



CREDENTIALING & PRIVILEGING APPLICATION PACKET

**Licensed Independent Practitioner
CRNA**

Dear Applicant,

We appreciate your interest in becoming a part of Five Points Surgery Center. Prior to beginning your service with Five Points, you must complete our credentialing process and be approved by our credentialing committee. Our credentialing policy is compliant with AAAHC standards.

Our Privileging applies to Physicians, Dentists, CRNAs and AAs (licensed independent healthcare practitioners) who wish to provide services at Five Points Surgery Center. We have streamlined our process and will make every effort to process your application in a timely and efficient manner.

The credentialing process consists of six steps, which are as follows:

Step 1: Applicant will submit a pre-application.

Step 2: Applicant will receive the applicant packet.

Step 3: Applicant will return completed applications along with requested documents.

Step 4: Application will be reviewed and processed by our Credentialing Specialist to make sure all information is complete and accurate and verified with the appropriate third parties.

Step 5: The completed applicant packet will be forwarded to the Facility Director and reviewed by the Credentialing Committee for forwarding to the Chief Executive Officer for final approval.

Step 6. Applicant will be notified of result.

Although we will do everything to ensure there are no delays, the credentialing process may take up to 60 days after receipt of the completed APPLICATION to verify, review and obtain final approval. To expedite the process, your application should be without blanks or missing requested documents; if anything is missing, the process will be delayed.

If at any time, you have questions please contact the Facility Director or Compliance Officer at Five Points so we may resolve any problems prior to submission. Our goal is to assist you while ensuring that we are compliant with the Accreditation Association for Ambulatory Health Care (AAAHC) and other relevant guidelines.

Sincerely,

Your Credentialing Team Specialist
Five Points Surgery Center

Email all correspondence to: credentialing@fivepointssurgerycenter.com





CREDENTIALING DOCUMENTATION LIST

Applicant Name: _____

Please type or print responses legibly and in ink. Please complete all subsequent forms in their entirety and upload all supplementary documentation (see list below). Incomplete applications will be returned to you and may result in a delay in the credentialing/privileging process.

Supplementary documents that must be completed and/or submitted include the following:

- ☐ Application
- ☐ Attestation Form
- ☐ Medicare Attestation Form
- ☐ Consent to Release Form
- ☐ Background Check Form
- ☐ Delineation of Privileges
- ☐ Internet Acceptable Usage Policy
- ☐ Confidentiality Form
- ☐ MIS Form
- ☐ Copy of Government-Issued Picture Identification
- ☐ Curriculum Vitae (CV) in Proper Format (mm/yyyy) with gaps over 30 days explained
- ☐ Copies of Diplomas (Undergrad, Post-Graduate, Medical School, Residency, Fellowship, Specialty)
- ☐ Copy of Current Licensure(s)
 - ☐ Indiana License to Practice
 - ☐ Indiana Drug Control License (if applicable)
 - ☐ Indiana Controlled Substance (if applicable) _____
 - ☐ Indiana Board Acknowledgement & Certificate(s)
 - ☐ Specialty Board Acknowledgement
- ☐ Current Drug Enforcement Administration (DEA) Registration
- ☐ National Provider Identification (NPI) Notification with number (on application)
- ☐ BLS for Healthcare Providers with AED Education
- ☐ ACLS for Healthcare Providers (if applicable)
- ☐ PALS for Healthcare Providers (if applicable)
- ☐ Two (2) Peer Reference Forms
 - ☐ Peer Reference One
 - ☐ Peer Reference Two
- ☐ Current Sedation Permit (if applicable)
- ☐ Proof of Prior Professional Liability Insurance (minimum 1million/3million) (policy declarations page or letter from insurer)
- ☐ Copy of Most Recent Hep B vaccination or proof of immunity by positive titer
- ☐ Copy of Most Recent MMR vaccination
- ☐ Copy of Current TB – PPD Results (within 12 months of submitting application)
- ☐ Copy of Varicella vaccination or proof of immunity by positive titer
- ☐ Copy of Influenza vaccination during each Flu season (November 10th – March 31st)
- ☐ Copy of Covid-19 vaccination
- ☐ NPDB (Internal)
- ☐ Background Check Results (Internal)

STANDARD PRACTITIONER APPLICATION

PLEASE:

1. COMPLETE THIS ENTIRE APPLICATION.
2. SUBMIT A COPY AND RETAIN THE ORIGINAL FOR YOUR RECORDS.
3. CURRICULUM VITAE WILL NOT BE ACCEPTED AS REPLACEMENT FOR A PART OF THIS APPLICATION.
4. SIGN AND DATE: ATTESTATION
5. SIGN AND DATE: RELEASE OF INFORMATION
6. SUBMIT REFERENCES TO BE COMPLETED AND RETURNED.
7. COMPLETE, SIGN AND DATE: DELINEATION OF PRIVILEGES
8. RETURN COMPLETED PACKET AND SUPPORTING DOCUMENTS TO FACILITY DIRECTOR OR CREDENTIALING TEAM TO BEGIN THE CREDENTIALING AND PRIVILEGING PROCESS.

I A. PERSONAL INFORMATION

1. _____
Name (Last, First, Middle)
2. _____
Degree/Professional Title
3. _____
Other Names You May Have Used (Maiden, a.k.a., etc.)
4. Gender: ☐ Male ☐ Female
5. _____
Home Address/Street
6. _____
City/State/Zip
7. (_____) _____
Home Telephone No.
8. (_____) _____
Home Fax No.
9. _____
E-mail Address
10. _____
Date of Birth (Month/Day/Year)
11. _____
Citizenship/Place of Birth
12. _____
Languages fluently spoken (in addition to English)
13. _____
Languages written in addition to English
14. _____
Social Security No.
15. _____
Ethnicity (Optional)
16. If you are not a US Citizen do you have authorization to work in the US? ☐ Yes ☐ No
17. NPI number _____ Medicare number _____ Medicaid number _____

I B. PRACTICE SPECIALTY FOR WHICH YOU ARE SEEKING AFFILIATION

1. Are you applying as a:

- | | | |
|---|--|---|
| ☐ ENT | ☐ Plastic Surgeon | ☐ General Surgeon |
| ☐ Pediatric Dentist | ☐ Oral Surgeon | ☐ Ophthalmologist |
| ☐ Anesthesiologist | ☐ CRNA | ☐ General Dentist |
| ☐ Anesthesiologist Assistant | | ☐ Other (Specify Specialty): _____ |

II A. MEDICAL / DENTAL / PROFESSIONAL SCHOOL

List all Medical / Dental / Professional Schools attended. Enclose copies of your diplomas and certificates. **For CRNA/AA's - please list undergraduate and post-graduate training.**

1. _____
Medical/Dental/Professional School
Degree Awarded
Date of Graduation (mm/yy)

Address
City
State
Zip
2. _____
Medical/Dental/Professional School
Degree Awarded
Date of Graduation (mm/yy)

Address
City
State
Zip



Name of Applicant: _____

II B. POST-GRADUATE TRAINING

List all training attended. Enclose copies of your certificates.

1. INTERNSHIP

Program successfully completed? ☐ Yes ☐ No

Institution/Hospital		Dates From (mm/yyyy)		Dates To (mm/yyyy)
Address	City	State	Zip	Program Specialty
		()		()
Program Director	Telephone No.		Fax No.	

2. RESIDENCY

Program successfully completed? ☐ Yes ☐ No

Institution/Hospital		Dates From (mm/yyyy)		Dates To (mm/yyyy)
Address	City	State	Zip	Program Specialty
		()		()
Program Director	Telephone No.		Fax No.	

3. FELLOWSHIP

Program successfully completed? ☐ Yes ☐ No

Institution/Hospital		Dates From (mm/yyyy)		Dates To (mm/yyyy)
Address	City	State	Zip	Program Specialty
		()		()
Program Director	Telephone No.		Fax No.	

Directions for Sections III and IV: List in chronological order (with the current affiliation first) all institutions where you have current affiliations and have had previous hospital privileges.

III. HOSPITAL / FACILITY HISTORY

1.

CURRENT Primary Admitting Facility		Dates From (mm/yyyy)		Dates To (mm/yyyy)
Address	City	State	Zip	Department/ Specialty
		()		()
Staff Category	Chairperson	Telephone No.		Fax No.

2.

Admitting Facility		Dates From (mm/yyyy)		Dates To (mm/yyyy)
Address	City	State	Zip	Department/ Specialty
		()		()
Staff Category	Chairperson	Telephone No.		Fax No.

IV. WORK HISTORY [add additional sheets if needed]

Chronologically list all work history activities since completion of postgraduate training.



Current Practice		Contact Name		Dates From (mm/yyyy)		Dates To (mm/yyyy)	
				()		()	
Address	City	State	Zip	Telephone No.		Fax No.	
Previous Practice/Employer		Contact Name		Dates From (mm/yyyy)		Dates To (mm/yyyy)	
				()		()	
Address	City	State	Zip	Telephone No.		Fax No.	
Previous Practice/Employer		Contact Name		Dates From (mm/yyyy)		Dates To (mm/yyyy)	
				()		()	
Address	City	State	Zip	Telephone No.		Fax No.	

1. _____ <i>Indiana State Medical / Dental / Professional License No.</i>	_____ <i>Date First Issued</i>	_____ <i>Expiration Date</i>
2. _____ <i>Drug Enforcement Administration Certification No. (DEA)</i>	_____ <i>Expiration Date</i>	
3. ALL OTHER STATE MEDICAL/PROFESSIONAL LICENSES:		
State: _____	License No.: _____	Expiration Date: _____
State: _____	License No.: _____	Expiration Date: _____
4. _____ <i>Medicare ID No.</i>		
5. _____ <i>UPIN (Unique Physician Identification Number)</i>	6. _____ <i>NPI (National Provider Identifier)</i>	

Name of Board/Certifying Entity	Certificate No.	Date Certified / Re-certified	Expiration Date	Specialty
1.				
2.				
3.				
If Eligible but not certified Please list below				

Have you ever taken and not passed a medical board examination? ☐ Yes ☐ No If yes, will you re-take? ☐ Yes ☐ No



Name of Applicant: _____

VII. PROFESSIONAL PEER REFERENCES

List three professional references familiar with the applicant's qualifications during the three years immediately preceding this application. One professional reference should be from the Chief of the department or service where the applicant last furnished professional services.

1. _____
Name _____ Title/Relationship _____ Telephone No. _____

Address _____ City _____ State _____ Zip _____ Fax No _____
Email Address: _____ Years Known: _____
2. _____
Name _____ Title/Relationship _____ Telephone No. _____

Address _____ City _____ State _____ Zip _____ Fax No _____
Email Address: _____ Years Known: _____
3. _____
Name _____ Title/Relationship _____ Telephone No. _____

Address _____ City _____ State _____ Zip _____ Fax No _____
Email Address: _____ Years Known: _____

VIII. PROFESSIONAL LIABILITY CARRIER INFORMATION

Does your current professional liability insurance cover you in all of your practice locations? ☐ Yes ☐ No

***Provide 10 years of Malpractice coverage
Use additional sheet if needed***

1. _____
Current Insurance Carrier _____ Policy No. _____

Address _____ City _____ State _____ Zip _____ Telephone No. _____

Coverage Amount: (Claim/Aggregate) _____ Type of Coverage _____ Exclusions from Coverage _____

Initial Date of Coverage _____ Retroactive Date of Coverage _____ Expiration Date _____
Type of coverage ____ Claims made ____ Occurrence
2. _____
Current Insurance Carrier _____ Policy No. _____

Address _____ City _____ State _____ Zip _____ Telephone No. _____

Coverage Amount: (Claim/Aggregate) _____ Type of Coverage _____ Exclusions from Coverage _____

Initial Date of Coverage _____ Retroactive Date of Coverage _____ Expiration Date _____
Type of coverage ____ Claims made ____ Occurrence
3. _____
Current Insurance Carrier _____ Policy No. _____

Address _____ City _____ State _____ Zip _____ Telephone No. _____

Coverage Amount: (Claim/Aggregate) _____ Type of Coverage _____ Exclusions from Coverage _____

Initial Date of Coverage _____ Retroactive Date of Coverage _____ Expiration Date _____
Type of coverage ____ Claims made ____ Occurrence



Name of Applicant: _____

IX. CLAIM / LAWSUIT HISTORY - 10 YEARS OF HISTORY

If you answer "YES" to any of the following questions, please provide details per the attached claims information sheet. Please explain any surcharge to your professional liability coverage on a separate sheet.	YES	NO
Have any professional liability lawsuits been filed against you during the past ten years (including those closed)?		
Are there any now still pending?		
Has any judgment, payment of claim, or settlement ever been made against you in any professional liability cases?		
Has any judgement or payment of claim or settlement amount exceeded the limits of this coverage?		
Have you ever been denied professional insurance, or has your policy ever been cancelled?		

X. HEALTH STATUS

If the answer to any question is "YES", reference the question on a separate sheet. Please provide a full explanation and attach.	YES	NO
Are you currently using any chemical substance(s), which in any way may impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?		
Are you currently engaged in the illegal use of controlled substances?		
Do you have a mental, physical condition, or emotional impairment which in any way may impair or limit your ability to practice medicine/dentistry with reasonable skill and safety with or without reasonable accommodation?		

Applicant must check one of the following:

1. _____ I certify that I am in good health and have no physical or mental limitations.
2. _____ I do have or have had a chronic illness, physical disability and/or medical limitations to my health, which may include alcohol or drug use, but believe that this does not significantly impair my ability to render high quality medical care.*

* If you answered #2 above, a **Full Statement of Explanation** must be attached. This must include the name and address of your physician. Your physician will only be contacted with your permission.

XI. PROFESSIONAL PRACTICE

Have any of the following been or are currently in the process of being <u>denied, revoked, not renewed, suspended, limited, restricted, reviewed, placed on probation, or placed under other disciplinary action</u> , either voluntarily or involuntarily in this or any other state, territory or country? If "YES", provide full explanation and attach.	YES	NO
Medical or professional license		
DEA Registration or Controlled Substance license		
Hospital medical staff membership		
Clinical privileges or other rights on any hospital medical staff		
Employment by any hospital, institution or the military		
Professional society membership		
Participation in any private, federal, or state health insurance program (i.e. Medicare, CHAMPUS, Medicaid)		
Participation in an HMO, PPO, or any other managed care organization		
Board Certification		



Name of Applicant: _____

XII. OTHER DISCLOSURES

At any time have you ever been:	YES	NO
Convicted of any criminal offense in any jurisdiction		
Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition in lieu of trial, or an accelerated rehabilitation disposition of felony charges in any state, territory or country		
Have you ever, at any time, or are you currently:	YES	NO
Under audit by a Health Care Agency (i.e. Medicare, Medicaid, MDCH, or any insurance)		
Under indictment for any crime		
The subject of an investigation by any private, federal or state health insurance program or state, territory or country licensing board		
The subject of any adverse action reports to a state or federal agency		
Sanctioned by a government program or agency for any reason		
To your knowledge, have you ever been reported to the National Practitioner Data Bank or the Indiana Board of Medical Examiners? (If yes, please explain)		
Have you ever, at any time, either voluntarily or involuntarily:	YES	NO
Withdrawn your application for medical staff membership at any facility		
Withdrawn your request for any clinical privileges at any facility		



ATTESTATION STATEMENT

By applying for clinical privileges. I hereby signify my willingness to appear for interviews in regard to my application, and I authorize FIVE POINTS SURGERY CENTER, its staff, and their representatives to consult with member of management and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice insurance carrier, who may have information bearing on my professional competence, character, and ethical qualifications.

I hereby further consent to inspection by "FIVE POINTS," its medical staff, and its representatives of all records and documents, including medical and credential records at other hospitals, which may be material to an evaluation of my qualifications for staff membership.

I hereby release from liability all representative of FIVE POINTS and its medical staff, in their individual and collective capacities, 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 FIVE POINTS or to the members of its medical/dental staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges.

I hereby consent to the release of information by other hospitals, other medical associations, and other authorized persons, on request, regarding any questions FIVE POINTS 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 and hold harmless FIVE POINTS and any other third party for so doing. I understand and agree that I, as an applicant or clinical privileges, have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics, and other qualifications and for the resolution of any doubts about such qualifications.

By accepting appointment and/or reappointment to the medical staff at FIVE POINTS SURGERY CENTER, I hereby acknowledge and represent that I have read and am familiar with the bylaws, rules, and regulations of FIVE POINTS SURGERY CENTER. I agree and will abide to the rules and regulations, as well as the principles, standards, and ethics of the national, state, and local associations and state law and regulations that apply to and govern my specialty and/or profession, which are the Governing Standards as may be enacted from time to time.

In addition, I agree to notify FIVE POINTS of any circumstances that would change my status in licensure, DEA, Medicare participation, liability insurance coverage, board certification status, or hospital privileges.

I understand and agree that any significant misstatements in or omissions from this application shall constitute cause for denial of appointment or cause for summary dismissal from the medical staff with no right of appeal. All information submitted by me in this application is true to the best of my knowledge and belief.

I further authorize a photocopy or facsimile of the requests, authorizations, and releases to this application to serve as original. By my signature on this application, I attest that I have received an annual TB test and that I am immunized against communicable diseases as recommended by the CDC guideline for health care workers.

Applicant's Signature: _____

Print Name: _____

Date: _____



**MEDICARE ATTESTATION ACKNOWLEDGEMENT STATEMENT
NOTICE TO DENTISTS AND PHYSICIANS**

Medicare payment to Five Points Surgery Center is based on each patient's procedures performed, as attested to by the patient's attending dentist/physician by virtue of his or her signature in the surgery center record. Anyone who misrepresents, falsifies, or conceals funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

I, _____, the undersigned, acknowledge having received the above notice.

(print or type name)

(legal signature)

(date)

(Legal signature means that which you would normally use on documents such as a will, checks, etc. Initials are not acceptable.)



Five Points Surgery Center

Standard Practitioner Application

CONSENT TO RELEASE INFORMATION FORM

I understand that this Consent to Release Information is made in connection with Physician/Practitioner contracting, credentialing, recredentialing or reappointment activity of FPSC. I further understand that FPSC is responsible for the evaluation of my professional training, experience, professional conduct and judgment. All information submitted by me or on my behalf pursuant to this Consent to Release Information is true and complete to the best of my knowledge and belief. I fully understand that any misstatement in or omission related thereto may constitute cause for the summary dismissal/denial of such participation in FPSC. I understand and agree that as an applicant for participation with FPSC, I have the 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 hereby authorize FPSC and its representative to contact and/or consult with any persons, entities or institutions (including, but not limited to, hospitals, HMOs, PPOs, other group practices and professional liability carriers) which I have been affiliated, have used for liability insurance or who may have information relevant to my character and professional competence and qualifications, whether or not such persons or institutions are listed as references by me. I consent to the release and communication of information and documents between FPSC and persons, entities or institutions in jurisdictions in which I have trained, resided, practiced, or applied for professional licensure, privileges or membership in plans for the purpose of evaluation of my professional training, experience, character, conduct, ethics and judgment, and to determine professional liability insurance and/or malpractice insurance claims history.

I also authorize and direct persons contacted by FPSC to provide such information regarding my character and/or professional competence and qualifications, my professional liability insurance and/or malpractice insurance claims history to representatives of FPSC and I understand in doing so, I am waiving my confidentiality rights to this information. I release and hold harmless from liability all persons, entities, or institutions who, in good faith and without malice for acts performed in gathering or exchanging information in this credentialing or recredentialing process. This release and hold harmless provision applies to all persons, entities and institutions who will provide and/or receive, as part of the FPSC's credentialing or recredentialing process, information which may relate to my past or present physical and/or mental condition, including substance abuse, alcohol dependency and mental health information.

I further authorize the release of the above information or any other information obtained from the application by a credentialing verification organization (CVO) to any health care organization designated by me or one that has entered into an agreement with the CVO where I currently have, am currently applying, or in the future will be applying for participation. I also authorize the CVO or FPSC to allow my file to be reviewed by the organizations' state or national accrediting and licensing bodies.

I further affirm that I currently do not have any physical and/or mental conditions and/or impairments, such as substance abuse, alcohol dependency and/or mental health concerns which interfere with my ability to practice medicine. I agree to notify representatives of FPSC of any changes in my professional licensure, scope of hospital privileges, participating provider status, status of my malpractice insurance, malpractice claims history information and practice locations. I understand that this application shall not be deemed complete until an on-site medical practice office review is completed, if applicable, as well as receipt of all information required by this application process. I further agree to appear before FPSC for interviews, if requested, or inquiries regarding evaluations of my professional qualifications at reasonable times and places.

A photocopy of this consent shall be as effective as an original when presented.

Practitioner's Printed Name: _____

Practitioner's Signature: _____

Date: _____



AUTHORIZATION FOR RELEASE OF INFORMATION FOR MEDICAL OR DENTAL STAFF APPOINTMENT AND FACILITY PRIVILEGES

In connection with my application to Five Points Surgery Center's Medical or Dental Staff, I authorize BACKGROUND INFORMATION to be obtained by Center to procure background information about my character or reputation, including but not limited to information as to my employment, education, driving record, social security number verification, criminal record, and/or other public records history. I authorize all persons to fully disclose information relevant to this investigation. I release from liability all persons, companies, and governmental or other agencies disclosing such information. I further authorize that a photocopy of this authorization may be considered as an original.

Additionally, I give the center permission to investigate any incidents of workplace misconduct of which I have been accused or for which I am alleged to have been involved during my appointment or employment with Medical or Dental Staff(s), Allied Health Professional Staff(s), or healthcare organization(s).

I have read, understand, and authorize any person, agency or other entity contacted by the Center to furnish the above-mentioned information.

I further understand that this authorization/release is valid throughout my term of appointment.

This form will not be accepted if altered, illegible or incomplete.

_____ Signature		_____ Date	
_____ *Type or Print Name		_____ Other Names (alias, maiden)	
_____ *Social Security #		_____ *Email	
_____ Current Address			
_____ City		_____ State	_____ Zip
_____ County of Resident			
_____ *Date of Birth	_____ *Gender (M or F)	_____ *Phone Number	

**** Without this information, we may not be able to
identify you in the course of our background check.***





**FIVE POINTS SURGERY CENTER (FPSC) CONFIDENTIALITY AND
INFORMATION ACCESS AGREEMENT**

IMPORTANT: Please read the entire Agreement and accompanying policy. If you have any questions, please ask them before signing. You will receive a copy of your signed agreement for your records and a copy will be retained with your credentialing packet.

This document is confirmation to Five Points Surgery Center that I am fully aware of the implications of misuse of any confidential and proprietary information pertaining to patients, caregivers, employees and center operations.

GENERAL AGREEMENT: During my duties with FPSC, I may receive or have access to verbal, written or computer-generated information concerning patients, providers or institutionally proprietary data. I agree that, except as authorized or directed by FPSC or by legal process, I will not at any time during or after my tenure disclose any such information to any person, or permit any person to examine or make copies of any documents prepared by me, coming into my possession or control, or to which I have access unless as needed during my required activities. I understand that unauthorized access or disclosure may result in disciplinary action and civil or criminal penalties; or both.

I understand that all business activities of FPSC are considered confidential. I also understand that if I am exposed to FPSC business information that I am obligated not to discuss or disclose such information to persons outside FPSC unless as needed during my required activities. Additionally, within FPSC, such information will only be discussed with employees whose job requires such knowledge.

INFORMATION ACCESS AGREEMENT: I recognize and acknowledge that access to Health System information requires unique responsibilities for care and security. Therefore, I agree to the following:

- I will keep my computer access identifications and passwords confidential and not share them with anyone. Nor will I use another's identification and password.
- I understand that my computer login ID is the equivalent to my legal signature, and I will be accountable for all work done under my login ID.
- I will use my computer access solely to perform my duties with a clear need-to-know criterion.
- I will use my access to patient information (including myself, family members and friends) solely to perform my duties with a clear need-to-know criterion.
- I will not enter or attempt to enter false information into a live production environment.
- I will use designated sign-off procedures when leaving a computer workstation or terminal.
- I will not provide protected patient information (PHI) in writing, discussion or other manner to those who do not have a need to know.
- I will not remove PHI from the surgery center without authorization.
- I will discard materials containing PHI according to the surgery center policy.
- I know that patient confidentiality and privacy is a patient right and I will respect that right.

Signature

Date

Applicant's Printed Name



Internet Acceptable Usage Policy Acknowledgment Form

As an employee or other authorized user of Five Points Surgery Center computer network, I have received and reviewed the Five Points Surgery Center Internet Acceptable Usage Policy (the "Policy"). I understand that my use of the company's computer network is conditioned on my full compliance with the provisions of that Policy. I further understand that violations of the Policy may subject me to disciplinary action, up to and including termination of my relationship with Five Points Surgery Center.

I recognize and understand that I am being provided with access to the company's corporate internal network for the purpose of facilitating the internal business purposes of Five Points Surgery Center. I acknowledge that, to the extent permitted by applicable law, Five Points Surgery Center reserves and will exercise the right to monitor, review, audit, record, and publish reports and usage patterns regarding my Internet usage activities, at any time and for any purpose, with or without notice to me. I further acknowledge that I have no reasonable expectation of privacy as to my internet usage on the company's corporate internal network, including without limitation the identities and content of sites visited, as well as the frequency and timing of such visits. I understand that I may not access or view internet sites containing offensive, pornographic, or otherwise objectionable or inappropriate materials. I also understand that I am responsible for my own internet activity using the company's corporate internal network and that Five Points Surgery Center cannot protect me from offensive or inaccurate information that I may access on the Internet.

By using the Five Points Surgery Center corporate internal network and accessing the internet through that network, I consent to the above terms and agree to abide by all terms of the Policy.

Signature of Employee

Date

Printed Name



**Medical / Allied Health Staff
Management Information System Form**

Practice Name: _____

Practice Manager: _____ Office Number: _____

Legal First Name

MI

Legal Last Name

Requested Start Date: _____ ☐ Permanent ☐ Temporary

(Recommended 30 Days After Application Completion)

Requested End Date: _____

(Complete only if temporary privileges requested; if no date, credentials will expire in 90 days)

Email Address: _____ Contact Number: _____

Medical/Allied Health Staff Status:

- | | | |
|------------------------------|-------------------------------|--------------------------------------|
| ☐ MD | ☐ NP | ☐ CDA |
| ☐ DMD | ☐ CRNA | ☐ DAI |
| ☐ DDS | ☐ AA | ☐ DAII |
| ☐ PA | ☐ RN | ☐ OTHER _____ |

☐ Confidentiality Policy

☐ IT Policy

Security Questions:

1. Mother's Maiden Name:
2. City of Birth:

Temporary password will be provided during Five Points Orientation

Signature: _____

Office Use Only

Network ID: _____ Date Created: _____ Created by: _____

Medical Staff: _____ Logged Tracking Chart: _____

APPLICANT PEER REFERENCE FORM

Please send this form to **two (2) of your peers** to complete.



Applicant Name: _____

Specialty: _____

To Whom It May Concern: I have submitted an application for appointment/reappointment to the staff of Five Points Surgery Centers. Please complete the information below and return it directly to **credentialing@fivepointssurgerycenter.com**. My signature authorizes you to complete the form at my request. Thank you for your prompt attention to this request.

Sincerely,

Applicant Signature

Date

Please answer to the best of your ability.	Yes	No
Does the practitioner demonstrate current clinical competence and provide appropriate care to patients?		
Does the practitioner demonstrate good diagnostic capabilities and good technical skills in the performance of invasive procedures, if applicable?		
Does the practitioner demonstrate effective communication skills with patients, families, and others involved in their care?		
To the best of your knowledge, does the practitioner have the appropriate mental and physical health to perform patient care duties?		
Have you observed or been informed of any physical or behavioral condition, including alcohol or drug dependence, related to this applicant that has or reasonably may affect his or her ability to perform professional duties?		
Does the practitioner maintain timely documentation of history and physical exams, progress notes, operative notes, narrative summaries, etc.?		
Does the practitioner exhibit personal integrity and adherence to professional ethics?		
Does the practitioner work well with others, communicate well with other providers, and have a good rapport with patients?		
Are you aware of the practitioner being subjected to any disciplinary action by any licensing or certifying board or any healthcare facility regarding medical staff membership and/or clinical privileges?		

The above evaluation is based on: *(check all that apply)*

- | | |
|--|---|
| ☐ Close observation of clinical performance | ☐ Practitioner's reputation in the community |
| ☐ General impression | ☐ Co-worker |
| ☐ Composite information from file | |

Recommendation:

- | | |
|---|--|
| ☐ Highly recommend | ☐ Do not recommend |
| ☐ Recommend as qualified and competent | ☐ Additional Comments |
| ☐ Recommend with reservation | _____ |

Reference Information

Print Name: _____ Signature: _____

Title: _____ Phone: _____ Date: _____

APPLICANT PEER REFERENCE FORM

Please send this form to **two (2) of your peers** to complete.

Applicant Name: _____

Specialty: _____



To Whom It May Concern: I have submitted an application for appointment/reappointment to the staff of Five Points Surgery Centers. Please complete the information below and return it directly to **credentialing@fivepointssurgerycenter.com**. My signature authorizes you to complete the form at my request. Thank you for your prompt attention to this request.

Sincerely,

Applicant Signature

Date

Please answer to the best of your ability.	Yes	No
Does the practitioner demonstrate current clinical competence and provide appropriate care to patients?		
Does the practitioner demonstrate good diagnostic capabilities and good technical skills in the performance of invasive procedures, if applicable?		
Does the practitioner demonstrate effective communication skills with patients, families, and others involved in their care?		
To the best of your knowledge, does the practitioner have the appropriate mental and physical health to perform patient care duties?		
Have you observed or been informed of any physical or behavioral condition, including alcohol or drug dependence, related to this applicant that has or reasonably may affect his or her ability to perform professional duties?		
Does the practitioner maintain timely documentation of history and physical exams, progress notes, operative notes, narrative summaries, etc.?		
Does the practitioner exhibit personal integrity and adherence to professional ethics?		
Does the practitioner work well with others, communicate well with other providers, and have a good rapport with patients?		
Are you aware of the practitioner being subjected to any disciplinary action by any licensing or certifying board or any healthcare facility regarding medical staff membership and/or clinical privileges?		

The above evaluation is based on: *(check all that apply)*

- | | |
|--|---|
| ☐ Close observation of clinical performance | ☐ Practitioner's reputation in the community |
| ☐ General impression | ☐ Co-worker |
| ☐ Composite information from file | |

Recommendation:

- | | |
|---|--|
| ☐ Highly recommend | ☐ Do not recommend |
| ☐ Recommend as qualified and competent | ☐ Additional Comments |
| ☐ Recommend with reservation | _____ |

Reference Information

Print Name: _____ Signature: _____

Title: _____ Phone: _____ Date: _____



PRIVILEGE REQUEST FORM | Certified Registered Nurse Anesthetists CRNAs Delineation Of Privileges

I hereby request surgical privileges in the specialty of **Certified Registered Nurse Anesthetists** as shown on this form. I understand that privileges granted are subject to review coinciding with my application for medical staff membership. I routinely perform the below procedure(s) requested and these are consistent with my abilities, training and experience.

I also understand the application for additional or new procedures can be made at any time with proper documentation.

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 checked.

PROCEDURES	Requested	Not Requested	Granted	Denied
Request laboratory/diagnostic studies				
Pre-anesthesia assessment				
Pre-anesthetic medication				
General anesthesia and adjuvant drug				
Administration and maintenance of anesthesia to ensure proper rate of delivery, sedation, and pain management				
Cardiopulmonary resuscitation management				
Invasive and non-invasive monitoring				
Airway management techniques including the use of nasal airways				
Mechanical ventilation/oxygen therapy				
Fluid, electrolyte, acid-base management				
Blood, blood products, plasma expanders				
Evaluate patients post-surgical or post-anesthesia responses, taking appropriate corrective actions or requesting consultation if complications occur				
Post anesthesia care and discharge				
Keep complete and accurate records of the patient responses				

Applicant Signatures

Applicant's Signature

Print Name

Date

Approval Signatures

Governing Board Approval

Print Name

Date



**APPLICATION FOR CLINICAL PRIVILEGES FOR CERTIFIED
ANESTHESIOLOGIST ASSISTANT (CAA) OR
CERTIFIED REGISTERED NURSE (CRNA)**

Application For Clinical Privileges for the Period of: _____ Through: _____

Name: _____

CAA REQUIREMENTS:

- Current valid, active, unlimited license to practice as an anesthesiologist assistant in the State of Indiana.
- Satisfactory completion of an anesthesiologist assistant training program that is accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP), its predecessors or successors.
- The CAA applicant must have achieved initial certification and maintained continuing certification as an anesthesiologist assistant by the National Commission on the Certification of Anesthesiologist Assistance (NCCAA) including completion of at least fifty hours of CME every two years and passing the Continuing Demonstration of Qualification Exam every six years or as defined by the NCCAA.

CRNA REQUIREMENTS:

- The CRNA must hold a valid, active, unlimited license as a registered nurse in the State of Indiana.
- The CRNA must have satisfactorily completed a nurse anesthesia education program granting a master's degree (or higher) accredited by the Council on Accreditation of Nurse Anesthesia Education Programs (COA), its predecessors or successors.
- The CRNA must have achieved initial certification by the Council on Certification of Nurse Anesthetist or its predecessor and maintain continuing certification as defined by the Council on Recertification of Nurse Anesthetist or the National Board of Certification and Recertification for Nurse Anesthetists

Definitions:

Anesthesia Care Team (ACT)- A team of individuals including at least an anesthesiologist and an anesthetist working under the supervision of the anesthesiologist to deliver anesthesia care to a patient.

Anesthetist- An individual who is either licensed as an Anesthesiologist Assistant by the State of Indiana or certified as a Registered Nurse Anesthetist and licensed as a Registered Nurse by the State of Indiana who is working as a member of an anesthesia care team as described by the Anesthesia Care Team Practice Protocol.

Supervising Anesthesiologist – An anesthesiologist who is licensed as a physician by the State of Indiana and who has agreed to work as a member of the anesthesia care team described by the Anesthesia Care Team Practice Protocol.



ANESTHESIA CARE TEAM PRACTICE PROTOCOL

A CAA or CRNA may provide care only in accordance with this written practice protocol that is agreed to and signed by an anesthetist and anesthesiologist(s) who agree to practice within the Anesthesia Care Team at Five Points Surgery Center. The complete listing of anesthesiologists who will supervise the anesthetist is included in the roster of the medical staff.

- The anesthetist will provide care only in manners consistent with the American Society of Anesthesiologists Care Team model.
- The supervising anesthesiologist may supervise anesthetists in anesthesia services that are customarily within the area of practice of the supervising anesthesiologist.
- Regardless of the anesthetist's earned or honorary degrees, the anesthetist may not identify herself/himself as a doctor or use the title "Doctor" in reference to herself/himself in any clinical situation where the individual is functioning as an anesthetist at Five Points Surgery Center.
- The supervising anesthesiologist will review and sign the anesthetic record of each anesthetic in which they and the anesthetists participate.
- The supervising anesthesiologist will personally participate in the induction of general anesthesia except in the event of simultaneous emergency situations.
- The supervising anesthesiologist must remain in physical proximity that allows the anesthesiologist to establish direct and timely contact with the patient when necessary. This responsibility may be met through coordination among anesthesiologists who have agreed to participate in the Anesthesia Care Team Model.
- This practice protocol must be signed by both anesthetists and by all anesthesiologists who agree to supervise an anesthetist.
- For the purposes of this protocol, the supervising physician as stated in Indiana State Form 561172 (11-16) will be also known as the Physician Sponsor. Other anesthesiologist members of the medical staff will serve as supervising physicians.
- The anesthetist's performance will be evaluated at least annually by the Medical Director regarding timeliness, clinical skills, cognitive performance and perioperative patient care.

☐

By checking this box, you are indicating your agreement with the above practices and principles as they pertain to the Anesthesia Care Team at Five Points Surgery Center.



Applicant Name: _____

ANESTHETIST PRIVILEGES

The anesthetist may perform the following consistent where applicable with the anesthetic plan determined by the supervising anesthesiologist.

☐ **By Checking this box, you are applying for all of the following privileges:**

- Obtain a comprehensive patient history and perform relevant elements of a physical exam.
- Obtain informed consent for administration of an anesthetic.
- Pretest and calibrate anesthesia delivery systems and obtain and interpret information from the systems and monitors.
- Implement medically accepted monitoring techniques.
- Establish basic and advanced airway interventions, including intubation of the trachea and performance of ventilator support.
- Administer medications and medical therapies and obtain and interpret laboratory tests necessary for the perioperative care of the patient.
- Provide cardiopulmonary resuscitation in response to a life-threatening situation.
- Place venous catheters.
- Administer supportive fluid.
- Enter perioperative orders to be cosigned by the supervising anesthesiologist.
- Participate in administrative, research, and clinical teaching activities as authorized by the dental or medical director or a supervising anesthesiologist.



Applicant Name: _____

Acknowledgement by the Anesthetist:

I have requested only those privileges for which, by education and training, I am qualified to perform and for which I wish to exercise at Five Points Surgery Center. I understand that:

- (a) in exercising any clinical privileges granted, I am practicing in accordance with surgery center and medical staff policies and rules.
- (b) in an emergency, any allied health practitioner who has clinical privileges is permitted to provide any type of patient care necessary as a lifesaving measure or to prevent serious harm within the scope of the individual's licensure and training.

Signed: _____ Date: _____

Sponsoring Physician 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 all requested privileges with the following conditions/modifications: |

Physician Sponsor Signature: _____ Date: _____

Medical Director Recommendations:

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

- | |
|--|
| ☐ Recommended all requested privileges |
| ☐ Recommended all requested privileges with the following conditions/modifications: |

Medical Director Signature: _____ Date: _____