patients in the intensive care setting in conformance with unit policies.] Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

**REFER AND FOLLOW PRIVILEGES**

Criteria: Education and training as for family medicine core privileges.

☐☐ ☐☐ Requested  

Perform outpatient preadmission and history and physical, order noninvasive outpatient diagnostic tests and services, visit patient in hospital, review medical records, consult with attending physician, and observe diagnostic or surgical procedures with the approval of the attending physician or surgeon.

**PEDIATRIC CORE PRIVILEGES**

Criteria: As for family medicine core plus:

**Required previous experience:** Demonstrated current competence and evidence of the provision of care, reflective of the scope of privileges requested, to at least 10 pediatric inpatients in the past 12 months.

**Maintenance of privilege:** Demonstrated current competence and evidence of the provision of care to at least [n] pediatric inpatients in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

☐☐ Requested  

Admit, evaluate, diagnose, and treat pediatric patients up to the age of 18 with common illnesses, injuries, or disorders. This includes the care of the normal newborn as well as the uncomplicated premature infant equal to or greater than 36 weeks gestation. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.
Family Medicine Clinical Privileges Source: Core Privileges Published by HCPro

Name: ____________________________
Effective from: ____/____/______ to ____/____/______

GYNECOLOGY CORE PRIVILEGES

Criteria: Must qualify for and be granted privileges in family medicine plus:

Required previous experience: Demonstrated current competence and evidence of provision of care, reflective of the scope of privileges requested, to at least 10 gynecologic inpatients in the past 12 months.

Maintenance of privilege: Demonstrated current competence and evidence of provision of care to at least [n] gynecologic inpatients in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

☐ Requested

Admit, evaluate, diagnose, treat, and provide consultation to postpubescent female patients with injuries and disorders of the female reproductive system and the genitourinary system. [May provide care to patients in the intensive care setting in conformance with unit policies.] Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

OBSTETRICAL CORE PRIVILEGES

Criteria: Must qualify for and be granted privileges in family medicine. Plus, applicant must provide documentation of three to four months’ obstetrical rotation during family medicine residency with [n] patients delivered. Current NALS certification.

Required previous experience: Demonstrated current competence and evidence of the performance of at least 10 deliveries in the past 12 months.

Maintenance of privilege: Demonstrated current competence and evidence of the performance of at least [n] deliveries in the past 24 months based on ongoing professional practice evaluation and outcomes.

☐ Requested

Admit, evaluate, and manage female patients with normal term pregnancy with an expectation of uncomplicated vaginal delivery, management of labor and delivery, and procedures related to normal delivery, including medical diseases that are complicating factors in pregnancy (with consultation). [May provide care to patients in the intensive care setting in conformance with unit policies.] Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

Qualifications for Geriatric Medicine (Applicable when a family medicine physician treats geriatric patients only, has completed a fellowship and/or holds subspecialty certification.)

☐ To be eligible to apply for core privileges in geriatric medicine, the initial applicant must meet the following criteria:

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)– or American Osteopathic Association (AOA)–accredited residency in either family medicine or internal medicine followed by an ACGME- or AOA-accredited fellowship in geriatric medicine.

AND/OR

Current subspecialty certification or active participation in the examination process [with achievement of certification within [n] years] leading to subspecialty certification in geriatric medicine by the American Board of Internal Medicine, or the American Board of Family Medicine, or a Certificate of Added Qualifications in Geriatric Medicine by the American Osteopathic Board of Family Physicians.

© Kathy Matzka, CPMSM, CPCS
Family Medicine Clinical Privileges  
Name: ________________________________
Effective from: ___/___/_____ to ___/___/_____

Required previous experience: Applicants for initial appointment must be able to demonstrate provision of inpatient care, reflective of the scope of privileges requested, for at least 24 patients as the attending practitioner during the past 12 months or demonstrate successful completion of an ACGME- or AOA-accredited residency, clinical fellowship, or research in a clinical setting within the past 12 months.

Reappointment requirements: To be eligible to renew core privileges in geriatric medicine, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and an adequate volume of experience ([n] inpatients) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

Core Privileges

GERIATRIC MEDICINE CORE PRIVILEGES
☐☐ ☐☐  
Requested  Admit, evaluate, diagnose, treat, and provide consultation to older adult patients with illnesses and disorders that are especially prominent in the elderly or have different characteristics in the elderly, including neoplastic, cardiovascular, neurologic, musculoskeletal, metabolic, and infectious disorders. [May provide care to patients in the intensive care setting in conformance with unit policies.] Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.
Family Medicine Clinical Privileges  
Source: Core Privileges Published by HCPro

Name: ________________________________

Effective from: ____/____/______ to ____/____/______

Special Noncore Privileges (See Specific Criteria)
If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore privileges must meet the specific threshold criteria governing the exercise of the privilege requested including training, required previous experience, and maintenance of clinical competence.

CESAREAN SECTION

Criteria: Must qualify for and receive family medicine obstetrics privileges.

Required previous experience: Demonstrated current competence and the successful completion of an accredited one- to two-year family medicine obstetric fellowship in the past 12 months or [n] cesarean births as primary operator during the past 12 months.

Maintenance of privilege: Demonstrated current competence and evidence of [n] cesarean births as the primary operator in the past 24 months.

☐Requested

ATTENDANCE AT DELIVERY TO ASSUME CARE OF NORMAL NEWBORNS

Criteria: Successful completion of an accredited residency which included training in this procedure, or the applicant must have completed hands-on training in this procedure under the supervision of a qualified physician preceptor. Current NALS certification.

Required previous experience: Demonstrated current competence and evidence of attendance at [n] deliveries in the past 12 months.

Maintenance of privilege: Demonstrated current competence and evidence of attendance at [n] deliveries in the past 24 months based on results of quality assessment/improvement activities and outcomes.

☐Requested

CIRCUMCISION

Criteria: Successful completion of formal training in this procedure or the applicant must have completed hands-on training in this procedure under the supervision of a qualified physician preceptor. Evidence of having performed [n] proctored procedures during training.

Required previous experience: Demonstrated current competence and evidence of the performance of at least [n] procedures in the past 12 months.

Maintenance of privilege: Demonstrated current competence and evidence of the performance of at least [n] procedures in the past 24 months based on results of quality assessment/improvement activities and outcomes.

☐Requested
Family Medicine Clinical Privileges  
*Source: Core Privileges Published by HCPro*

Name: ________________________________  
Effective from: ___/___/______ to ___/___/______

**FLEXIBLE SIGMOIDOSCOPY**

**Criteria:** Successful completion of an ACGME- or AOA-accredited residency in family medicine that included training in flexible sigmoidoscopy or evidence of prior training and experience.

**Required previous experience:** Demonstrated current competence and evidence of at least 30 procedures in the past 12 months.

**Maintenance of privilege:** Demonstrated current competence and evidence of the performance of at least [n] procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

☐ Requested

**LUMBAR PUNCTURE**

**Criteria:** Successful completion of an ACGME- or AOA-accredited residency in family medicine that included training in lumbar puncture, or evidence of active clinical practice in the procedure.

**Required previous experience:** Demonstrated current competence and evidence of the performance of at least [n] lumbar punctures in the past 12 months.

**Maintenance of privilege:** Demonstrated current competence and evidence of the performance of at least [n] lumbar punctures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

☐ Requested

**VENTILATOR MANAGEMENT**

**Criteria:** For ventilator cases not categorized as complex (up to 36 hours), successful completion of an ACGME- or AOA-accredited postgraduate training program that provided the necessary cognitive and technical skills for ventilator management not categorized as complex.

For complex ventilation cases, the applicant must demonstrate successful completion of an accredited fellowship that provided the necessary cognitive and technical skills for complex ventilator management.

**Required previous experience:** Demonstrated current competence and evidence of the management of at least [n] mechanical ventilator cases in the past 12 months.

**Maintenance of privilege:** Demonstrated current competence and evidence of the management of at least [n] mechanical ventilator cases in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

*Source: California Thoracic Society Position Paper—Clinical Privileges for Mechanical Ventilator Management 05/25/06*

☐ Requested  Ventilator Management (not complex including CPAP—up to 36 hours)

☐ Requested  Complex, including BiPAP. *More than 36–48 hours, or for patients defined as those having any of the following ongoing characteristics or any other of similar complexity: PEEP requirement ≥ 10 cm of water; FIO₂ requirement ≥ 0.6; static plateau pressure ≥ 30 cm of water; presence of significant preexisting pulmonary disease; multisystem organ failure; chronic ventilator dependence; patient not meeting previous criteria, but clinical condition deteriorating.*

**ADMINISTRATION OF SEDATION AND ANALGESIA**

☐ Requested  See Hospital Policy for Sedation and Analgesia by Non-Anesthesiologists
Family Medicine Clinical Privileges

Name: ____________________________
Effective from: ___/___/______ to ___/___/______

Core Procedure List

This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

To the applicant: If you wish to exclude any procedures, please strike through those procedures that you do not wish to request, initial, and date.

General

1. Arthrocentesis and joint injection
2. Burns, superficial and partial thickness
3. Chronic ventilator management
4. I & D abscess
5. Local anesthetic techniques
6. Manage uncomplicated minor closed fractures and uncomplicated dislocations
7. Perform history and physical exam
8. Perform simple skin biopsy or excision
9. Peripheral nerve blocks
10. Placement of anterior and posterior nasal hemostatic packing
11. Remove nonpenetrating foreign body from the eye, nose, or ear
12. Suture uncomplicated lacerations

Pediatrics

1. I & D abscess
2. Manage uncomplicated minor closed fractures and uncomplicated dislocations
3. Perform history and physical exam
4. Perform simple skin biopsy or excision
5. Remove nonpenetrating corneal foreign body
6. Suture uncomplicated lacerations

Gynecology

1. Biopsy of cervix, endometrium
2. Colposcopy
3. Cryosurgery/cautery for benign disease
4. Diagnostic cervical dilation and uterine curettage
5. Excision/biopsy of vulvar lesions
6. Incision and drainage of Bartholin duct cyst or marsupialization
7. Insertion of intrauterine devices
8. Perform history and physical exam
9. Removal of foreign body from vagina
10. Suturing of uncomplicated lacerations
11. Uterine curettage following incomplete abortion
Family Medicine Clinical Privileges Source: Core Privileges Published by HCPro

Name: ________________________________

Effective from: ___/___/______ to ___/___/______

**Obstetrics**

1. Amniotomy
2. Augmentation of labor
3. D&C including suction and postpartum
4. Excision of vulvar lesions at delivery
5. External and internal fetal monitoring
6. Induction of labor with consultation and pitocin management
7. Initial management of post partum hemorrhage (PPH)
8. Investigative OB ultrasound for presentation only
9. Management of prenatal and postpartum care
10. Management of uncomplicated labor including normal spontaneous vaginal delivery or a term vertex presentation
12. Normal spontaneous vaginal delivery
13. Oxytocin challenge test
14. Perform history and physical exam
15. Post partum endometritis
16. Pudendal anesthesia
17. Repair of episiotomy—first, second, and third degree
18. Repair of vaginal lacerations
19. Vacuum assisted delivery

**Geriatric Medicine**

1. Apply the general principles of geriatric rehabilitation, including those applicable to patients with orthopedic, rheumatologic, cardiac, and neurologic impairments
2. Assess patient to includes medical, affective, cognitive, functional status, social support, economic, and environmental aspects related to health
3. Manage areas of special concern such as falls and incontinence
4. Manage aspects of preventive medicine, including nutrition, oral health, exercise, screening, immunization, and chemoprophylaxis against disease
5. Manage the appropriate interdisciplinary coordination of the actions of multiple health professionals, including physicians, nurses, social workers, dieticians, and rehabilitation experts, in the assessment and implementation of treatment
6. Perform history and physical exam
7. Recognize and evaluate cognitive impairment
8. Treat and prevent iatrogenic disorders
Family Medicine Clinical Privileges  

Name: ____________________________

Effective from: ___/___/______ to ___/___/______

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and that I wish to exercise at Hospital, and I understand that:

a. In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signature: ____________________________   Date: ________________

[DEPARTMENT CHAIR/CHIEF]'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

Recommend all requested privileges.
Recommend privileges with the following conditions/modifications:
Do not recommend the following requested privileges:

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<th>Privilege</th>
<th>Condition/Modification/Explanation</th>
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Notes

________________________________________________________________________

________________________________________________________________________

[Department Chair/Chief] Signature: ____________________________   Date: ________________

FOR MEDICAL STAFF OFFICE USE ONLY

Credentials Committee action  Date: ________________
Medical Executive Committee action  Date: ________________
Board of Trustee action  Date: ________________
Modified Core Example

Qualifications

To be eligible to apply for privileges in family medicine, the applicant must meet the following criteria:

Training:

MD or DO with successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency in family medicine. (Does not apply to current medical staff appointees.)

Board Certification

One of the following requirements must be met:

1. Current certification in family medicine by the American Board of Family Medicine or the American Osteopathic Board of Family Physicians; or
2. Actively seeking Board certification with achievement of certification within 1 year of appointment.

Board certification requirements do not apply to any practitioner already a member of the Medical Staff as of ____________________.

Required previous experience

Applicants for initial appointment or initial privileges must be able to demonstrate adequate experience reflective of the scope of privileges requested in order for the medical staff to make a reasoned decision regarding the competency of the practitioner.

Reappointment requirements

To be eligible to renew privileges in family medicine, the applicant must demonstrate current demonstrated competence and an adequate volume of experience with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation, monitoring through the Medical Staff Quality Improvement Program, and patient care outcomes.

Privileges Requested

Applicant Instructions: Check off the “Requested” box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges. Requests for privileges not included on this form should be made in writing and include documentation of training and experience. Please check only the boxes reflective of your practice specific to this hospital.

☐ Referring Staff Category Privileges - Refer patients to the Hospital for outpatient testing and/or procedures and refer patients to Active Staff members or Hospitalists for inpatient treatment. (Referring Staff may visit their referred patients in the Hospital, review patients’ medical records and receive information concerning patients’ medical condition and treatment, but may not participate in any inpatient treatment or make any entries in the medical record.)
Applicants for Refer and Follow category are not eligible to request additional privileges. Stop here and review and sign the Acknowledgment section of this form.

- **Active Staff Privileges** - > 2 patient admissions per month or > 24 per year
- **Courtesy Staff Privileges** - < 2 patient admissions per month or < 24 per year
- **Consulting Staff Privileges** - Evaluate, diagnose, treat, and provide consultation to adolescent and adult patients on request of an Active or Courtesy Staff member.

**Adult Medicine Privileges/Procedures**

- Admit, evaluate, diagnose, treat, and provide consultation to adolescent and adult patients; assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services; provide care to patients in the intensive care setting; performance of history and physical exam; care of the normal newborn and uncomplicated premature infant equal to or greater than 36 weeks gestation.
- Arthrocentesis and joint injection
- Bone marrow aspiration/biopsy
- Burns, superficial and partial thickness
- I & D abscess
- Local anesthetic techniques
- Lumbar puncture
- Manage uncomplicated minor closed fractures and uncomplicated dislocations
- Osteopathic manipulative treatment using isotonic, isometric forces
- Perform simple skin biopsy or excision
- Peripheral nerve blocks
- Placement of anterior and posterior nasal hemostatic packing
- Remove nonpenetrating foreign body from the eye, nose, or ear
- Suture uncomplicated lacerations
- Vasectomy
- Administration of Conscious Sedation and Analgesia

**Additional Qualifications for Conscious Sedation and Analgesia:**
- Initial applicants must complete Qualifying Examination for Sedation/Analgesia
- For recredentialing, must have performed a minimum of ten (10) cases per year within the two (2) year reappointment period (total of 20 cases) OR must retake and successfully pass the Qualifying Examination for Sedation/Anesthesia.
Modified Core Example for Family Medicine

Pediatric Privileges/Procedures
- Newborn Circumcision
- I & D abscess
- Lumbar puncture
- Manage uncomplicated minor closed fractures and uncomplicated dislocations
- Perform simple skin biopsy or excision
- Remove nonpenetrating corneal foreign body
- Suture uncomplicated lacerations
- Administration of Conscious Sedation and Analgesia

Additional Qualifications for Conscious Sedation and Analgesia:
- Initial applicants must complete Qualifying Examination for Sedation/Analgesia
- For recredentialing, must have performed a minimum of ten (10) cases per year within the two (2) year reappointment period (total of 20 cases) OR must retake and successfully past the Qualifying Examination for Sedation/Anesthesia.

Gynecology Privileges/Procedures
- Biopsy of cervix, endometrium
- Colposcopy
- Cryosurgery/cautery for benign disease
- Diagnostic cervical dilation and uterine curettage
- Excision/biopsy of vulvar lesions
- Incision and drainage of Bartholin duct cyst or marsupialization
- Insertion and removal of intrauterine devices
- Removal of foreign body from vagina
- Suturing of uncomplicated lacerations
- Uterine curettage following incomplete abortion

Obstetrical Privileges/Procedures
- Amniotomy
- Attendance at delivery to assume care of normal newborns
- Augmentation of labor
- Cesarean section
- D&C including suction and postpartum
- Excision of vulvar lesions at delivery
- External and internal fetal monitoring
- Induction of labor, medical
- Induction of labor, rupture of membranes
- Initial management of post partum hemorrhage (PPH)
- Investigative OB ultrasound for presentation only
- Management of prenatal and postpartum care
- Management of uncomplicated labor including normal spontaneous vaginal delivery or a term vertex presentation
- Manual removal of placenta, post delivery
- Normal spontaneous vaginal delivery
- Oxytocin challenge test
- Post partum endometritis
- Pudendal anesthesia
- Repair of episiotomy—first, second, and third degree
- Repair of vaginal lacerations
- Vacuum assisted delivery
Acknowledgement of Practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, for which my professional liability insurance will cover, and that I wish to exercise at [Hospital Name]. I understand that:

a. In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

c. If any privileges are covered by an exclusive contract or an employment contract, practitioners who are not a party to the contract are not eligible to request the privilege(s), regardless of education, training, and experience.

Signature: _____________________________       Date: _________________

Department Chair’s Recommendation

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ I recommend all requested privileges.

☐ I recommend privileges with the following conditions/modifications (include explanation):

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<th>Privilege</th>
<th>Condition(s)/Modification(s)/Explanation</th>
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☐ I do not recommend the following requested privileges (include explanation):

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<th>Privilege</th>
<th>Condition(s)/Modification(s)/Explanation</th>
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_______________________________________                   ___________________
Department Chair Signature                                    Date
Procedure for Determining “Core” Privileges in Each Specialty

1. The medical staff office shall provide to each department chief the following information:
   a. The current privilege form listing the procedures or clinical activities currently considered within the specialty area.
   b. Information concerning privileges that the hospital granted which would traditionally have been considered outside of the applicants’ specialty areas and the training and/or experience the applicants demonstrated to support their requests. This information will be useful in determining what, if any, “grandfather” clauses might be needed as new criteria are adopted.
   c. Information concerning the training and experience required to qualify for Board certification in the relevant specialties.

2. The department chief shall review the information provided and shall prepare a preliminary set of core privileges for each specialty included within his or her department, and the threshold criteria applicants would be required to meet to be granted those privileges. The department chief may delegate to a subspecialist within the department the task of preparing preliminary core privileges and threshold criteria for those subspecialties. If there are to be several levels of privileges, criteria should be developed for each level. Criteria for special procedures can be developed using the same format and procedures.

3. Threshold criteria shall outline at least the following:
   a. Minimum formal training — ACGME and/or AOA-accredited residency, fellowship, rotations during residency, continuing medical education seminars, etc.
   b. Acceptable alternatives — This should be expressed in quantifiable, objective standards, e.g., “completion of an eight-month rotation in the relevant specialty area” or “documented performance of at least ten of the procedures.”
   c. References/evaluations — For example, “satisfactory evaluation from residency program director or chief of relevant department from previous hospital.” Evaluation forms will generally provide more useful information than letters of reference.
   d. Experience — This is especially important for granting procedures to applicants who completed a residency some time ago. For example, the criteria may require such applicants to provide evidence that they have performed the particular procedure at least 15 times in the last 12 months.

4. The department chiefs shall submit the core privilege lists and threshold criteria they have developed to the Credentials Committee. The Credentials Committee shall review the submissions of the department chiefs to determine if there are privileges which overlap specialties and/or departments. The Credentials Committee, after consulting with the affected department chiefs if necessary, shall resolve any conflicts and shall forward its recommendations regarding core privilege lists and threshold criteria to the Executive Committee.

5. The Executive Committee shall review the core privilege lists and threshold criteria submitted by the Credentials Committee, clarify any questions or conflicts that may remain, and then forward the core privilege lists and threshold criteria to the Board.

6. The Board shall review the core privilege lists and threshold criteria. If the Board has any questions or concerns, it may refer the matter back to the Executive Committee for clarification. The core privileges and threshold criteria required for each specialty shall be effective upon adoption by the Board.

REPRINTED FROM THE MEDICAL STAFF LEADER HANDBOOK
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Worksheet for Development of Core Privileges

Specialty/Subspecialty _____________________________________________

Instructions: Begin by filling out the first column with all the procedures that a provider in this specialty would receive training for in an ACGME approved training program. Use the two additional columns as check off boxes for the procedures listed in column one.

<table>
<thead>
<tr>
<th>Procedures included in current residency training program</th>
<th>Procedures/privileges included in residency training program that are included on the current privilege list for this specialty</th>
<th>Privileges currently performed that cross specialties or are controversial in nature</th>
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WORKSHEET FOR DEVELOPMENT OF CORE PRIVILEGES – Page 2

Procedures/privileges currently granted at this facility that are NOT included in residency training program for this specialty

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Criteria for Performing</th>
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List any procedures not included in training received before a certain date (ie: laparoscopic surgery, use of laser). These procedures should not be included in the core.

<table>
<thead>
<tr>
<th>Name of procedure</th>
<th>Year included in training program</th>
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Other notes/comments:

____________________________________________________
### Work Sheet for Consideration of New Privilege

**Name of procedure/privilege**

Education required to request privilege (check all that apply)

- [ ] MD - Medical Doctor
- [ ] DO - Osteopathic Physician
- [ ] DDS - Oral and Maxillofacial Surgeon
- [ ] DMD - Dentist
- [ ] DPM - Podiatrist
- [ ] APN – Advance Practice Nurse (specify specialty)
- [ ] PA – Physician Assistant (specify specialty)
- [ ] DC – Chiropractic
- [ ] Other (specify)

**Training Required:**

*Enter any required training here.*

Experience required

*Enter any required experience here.*

**Additional Requirements:**

- [ ] CME
- [ ] Manufacturer’s Training Course/Certificate
- [ ] Board Certification
- [ ] Peer Recommendations

Is monitoring or proctoring required?

- [ ] No
- [ ] Yes.

*If yes, specify the following:*

- [ ] Number of procedures
- [ ] Length of time
- [ ] In order to complete proctorship/monitoring requirements, the applicant must perform

  _____ (number) procedures within _________(time frame).

**What type of review or follow up will be conducted?**

*Enter any required review or follow up here.*
DOCUMENTING RECOMMENDATIONS

Sample language for medical staff minutes:

“Committee members reviewed the applications, the supporting documentation, the Department Chairmen’s recommendations, and information received during the credentialing and privileging processes [or insert OPPE/FPPE etc., as appropriate]. Based on this review, it is the committee’s opinion that the following applicants meet the requirements for Medical Staff appointment and have documented appropriate education, training, experience, current competency, clinical judgment, professionalism, and health status to perform the privileges requested. It was moved, seconded, and carried to recommend to the [fill in Credentials Committee or MEC as appropriate] approval of the following appointments and clinical privileges [or insert cessation of FPPE, etc].”

Sample language for Board minutes:

“Board members reviewed the applications, the supporting documentation, the Department Chairmen’s recommendations, Medical Executive Committee’s recommendations, and information received during the credentialing and privileging processes [insert OPPE/FPPE etc., as appropriate]. Based on this review, it is the Board’s opinion that the following applicants meet the requirements for Medical Staff appointment and clinical privileges [insert cessation of FPPE etc., as appropriate] as recommended and it was moved, seconded, and carried to approve of the following appointments and clinical privileges [insert cessation of FPPE, etc].”
Recommendation and Approval Form for Medical Staff Appointment and Clinical Privileges

Practitioner Name:____________________________________________________________________
Staff Status:__________________ Department:__________________Specialty:_________________________

**Departmental Recommendation**

Based on the evaluation of the education, training, current competence, health status, skill, character, and judgment of the applicant the following recommendations are made:

- Privileges be granted/renewed
- Medical staff membership be granted/renewed
- Additional privileges requested be granted
- Privileges be modified as follows:

- Privileges not be granted/renewed
- Medical staff membership not be granted/renewed (comment below)
- Additional privileges requested be denied (comment below)

Comments:_________________________________________________________________________________

_________________________  ____________________________
Department Chairman                  Date

**Credentials Committee Recommendation**

Based on the evaluation of the education, training, current competence, health status, skill, character, and judgment of the applicant and on the evaluations and recommendations of the Department Chairman the following recommendations are made:

- Concur with recommendation(s) of the Department Chairman and forward these recommendations to the Medical Executive Committee
- Do not concur with the recommendations of the Department Chairman, and instead make the following recommendations

_________________________  ____________________________
Credentials Committee Representative                                 Date

**Medical Staff Executive Committee Recommendation**

Based on the evaluation of the education, training, current competence, health status, skill, character, and judgment of the applicant, and on the evaluations and recommendations of the Department Chairman and Credentials Committee, the following recommendations are made:

- Concur with recommendation(s) of the Department Chairman and Credentials Committee and forward these recommendations to the governing body for consideration.
- Do not agree with the recommendations of the Department Chairman, and Credentials Committee and instead make the following recommendations:

_________________________  ____________________________
Medical Staff Executive Committee Representative                                    Date

**Governing Body Approvals/Action Taken**

Based on the evaluation of the education, training, current competence, health status, skill, character, and judgment data and information, and on the recommendations of the Medical Staff, the following action is taken:

- Concur with and approve the recommendation(s) of the Medical Staff.
- Do not concur with the recommendations of the Medical Staff. Action taken is documented in Board minutes of __________________.(date)

_________________________  ____________________________
Board of Trustees Representative             Date
NOTIFICATION OF INTERNAL AND EXTERNAL PARTIES REGARDING PRACTITIONER PRIVILEGES

Policy:

Key external and internal persons and organizations must be notified whenever a change occurs in a practitioner’s privileges or when a new practitioner is granted privileges or appointment. Some internal sources require information regarding clinical privileges granted, while others require only a general notification.

Procedure:

Internal Sources:

General Notification of New Practitioner:

When a new practitioner is granted medical staff appointment or clinical privileges, a general notification should be distributed via email or memo to all hospital departments. The following information should be included:

Full name, credential, address, phone, fax, pager/paging service number, partners, alternates, effective date, picture, sponsoring physician (if AHP).

General Notification Practitioner Leaving Staff:

When a practitioner leaves the staff, a general notification should be distributed via email or memo to all hospital departments. The following information should be included:

Full name, credential, forwarding address (if applicable), and effective date.

Notification of Privileges

When new privileges are granted either to a new applicant or an existing medical staff member or allied health professional; or when there is a modification (addition, deletion, termination, proctorship, etc.) to current privileges; the following internal personnel should be notified via email or memo and a copy of the privileges (or modification to privileges) should be included with the notification. (Note: Will need to modify this language to reference privileges that are posted via intranet or other electronic means).

[Name] Admitting Department
[Name] Operating Room
[Name] Nursing Administration (for distribution to all nursing units)
[Name] Administration
[Name] Emergency Department
[Name] Outpatient/Ambulatory Clinic(s)
[Name] Quality Management
The Health Care Quality Improvement Act of 1986 includes a requirement for reporting of certain adverse actions to the National Practitioner Data Bank. Hospitals must report:

1. A professional review action which adversely affects a physician's or dentist's clinical privileges for more than 30 days and is based upon the physician's or dentist's professional competence or professional conduct; and

2. The voluntary surrender of clinical privileges by a physician or dentist who is under investigation relating to questions of professional competence or conduct, or in return for no investigation or professional review action being conducted.

A professional review action includes denying, reducing, restricting, revoking and suspending privileges, and also includes a decision not to renew clinical privileges if that action is based on the physician's or dentist's professional competence or conduct.

Hospitals must submit adverse action reports to the appropriate state licensing board within 15 days of final Board action in the case of an adverse action or within 15 days of the date the physician surrenders his or her clinical privileges. These reports must be submitted electronically to the National Practitioner Data Bank as an Adverse Action Report. Within 15 days, a printed copy of the electronic report must be forwarded to the state medical licensing board.

Revisions to previously reported adverse actions must also be reported. For example, if a physician's clinical privileges are reinstated after a 45 day suspension, both the suspension and the reinstatement must be reported.

Note: All reports to state licensing boards and the NPDB should be coordinated with the Legal Department.