



Dear Doctor,

Thank you for your interest in obtaining temporary privileges with Carolinus Specialty Hospital.

To facilitate this process, please return the following information:

- Completed and signed temporary application
- Copy of North Carolina Physicians License
- Copy of DEA Permit
- Copy of Photo Identification (drivers license, military ID)
- Copy of current Malpractice Insurance Coverage
- Release of Liability Consent
- Completed Pharmacy and Medical Record Form
- Completed and signed Delineation of Privileges
- 1 Peer Reference
- Copy of CV

We welcome you to our new hospital and look forward to a mutually successful venture. We are dedicated to providing high quality caring to our patients and a nurturing environment for our staff that rewards growth and development. If you have any questions please call me at 704-335-9113.

Yours truly,

Susan Davis

Susan Davis, CEO



REQUEST FOR TEMPORARY PRIVILEGES

Practitioner Name: _____

Full Address: _____

Telephone #: _____ Fax #: _____

I hereby request Temporary Privileges in accordance with the facility Medical Staff Bylaws for specific privileges, within my specialty training of _____, as requested on the attached delineation of clinical privileges request form for the following circumstances:

- To Meet Important Patient Care, Treatment or Service Need:**(granted to provide care to another practitioner's patient of _____ which said practitioner does not possess privileges to provide such care OR if patient care will suffer)

Patient Name: _____ Room #: _____

Coverage being provided for: (Practitioner's Name): _____

- FULL MEDICAL STAFF MEMBERSHIP APPLICATION IN PROCESS**

I acknowledge that the granting of temporary privileges is a courtesy on the part of the hospital and that the denial, restriction or termination of such temporary privileges does not entitle me to any procedural rights provided in the Medical Staff Bylaws of the hospital. I agree to abide by the bylaws, manuals, rules and regulations, and policies of the medical staff and hospital in all matters relating to my temporary privileges.

THE FOLLOWING DOCUMENTS MUST ACCOMPANY THIS REQUEST:

- Copy of Current State Board Licensure
- Copy of your current Federal (DEA) Registration
- Copy of current State Controlled Substance Registration, if applicable
- Copy of Liability Ins. Coverage (stating dates of coverage and limits of liability)
- Board Certification, if applicable
- Clinical Privilege Form
- Photo ID
- Peer Reference Form
- PPD Status Form

Signature: _____ Date: _____

Documentation must be received and processed to provide evidence of current licensure, relevant training, current competence, and ability of the practitioner to perform the privileges requested prior to being granted temporary privileges. Requested privileges may be restricted during the temporary period at the discretion of the Medical Staff.

CAROLINAS SPECIALTY HOSPITAL
TEMPORARY PRIVILEGES APPLICATION

IDENTIFYING INFORMATION				
LAST NAME	FIRST NAME	MI	BIRTHPLACE	DATE OF BIRTH
OFFICE ADDRESS			CITY, STATE ZIP CODE	OFFICE TELEPHONE NUMBER ()
HOME ADDRESS			CITY, STATE ZIP CODE	HOME TELEPHONE NUMBER ()
BEEPER/PAGER TELEPHONE NUMBER ()			OFFICE FAX TELEPHONE NUMBER ()	
IF GROUP, GROUP NAME:				
OFFICE MANAGER:				
SOCIAL SECURITY NUMBER:			NPI NUMBER:	
MEDICARE PROVIDER NUMBER:			MEDICAID PROVIDER NUMBER:	
MEDICAL EDUCATION (Graduates of foreign medical schools must provide a copy of their ECFMG Certification or evidence of completion of a Fifth Pathway Program)				
School Attended:		Degree Awarded:		Date Received (mm/yyyy):
BOARD CERTIFICATION (Evidence of board certification, if certified, must be attached to this application)				
Are you presently Board Certified? Y / N		Specialty:		Date Certified (yyyy):
PRINCIPLE HOSPITAL: Phone: ()			Staff Category/Status:	
PROFESSIONAL REFERENCE (This person must have personal knowledge of your current clinical abilities, ethical character, health status, and ability to work cooperatively with others)				
Practitioner's Name			Phone Number ()	

HEALTH STATUS	
IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS YES, YOU MUST PROVIDE FULL DETAILS ON A SEPARATE SHEET OF PAPER.	
1. Has any action, proceeding or investigation ever been initiated or taken against you by any governmental or law enforcement agency for your alleged violation of law which may be applicable to your professional practice or provision of care to patients?	Yes No
2. Do you presently have a physical or mental health condition, including alcohol or drug dependence, that affects or is reasonably likely to affect your ability to perform professional or medical staff duties appropriately?	Yes No
3. Are you currently under care for a continuing health problem that would impair your ability to exercise the clinical privileges requested?	Yes No
4. Have you at any time during the past five (5) years been hospitalized or received any other type of institutional care for a health problem? If yes, did it place any limitations on your ability to exercise the clinical privileges you have requested?	Yes No Yes No
5. Have you ever taken a leave of absence from you medical practice for any reason for 30 days or more? If yes, please provide inclusive date and reason for leave.	Yes No

CAROLINAS SPECIALTY HOSPITAL
TEMPORARY PRIVILEGES APPLICATION
IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS YES, YOU MUST PROVIDE FULL
DETAILS ON A SEPARATE SHEET OF PAPER.

CLAIMS HISTORY	
1. Have any professional liability claims been made against you?	Yes No
2. Has any judgment been entered against you in any professional liability case?	Yes No
3. Has any settlement been made in any professional liability case in which you or your professional liability insurance carrier had to or agreed to make a monetary payment?	Yes No
4. Have you been denied professional liability insurance, has your policy been canceled, has your professional liability insurer refused to renew your policy or placed limitations on the scope of your coverage, or has any professional liability carrier expressed an intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage?	Yes No
PRACTICE HISTORY	
Have any of the following ever been, or are any currently in the process of being denied, canceled, revoked, suspended, reduced, limited, placed on probation, under investigation, not renewed, relinquished either voluntarily or involuntarily?	
1. Medical license in any state	Yes No
2. Academic appointment	Yes No
3. Membership on any hospital medical staff	Yes No
4. DEA or DPS registration	Yes No
5. Clinical privileges	Yes No
6. Fellowship/Board certification	Yes No
7. Professional society memberships	Yes No
8. Any other type of professional sanction, including Medicare/Medicaid sanctions	Yes No
9. HMOs, PPOs, or Managed Health Care Plan professional liability insurance	Yes No
10. Have you ever been convicted of a felony?	Yes No
11. Have you ever been convicted of or pleaded no contest to any criminal charges (other than motor vehicle speeding violations)?	Yes No
12. Have you ever been convicted of or pleaded no contest to a drug or alcohol related offense?	Yes No
13. Have you ever been charged with or convicted of any crime related to your clinical practice, including Medicare or Medicaid related crimes?	Yes No
14. Have you ever been involuntarily terminated or forced to resign, or have you ever resigned voluntarily while under investigation or threat of sanction, from a clinical position with the Armed Forces, any federal, state, or local agency, or any other employment or practice arrangement?	Yes No
15. Have you ever executed or are you currently subject to an agreement limiting or prohibiting the geographic area or hospitals in which you can provide medical services?	Yes No

I fully understand that any significant misstatements in or omissions from this application constitute cause for denial of privileges. All information submitted by me in this application is true to the best of my knowledge and belief. In making this application for temporary privileges at this hospital, I acknowledge that I have received the Medical Staff Bylaws of the hospital and that I am familiar with the principles and standards of the Joint Commission on Accreditation of Healthcare Organizations and the principles, standards and ethics of the national, state and local associations that apply to and govern my specialty and/or profession, I agree to be bound by the terms thereof if I am granted temporary clinical privileges, and I further agree to be bound by the terms thereof without regard to all matters relating to the consideration of my application for appointment to the medical staff, and I further agree to abide by such hospital and medical staff policies and rules and regulations as may be from time to time enacted.

Signature: _____ Date: _____

Printed Name: _____

PROPRIETARY AND CONFIDENTIAL

**TEMPORARY PRIVILEGES APPLICATION
AUTHORIZATION AND RELEASE OF LIABILITY**

I fully understand that any significant misstatements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical staff. All information submitted by me in this application is true to the best of my knowledge and belief.

By applying for appointment to the medical staff I hereby signify my willingness to appear for the interviews in regard to my application, authorize the hospital, its medical staff and their representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the hospital, and its medical staff and its representatives of all records and documents, including medical records, at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out clinical privileges requested as well as my moral and ethical qualifications for staff membership. I hereby release from liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the hospital, or its medical staff, in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by this hospital, or its medical staff, to other hospitals, medical associations and other interested persons on request regarding any information the hospital and medical staff may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability this hospital and its staff for so doing.

I understand and agree that I, as an applicant for medical staff membership, have burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I will not participate in any form of fee-splitting. Moreover, I pledge myself to shun unwarranted publicity, dishonest money-seeking, and commercialism; to refuse money trades with consultants, practitioners, makers of surgical appliances and optical instruments, or others; to teach the patient his financial duty to the physician and to expect the practitioner to obtain his compensation directly from the patient; to make my fees commensurate with the service rendered and with the patient's rights; and to avoid discrediting my associates by taking unwarranted compensation.

I have not requested privileges for any procedures for which I am not certified. Furthermore, I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have requested privileges.

Date

Signature of Practitioner

Printed Name of Practitioner

PHARMACY/MEDICAL STAFF SIGNATURE FORM

In accordance with the policy of the Hospital and The Joint Commission on Accreditation of Healthcare Organizations, this form is to be completed/signed and returned with your completed application. It will be filed in the Medical Staff Office, Health Information Management Department and Pharmacy for reference.

Practitioner's Name Printed

Office Address

City, State, Zip Code

DEA Number

NPI Number

Practitioner's Signature

Practitioner's Initials

Date

CC: Pharmacy Department
Health Information Services
Business Office

NOTICE TO PHYSICIANS
Content of physician acknowledgement statement

By signature below, I acknowledge the following:

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.

Medicare Payment under the *long-term acute care hospital* prospective payment system is based in part on each patient's principal and secondary diagnoses and major procedures performed, as evidenced by the physician's entries in the patient's medical record. The hospital must assure that physicians complete an acknowledgement statement to this effect in accordance with paragraphs (b)(1) and (b)(2) of this section. 42 CFR 412.508

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.

ACKNOWLEDGEMENT:

SIGNATURE

DATE

Printed Name

MEDICAL SERVICES

DELINEATION OF PRIVILEGES

APPLICANT'S NAME: _____ DATE: _____

This is my:	<input type="checkbox"/> Initial Application	<input type="checkbox"/> Re-appointment Application	<input type="checkbox"/> I am modifying my privileges
Status:	<input type="checkbox"/> Active	<input type="checkbox"/> Courtesy	<input type="checkbox"/> Consultant <input type="checkbox"/> Temporary

I. Training: Successful completion of an approved residency training program in Internal Medicine or Family Practice, certification by the applicable Board, or admissibility to take the Board with achievement of Board Certification within (two years for FP & six years for IM) of completion of residency training.

II. Experience: The successful applicant must be able to demonstrate provision of inpatient service to at least 15 patients in the past 12 months. (Note: Applicants who are unable to document compliance with noted experience requirements may work on under a preceptor member of the Medical Staff in order to attain required experience).

III. Check the applicable category:

- CATEGORY I:** Core privileges include the admission, work up, diagnosis and provision of non-surgical treatment including consultation patients admitted to the hospital or in need of care to treat general medical problems. These privileges do not include any of the procedures listed in the special requests nor any of the privileges included in the subspecialty areas.

Check the appropriate designations listed below:

- Internal Medicine**
- Family Practice**

- CATEGORY II:** Successful completion of an approved residency training program in Internal Medicine followed by an approved fellowship in the area sub-specialization. Applicant must achieve Internal Medicine Board certification as listed above, and must be qualified for certification by the applicable subspecialty Board and achieve subspecialty certification within six years of completing subspecialty training. These physicians may admit and treat without limitation. These physicians may also act as consultants to others and provide care for complex problems in their sub-specialty area. In turn, they should request consultation whenever needed.

Check the appropriate designations listed below:

- Internal Medicine**
- Family Practice**

Check the appropriate specialty designations listed below:

- Allergy/Immunology
- Cardiology
- Endocrinology/Metabolism
- Emergency Medicine
- Gastroenterology
- Geriatric Medicine
- Hematology
- Infectious Diseases
- Metabolic Immunology
- Nephrology
- Oncology
- Pulmonary Medicine
- Rheumatology

Other (Specify) _____

Check the specific tasks/procedures listed below for which privileges are requested. Report number of procedures performed within the last 12 months, or the number of procedures performed in Residency program if within the past 5 years, or number of proctored procedures by a member of our medical staff. Numbers in **Bold** are required.

	Category II		# Performed last 12 months	or	# Performed Residency	or	Proctored Procedures
	Internal Medicine						
IM 1	<input type="checkbox"/> Biopsy: specify	10		10		5	
IM2	<input type="checkbox"/> Cardioversion	*		*		*	
IM3	<input type="checkbox"/> Central Lines; Arterial and Venous Insertion	20		20		10	
IM4	<input type="checkbox"/> Femoral line Placement	20		20		10	
CS1	<input type="checkbox"/> Moderate Sedation						
	<input type="checkbox"/> Other (specify)						
	Pulmonary						
PU1	<input type="checkbox"/> Bronchoscopy with Conscious Sedation	10		10		5	
PU2	<input type="checkbox"/> Central lines: Arterial and Venous Insertion	20		20		10	
PU3	<input type="checkbox"/> Chest tube Insertion - Thoracostomy	*		*		*	
PU4	<input type="checkbox"/> Indirect Laryngoscopy	*		*		*	
PU5	<input type="checkbox"/> Endotracheal intubation with conscious sedation	20		20		10	
PU6	<input type="checkbox"/> Thoracentesis	*		*		*	
PU7	<input type="checkbox"/> Pulmonary Function Testing ; includes hypoxic and hypercarbic stimulation of ventilation and bronchial provocation tests.	*		*		*	
CS1	<input type="checkbox"/> Moderate Sedation						
	<input type="checkbox"/> Other (specify)						
	Category II		# Performed last 12 months	or	# Performed Residency	or	Proctored Procedures
	Cardiology						
CA1	<input type="checkbox"/> Central lines insertion; Arterial and Venous	20		10		10	
CA2	<input type="checkbox"/> Femoral line placement	20		20		10	
CA3	<input type="checkbox"/> Insertion of transvenous cardiac pacemaker	20		10		10	
CA4	<input type="checkbox"/> Pericardialcentesis	5		5		5	
CS1	<input type="checkbox"/> Moderate Sedation						
	<input type="checkbox"/> Other (specify)						
	Renal						
RE1	<input type="checkbox"/> Hemodialysis	20		20		10	
RE2	<input type="checkbox"/> Femoral line insertion	20		10		10	
RE3	<input type="checkbox"/> Hemofiltration	20		20		10	
RE4	<input type="checkbox"/> Peritoneal dialysis; Acute and Chronic	15		15		5	
RE5	<input type="checkbox"/> Renal biopsy - Percutaneous	5		5		5	
RE6	<input type="checkbox"/> Apheresis (Phersis); includes plasmapheresis, leukopheresis, platelet pheresis, red cell pheresis	5		5		5	
CS1	<input type="checkbox"/> Moderate Sedation						
RE6	<input type="checkbox"/> Other (specify)						
	Neurology						
NE1	<input type="checkbox"/> EEG Interpretation	50		50		25	
CS1	<input type="checkbox"/> Moderate Sedation						
NE2	<input type="checkbox"/> Other (specify)						

* Considered core competency in this specialty. If physician is not in this specialty credentialing committee to review and approve.

	Other Specialty (specify)						
	<input type="checkbox"/>						

Life Threatening Emergency: At the time of a clinical emergency, a practitioner who holds clinical privileges and is a member of the medical staff may render whatever care he/she believes to be indicated.

Applicant Signature

Date

Medical Executive Committee

Date

* Considered core competency in this specialty. If physician is not in this specialty credentialing committee to review and approve.

Carolinas Specialty Hospital

SURGICAL SERVICES

DELINEATION OF PRIVILEGES

APPLICANT'S NAME: _____ DATE: _____

This is my:	<input type="checkbox"/> Initial Application	<input type="checkbox"/> Re-appointment Application	<input type="checkbox"/> I am modifying my privileges
Status:	<input type="checkbox"/> Active	<input type="checkbox"/> Courtesy	<input type="checkbox"/> Consultant

Surgical Services: Physicians with Surgical Services privileges will have training and/or experience on a level commensurate with that provided by the specific approved surgical specialty and subspecialty training program. Applicants will have successfully completed an approved residency training program in the surgical specialty or subspecialty and achieve certification by the applicable specialty or subspecialty Board, or for new graduates, achieve Board Certification with three years of completion of the training program.

These physicians may admit and treat without limitation. They should request consultation for complex and/or multi-system problems and conditions outside their specialty area of training or experience.

Check the appropriate specialty listed below:

- Cardiovascular
- Head/Neck
- General Surgery
- Gynecology
- Neurosurgery
- Ophthalmology
- Oral/Maxillofacial surgery
- Orthopedic Surgery
- Otolaryngology
- Plastic Surgery
- Thoracic
- Urology
- Other (Specify) _____

Life Threatening Emergency: At the time of a clinical emergency, a practitioner who holds clinical privileges and is a member of the medical staff may render whatever care he/she believes to be indicated.

Check the specific tasks/procedure listed below for which privileges are requested:

SPECIFIC TASKS/PROCEDURES	ACTION REQUIRED					
	APPROVAL		DENIAL		SPEC COND	
	MEC REC	Board App	MEC REC	Board App	MEC REC	Board App
<input type="checkbox"/> Consultation						
<input type="checkbox"/> Diagnostic Evaluation						
<input type="checkbox"/> Surgical Care management						
<input type="checkbox"/> History & Physical						
GENERAL SURGERY						
<input type="checkbox"/> Repair of Laceration						
<input type="checkbox"/> Lumbar Puncture						
<input type="checkbox"/> Moderate Sedation						
<input type="checkbox"/> Debridement						
<input type="checkbox"/> Tracheostomy						
<input type="checkbox"/> Thoracentesis						
<input type="checkbox"/> Resection of Skin Lesions						
<input type="checkbox"/>						
OTOLARYNGOLOGY						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
OPHTHALMOLOGY						
<input type="checkbox"/> General Ophthalmic care						
ORTHOPEDICS						
<input type="checkbox"/> Nails						
<input type="checkbox"/> Skin Lesions						
<input type="checkbox"/>						

Applicant Signature

Date

Medical Executive Committee

Date

KMS Credentialing Resources

P.O. Box 570, Tomball, Texas 77377, Phone: (512) 799-9144 Fax: (281) 257-5403

Information provided for and on behalf of the hospital's medical peer review committee for purposes of medical peer review only. Information will be maintained in a confidential manner consistent with the statutory privileges for medical peer review.

February 20, 2009

PLEASE FAX RESPONSE TO (281) 257-5403

This page only.

RE: _____

Specialty: _____

Credentialing Services Provided for: _____

The above named practitioner is seeking staff appointment/privileges and has given your name on the application as someone who has personal knowledge of his/her clinical abilities, ethical character, health status, and ability to work cooperatively with others. Based on your knowledge of this practitioner, please complete the following information.

Areas of Evaluation	Superior	Above Average	Average	Poor	Insufficient Information
Basic Clinical Knowledge					
Clinical Judgment, Technical Skill, Current Competence					
Cooperativeness with others					
Ethical Conduct					
Emotional Stability					
Physical Health					
Rapport with Peers					
Rapport with Patients					
Sense of Responsibility					
Thoroughness of Medical Records					
Work habits					
Professional Attitude					
Professional Character					
Participation in Medical Staff Activities					

If you indicated "poor" to any of the above questions, please provide explanation: _____

Length of time you have known this practitioner: _____

RECOMMENDATION:

- _____ Recommend without reservation
- _____ Recommend with reservation
- _____ Do not recommend
- _____ I do not feel I have sufficient knowledge to evaluate

Would you like someone from our office to contact you for additional information about this practitioner? (Y/N) _____ **

**If "YES" please provide a phone number that we can contact you _____

Please review the attached request for clinical privileges and give us your opinion as to the above referenced professional's competency and training to conduct those privileges and provide your comments: _____

Signature: _____ **Date:** _____

NOTE: Credentialing services are being provided by the KMS Credentialing Resources. All correspondence resulting from this request should be forwarded directly to KMS Credentialing Resources. This document contains confidential information that is legally privileged, belonging only to the sender. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or the taking of any action in reliance on the contents of this faxed information is strictly prohibited. If you receive this document in error, please notify the sender immediately by calling 512-799-9144 Thank you.