HARRIS METHODIST SOUTHLAKE
Center for Diagnostics & Surgery

* * * Notice to Applicant * * *

Our goal is to process your application quickly and get all information verified within 60 days of receipt.
Incomplete applications will not be processed and may be returned to the sender.
Here are things you can do to help in processing your application:

1. Provide the name, **current** addresses, telephone numbers and fax numbers for your training program director and the current program director, if different; all past and present hospital affiliations (medical staff office), with dates of affiliation, etc. **Please be accurate with dates.**

2. Include names and complete addresses for **all** professional liability coverage for the past five (5) years, including any self-insured trusts, and details of **all** malpractice claims, settlements or judgements, closed or pending, including the amounts of any settlements during the past ten (10) years. (Attachment G)

3. Submit a recent photo of yourself with your application. You will be asked to provide a government or state issued ID.

4. Provide three (3) professional references as indicated on the application with current, complete addresses, telephone and fax numbers for each one. **Avoid references with obvious conflict of interest issues. Please contact the individuals listed on your application and ask them to provide a prompt reply to our requests for verification**

5. Provide a list of all cases performed in residency OR if out of training for two (2) or more years, provide a list of cases performed during the past two years at your most recent active hospital (with complications, if applicable). **The privileges request form will indicate the minimum number of cases needed.** Review the privileges you are requesting and submit all information necessary to document training, experience and current competency according to the criteria when applicable (as noted on privilege form or attached criteria).

6. **Incomplete and/or incorrect information** on the application may cause delays in the credentialing process, and may result in a denial of your application. **"See CV"** or **"See previous application"** is unacceptable on an application for medical staff membership and privilege. **Write legibly.**

7. Review your entire application for accuracy and completeness, making sure **all** questions are answered appropriately. Check the dates you have provided for any "gaps" of time, i.e., vacation, leave of absence, relocating, etc. If gaps exist, provide a written explanation. **Any misstatement or omission of information will be considered falsification and may be grounds for the rejection of your application and the refusal to consider any future applications.** Remember that **you are responsible** for providing **all** information necessary to process your application for membership and privileges.

8. Remember if a hospital to which you are applying requires an application fee, your check should be made payable to that hospital. **The application fees for Health Texas Harris Methodist Southlake are $200 for Initial application and $100 for Reapplication.**

9. **Medical Staff Bylaws/Rules & Regulations** are located on the web site: www.hmsouthlake.com under Medical Staff Services. Review the Physician Compliance Module, Physician Policies; Orientation Manuals will be provided within 30 days of Board approval to **Health Texas Harris Methodist Southlake.**

10. Please provide copies of all supporting documentation; Sign and return all of the Department addendums; Provide two (2) years CME's or CEU's necessary for licensure; Include a current copy (within the last 12 months) of your PPD test results/chest X-Ray results, etc. You may be asked to provide additional information as needed.

11. **ALLIED HEALTH REFERENCES:** Name **two members of your same discipline and one physician** who have personal knowledge of your current professional abilities, ethical character, health status, and ability to work cooperatively with others and who will provide specif written comments on these matters upon request from HMSCDS and Medical Staff authorities. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time. **None of the individuals should be related to you by family or recently initiated or impending professional partnership/financial association and each should currently have a hospital affiliation.**

HARRIS METHODIST SOUTHLAKE
Center for Diagnostics & Surgery

Attachment H

HOSPITAL ADDENDUM

TO THE TEXAS DEPARTMENT OF INSURANCE (TDI) STANDARDIZED CREDENTIALING APPLICATION

(Attach recent wallet size photo)

SECTION ONE - PERSONAL INFORMATION		
Last Name:	First Name:	Middle Name:
Mobile/Cellular Phone Number:	Pager Number (Required):	Answering Service Number:
Marital Status: _____S _____M	Name of Spouse:	E-mail address (Required):

SECTION TWO - EDUCATION INFORMATION		
Did you complete all your internship/residency/fellowship training programs?	Yes	No
If no, please explain. If additional space is needed, please supply the information as an attachment.		

SECTION THREE – PROFESSIONAL LIABILITY INSURANCE & CLAIMS HISTORY		
Current Type of Policy: Occurrence Claims-Made		
1. Has your insurance carrier ever refused to renew your policy, placed limitations on your scope of coverage, excluded any specific area of practice from your coverage or terminated your coverage?	Yes	No
2. Has your present professional liability insurance carrier excluded any specific area of practice from your coverage?	Yes	No
3. Have you ever been denied professional liability insurance coverage or rated in a higher than average risk class for your specialty?	Yes	No
If you answered yes to any of these questions, please explain. If additional space is needed, please supply the information as an attachment.		
4. Have you *EVER* had any malpractice actions that are pending, settled, arbitrated, mediated, dismissed or litigated?	Yes	No
If you have answered yes to question 4, please complete and submit Attachment G of the TDI Application for each claim.		

HARRIS METHODIST SOUTHLAKE
Center for Diagnostics & Surgery

SECTION FOUR – PROFESSIONAL WORK HISTORY

THE TDI APPLICATION REQUESTS WORK HISTORY FOR ONLY THE PAST FIVE (5) YEARS. PLEASE PROVIDE ALL PROFESSIONAL WORK HISTORY SINCE YOUR COMPLETION OF TRAINING, INCLUDING CLINICS, MEDICAL CENTERS, SOLO PRACTICES, SELF-EMPLOYMENT, EMPLOYMENT OR ANY PRACTICE FROM WHICH YOU RECEIVED AN INCOME BEYOND WHAT YOU DOCUMENTED IN THE TDI APPLICATION IN THE SPACE PROVIDED BELOW. IF ADDITIONAL SPACE IS NEEDED, PLEASE SUPPLY THE INFORMATION AS AN ATTACHMENT. SEE CV OR PREVIOUS APPLICATION IS UNACCEPTABLE.

Name and Nature of Affiliation:				**Dates of Affiliation:**
				From: / / To: / /
Title or Position With Affiliation:				
Complete Address:	City:	State:	Zip:	Phone ( ) Fax ( )
Reason for Discontinuance if No Longer Affiliated:				
Name and Nature of Affiliation:				**Dates of Affiliation:**
				From: / / To: / /
Title or Position With Affiliation:				
Complete Address:	City:	State:	Zip:	Phone ( ) Fax ( )
Reason for Discontinuance if No Longer Affiliated:				
Name and Nature of Affiliation:				**Dates of Affiliation:**
				From: / / To: / /
Title or Position With Affiliation:				
Complete Address:	City:	State:	Zip:	Phone ( ) Fax ( )
Reason for Discontinuance if No Longer Affiliated:				

THE TDI APPLICATION REQUESTS AN EXPLANATION FOR ANY TIME GAPS GREATER THAN SIX MONTHS. EXPLAIN BELOW ALL TIME GAPS IN WORK HISTORY 30 DAYS OR GREATER INCLUDING ANY GAP IN ANY INTERSHIP/RESIDENCY/FELLOWSHIP TRAINING OR DURING ANY TEACHING APPOINTMENT. **IF ADDITIONAL SPACE IS NEEDED, PLEASE SUPPLY THE INFORMATION AS AN ATTACHMENT.**

HARRIS METHODIST SOUTHLAKE Center for Diagnostics & Surgery

SECTION FIVE – HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

1. Have you ever withdrawn an application for medical staff membership or clinical privileges or failed to seek reappointment or renewal of medical staff membership or privileges? Yes No
2. Has your appointment, staff category, scope of clinical privileges, employment or the nature of your medical practice changed at any hospital or other healthcare institution within the last two years? Yes No
3. Have your clinical privileges or Medical Staff membership at any hospital or other healthcare institution ever been voluntarily or involuntarily limited, reduced, excluded, denied, suspended, revoked, restricted, surrendered, relinquished, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have investigations or proceedings toward any of those ends been instituted or recommended by any hospital or other healthcare entity, medical staff or committee, or governing board? Yes No
4. Do you or a member of your immediate family maintain ownership (direct or indirect), or receive compensation from any company or entity providing healthcare services (e.g. clinical labs, hospitals, or diagnostic testing centers) where you could benefit financially from patient referrals (excluding syndications and/or retirement plans)? Yes No

If the answer to any of the above questions is yes, please provide detailed information on separate attachment.

SECTION SIX – ADDITIONAL INFORMATION

1. Have any investigations or disciplinary action ever been initiated or are there now pending challenges against you by any state licensure board? Yes No
2. Has your license to practice ever been involuntarily or voluntarily denied, limited, suspended, revoked, relinquished or surrendered or have you ever been subject to any disciplinary actions, by a state licensing board? Yes No
3. Have you ever been required to obtain additional education or training, proctoring, supervision, or consultation as a result of peer review of quality assurance/improvement or utilization review activities by any type of healthcare entity? Yes No
4. Have you ever been disciplined, excluded from, suspended, reprimanded, sanctioned, censured, investigated, disqualified, declared an ineligible person or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to any other private, federal or state governmental health care plans or programs, or are there any such actions pending? Yes No
5. Have you ever been convicted of, pled guilty to, pled nolo contendere to, or formally charged with a felony or misdemeanour (including DUI) other than minor traffic violations? Yes No
6. Have you ever been charged with or convicted of any crime related to your clinical practice including Medicare or Medicaid related crimes or have you ever been subject to civil money penalties under the Medicare or Medicaid program? Yes No
7. Have your Federal DEA and/or Controlled Substances Certificate(s), registrations or authorization(s) in any state, ever been denied, limited, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished, or are any such challenges currently pending? Yes No
   If so, which registration number and state?
8. If not board certified, have you ever taken the exam given by any specialty board, but failed to pass? Yes No
9. Has your membership in any medical/professional society or association been voluntarily or involuntarily challenged, denied, limited, suspended, revoked or relinquished, or are there any actions currently pending that would affect your membership in any medical/professional society? Yes No

If the answer to any of the above questions is yes, please provide detailed information on separate attachment.

HARRIS METHODIST SOUTHLAKE
Center for Diagnostics & Surgery

SECTION SEVEN – HEALTH STATUS

1. Have you been diagnosed with or in the past received treatment for a physical, mental, chemical dependency or emotional condition which could impair your current ability to provide patient care or fulfil the essential functions of medical staff membership or participation in any healthcare institution? Yes No
2. Are you currently under a monitoring or rehabilitation contract/agreement for any health condition including substance abuse or mental illness, or disruptive behaviour that could impair your current ability to provide patient care or fulfil the essential functions of medical staff membership or participation in any healthcare entity? Yes No
3. Tuberculin (PPD) Test Results:
   Date of Last PPD Test (MM/DD/YYYY):
   Results of Tuberculin (PPD) Test? ____Positive ____Negative If positive, was x-ray taken: Yes No
4. If results of PPD test were positive, have you experienced any of the following symptoms: persistent cough of more than two months, coughing up blood, recurrent night sweats, unexplained weight loss and/or fever? Yes No
5. Are you unable to have a PPD test due to an allergic (anaphylactic) reaction or medical condition? Yes No

If the answer to any of the above questions is yes, please provide detailed information.

SECTION EIGHT – CONTINUING MEDICAL EDUCATION

1. Have you met the minimum continuing medical education requirements for renewal of your license in the past two years? Yes No
2. Please list below or attach a list of the CME credits attained relative to your specialty during the past two years. Also attach a copy of certificates, logs or other documentation of attendance at programs listed. Yes No

Program Title	*Dates Attended*	*Credit Hours/Category*

APPLICATION ACKNOWLEDGEMENT

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

APPLICANT'S SIGNATURE

____DATE ______________________________

APPLICANT'S PRINTED NAME ____

HARRIS METHODIST SOUTHLAKE
Center for Diagnostics & Surgery

MEDICAL RECORDS SIGNATURE SHEET

Printed Name: ____

Signature: ____

Initials: ____

Service Area: ____

Date: ____

HARRIS METHODIST SOUTHLAKE
Center for Diagnostics & Surgery

HARRIS METHODIST SOUTHLAKE

MEDICARE PROVIDER #____________________

MEDICARE ATTESTATION

The following is an extract from the Federal Register (Catalogue of Federal Domestic Assistance Program No. 93.773, Medicare-Hospital Insurance; and Program No. 93.774, Medicare-Supplementary Medical Insurance Program):

"Notice to Physicians"

Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

I have read the above notice:

______________________________________ ______________________

Physician Signature Date

MEDICAID ATTESTATION

"Notice to Physicians"

Medicaid payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal or State funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal and State laws.

______________________________________ ______________________

Physician Signature Date

____

Physician Printed Name

The above statement will be retained as required for as long as you hold medical staff privileges at Harris Methodist Southlake.

HARRIS METHODIST SOUTHLAKE
PHARMACY DEA SIGNATURE FORM

TO: Pharmacy Department

DATE: ______________________________

FROM: ______________________________
Printed Name of Practitioner

____
Signature of Physician

____
Current DEA Number

HARRIS METHODIST SOUTHLAKE
Center for Diagnostics & Surgery

CALL COVERAGE FORM:

NAME (PLEASE PRINT OR TYPE) | SPECIALTY/SUBSPECIALTY

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

THIS FORM MUST BE COMPLETED AND SIGNED BY A PHYSICIAN WHO IS CURRENTLY A MEMBER OF THE MEDICAL STAFF AND PRACTICES IN THE SPECIALTY/SUBSPECIALTY IN WHICH YOU HAVE REQUESTED PRIVILEGES. NO EXCEPTIONS!

I agree to provide patient coverage for the above named physician at Harris Methodist Southlake Center for Diagnostics & Surgery in the event that such physician is unavailable for the medical management of his/her patient.

COVERING NAME (PLEASE PRINT OR TYPE)

COVERING SIGNATURE

COVERING SPECIALTY/SUBSPECIALTY

DATE

HARRIS METHODIST SOUTHLAKE
Center for Diagnostics & Surgery

COMPLIANCE PROGRAM ACKNOWLEDGMENT STATEMENT

I, ______________________________, hereby acknowledge that I have been made aware of the Compliance program and its purpose and intent. I understand that my participation in or lack of is critical to the overall success of **Harris Methodist Southlake Center for Diagnostics and Surgery** and its strategic goals. It is further understood that I will abide by all policies and procedures set forth.

Secondly, I have received a copy of the Standards of Conduct and will abide by them and utilize them as they relate to the provision of care to the patients of HMSCDS.

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

________________________________ ___________
Physician Signature Date

____
Physician Name (Print)

STANDARDS OF CONDUCT are located under PHYSICIAN COMPLIANCE on the Health Texas Harris Methodist Hospital of Southlake web site: www.hmsouthlake.com under Medical Staff Services

HARRIS METHODIST SOUTHLAKE
Center for Diagnostics & Surgery

Surgeon Designation Form for Anesthesiologists

Due to the significant number of requests for applications for anesthesiology privileges, the Medical Executive Committee of Harris Methodist Southlake (HMS) has recommended that all anesthesiologists applying to this medical staff be required to designate a surgeon or surgeons for whose patients you will be providing care. Please complete this form and submit it with your application. Your application will be prioritized according to the date it is submitted plus whether the surgeon you designate is also applying or has been approved for medical staff membership at HMS.

Reminder: The surgeon(s) you designate must be on the Medical Staff at Harris Methodist Southlake or must be in the application process. Please list only those surgeons you currently work with or those who have specifically asked that you apply. The information you submit will be verified.

Name of surgeon(s) you are designating as the surgeon you will be working with at HMS:

____

____

____

Name of surgeon(s) who have specifically requested that you apply for privileges at HMS:

____

____

____

HARRIS METHODIST SOUTHLAKE
Center for Diagnostics & Surgery

Omnicell
Password Verification Statement for Anesthesiology

Last Name First Name Title Department

Agency Name: ____

Start Date: ______________________ End Date: ____________________

Your ID code for the Omnicell will be the first letter of your name and your last name.
ie: Kim Shipley = kshipley

Your pre-assigned P.I.N. is PASS. The first time you access Omnicell you must change your P.I.N. to something only you know.

Note: This P.I.N. is confidential. No one will be able to look it up for you if you forget it.

Please read the statement below and sign at the bottom to verify that you have read and understand the following statement:

I understand that my Omnicell ID in combination with my P.I.N. will be my electronic signature for all transactions in the system and will be permanently attached to those transactions with a time stamp and date. These records will be maintained and archived as per the policies of Harris Methodist Southlake Center for Diagnostics & Surgery and will be available for inspection by the Drug Enforcement Administration (DEA) and the Department of Professional Regulation (DPR), as is presently done with my handwritten signature for Controlled substance records.

I also understand that to maintain the integrity of my electronic signature, I must not give this password to any other individual.

____________________________ ________________________
Signature Date

Please send to Pharmacy to be loaded into Omnicell and to be filed.

HARRIS METHODIST SOUTHLAKE CENTER FOR DIAGNOSTIC AND SURGERY
MEDICAL STAFF
POLICY: MANAGEMENT OF THE DISTRUPTIVE PRACTITIONER

F. Refusal to Cooperate

A Member's failure to appear for counseling or refusal to take any required action or to cooperate with a Medical Staff Officer, the Quality Review Committee, Credentials Committee, Medical Executive Committee or any Special Committee as defined in Article XI – Committees and Functions of the Medical Staff Bylaws regarding such informal activity, <u>may result in automatic relinquishment of Medical Staff Membership and Privileges.</u>

ACKNOWLEDGMENT

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

If at any time I feel as if I am impaired physically or emotionally I will self refer myself to the Medical Staff Behavioral Event Review Committee or the appropriate health care professional or agency for evaluation and/or treatment.

(Note: Presence of this signed statement in the Practitioner's Medical Staff credentials file is required prior to any favorable action by the Board of Trustee's on the Practitioner's application or re-application. Refusal to sign this statement does not exonerate any practitioner from abiding to the Medical Staff Bylaws, Rules & Regulations or any Harris Methodist Southlake Center for Diagnostics and Surgery Hospital Policies.)

________________________________ ____________
Signature Date

____
Please Print Name

____
Please Print Name

Disruptive Practitioner Policy is located under MEDICAL STAFF POLICIES on the Health Texas Harris Methodist Hospital of Southlake web site: www.hmsouthlake.com under Medical Staff Services