

Dear Doctor:

Thank you for your interest in applying for Medical Staff Membership and or Clinical Privileges at Northwest Texas Healthcare System/Northwest Texas Surgery Center and or Alliance Regional Health Network. If you meet the following criteria and desire an application for Medical Staff appointment and clinical privileges, please complete the enclosed pre-application. **Please note: application processing takes 4 to 6 weeks.** We will notify you if your assistance is needed.

Criteria for Medical Staff Membership/Privileges

Membership in the Medical Staff of Northwest Texas Healthcare System is a privilege which will be extended only to professionally competent physicians, dentists and podiatrists who continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws.

The applicant must submit verifiable documentation of education, training, ability and current competency relevant to the clinical privileges being requested. The physician must reside and practice in Potter or Randall county. Physicians are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health prevention of illness, treatment of disease, and care at the end of life.

All Physicians are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

All Physicians must submit and maintain a current valid, unrestricted Texas license, or institutional permit to practice the applicant's profession; (if applicable) Federal Drug Enforcement Administration (DEA); registration with the Texas Department of Public Safety (DPS); and professional liability insurance.

All Physicians must attend orientation. Your office will be contacted to schedule a time convenient for you.

Northwest Texas Healthcare System is proud to announce physicians with the appropriate training may apply for privileges to use the daVinci Robotic Platform. Please contact the Medical Staff Office for information required to apply for these privileges.

If you have any questions, please feel free to contact myself at 806-354-1112 or the Medical Staff Office at 806-354-1126.

Sincerely,

Nathan Goldstein III, MD
Chief Medical Officer

Northwest Texas Healthcare System *Providing Credentialing for*
Northwest Texas Surgery Center *Alliance Regional Health Network*
P. O. Box 1110 Amarillo, Texas 79105(☎806-354-1126 ☎806-354-1203

The Pre-application must be legible. Please read the enclosed Instructions. If needed, please attach additional pages. If the pre-application is not complete, it will be returned.

[] Medical/Dental Staff **membership** and Clinical Privileges at Northwest Texas Healthcare System

[] Medical/Dental Staff **membership** and Clinical Privileges at Northwest Texas Surgery Center

[] Membership as a provider for Alliance Regional Health Network (PPO provider for NWTHS/SC)

I. PERSONAL IDENTIFICATION DATA

Full Name: _____

Email Address: _____ Cell Phone: _____

II. PROFESSIONAL DATA

A. GENERAL INFORMATION:

1. Clinical Specialty/Sub-specialty: _____

2. Name of others or group with whom you will be associated in Amarillo: _____

3. **Anticipated Start Date:** _____

III. BOARD CERTIFICATION:

Board Specialty: _____ Date: _____

Have you ever been examined by any specialty board, but failed to pass the examination? [] YES [] NO

If yes, please provide full explanation.

- a. Have you ever been placed on academic or professional probation? [] YES [] NO
- b. Has your license to practice medicine in any state ever been voluntarily or involuntarily relinquished, suspended, denied, limited, revoked, refused or have you ever been asked to surrender your license? [] YES [] NO
- c. Have any disciplinary actions been initiated or are any pending against you by any state licensing board? [] YES [] NO
- d. Has your narcotic registration ever been voluntarily or involuntarily relinquished, suspended, denied, limited, revoked, refused or have you ever been asked to surrender your registration? [] YES [] NO
- e. Has your employment, medical staff appointment, or clinical privileges ever been voluntarily or involuntarily suspended, diminished, revoked, refused, or limited at any hospital, or other healthcare facility? [] YES [] NO
- f. Have you ever voluntarily or involuntarily withdrawn your application for appointment, reappointment or clinical privileges, or resigned from the medical staff, or place of employment before a decision was made by a hospital or Healthcare facility governing board? [] YES [] NO
- g. Have you ever voluntarily or involuntarily terminated your medical staff membership in lieu of an investigation or formal action? [] YES [] NO
- h. Are there presently, or previously any disciplinary proceedings or investigations taking place at any hospital, Healthcare facility, or organization, relating to your clinical competence or professional conduct? [] YES [] NO
- i. Have you ever been the subject of focused individual monitoring, or an investigation at any hospital or

Healthcare facility? YES NO

j. Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings in any professional organization? YES NO

k. have you had any recent, or previously experienced significant physical or mental health problems or had involvement with substance abuse including drugs or alcohol? YES NO

If answer is YES, please provide a full explanation of the details, and attach significant documentation.

IV. PROFESSIONAL LIABILITY INSURANCE (ATTACH COPY OF POLICY)

a. Has your professional liability insurance coverage ever been denied or terminated by your insurance company? YES NO

If “yes”, please provide details on page 7

c. Has your present professional liability insurance carrier excluded any specific procedures from your coverage, or are there presently any limitations on your professional liability insurance? **If yes, provide documentation** YES NO

LEGAL ACTIONS

1. Have any professional liability suits ever been filed against you? YES NO

2. Is there presently any professional liability suits pending against you? YES NO

If you answer "Yes", please provide an explanation of the details on a separate sheet, and attach.

V. HEALTH STATUS: ATTESTATION: I hereby certify that I am in good health and am capable of providing competent and continuous care of my patients. (Initials) _____

NOTE: IF YOU HAVE NOT BEEN TB TESTED WITHIN THE PAST TWO YEARS, PLEASE MAKE ARRANGEMENTS FOR SUCH. IF THERE IS A MEDICAL REASON WHY TESTING HAS NOT BEEN DONE, PLEASE PROVIDE DOCUMENTATION.

VI. APPLICANT'S STATEMENT AND RELEASE (Please sign the enclosed Request for Appointment and Release form and return with application.)

I hereby apply for Medical/Dental Staff appointment and/or clinical privileges, I am willing to make myself available for interviews in regard to this Application. As an applicant, I understand that it is my responsibility to produce adequate information for proper evaluation of my application and current competence. I also agree to provide the hospital, or its designee with updated, current information regarding all questions on this application form, I agree to provide additional information as may be requested by the hospital or its authorized representatives. Failure to produce any requested information may prevent my application from being processed.

By applying for appointment and/or clinical privileges to practice at Northwest Texas Healthcare System/Northwest Texas Surgery Center/Alliance Regional Health Network, I accept the terms and conditions set forth below and to the fullest extent permitted by law, extend immunity to release from any and all liability. I also agree not to sue, and I intend to be legally bound thereby:

1. Medical Staff appointment and/or clinical privileges at this hospital/surgery center and or as a provider for alliance regional health network are not a right of every licensed professional who makes application for the same,

2. my request will be evaluated in accordance with prescribed procedures defined in the hospital/surgery center and Medical/Dental Staff Bylaws, and Policies on Appointment and Reappointment, also policies, rules, regulations, procedures and directives,

3. all Medical Staff recommendations relative to my application are subject to the ultimate action of the Governing Boards, of the hospital and alliance regional health network whose decision shall be final,

4. if appointed, my initial appointment and clinical privileges shall be provisional for the time period determined by the governing board,

5. I have the responsibility of keeping this application current by informing the hospital through the Administrator or his/her designee, of any changes, including but not limited to any previous or current challenges, reprimands, suspensions, limitations, denials, relinquishments, by any state or federal licensing/certifying Board, malpractice insurance carriers, other Healthcare facilities, organizations or hospitals,

6. Reappointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the hospital/surgery center, acceptance performance of all related responsibilities, as well as the other factors deemed relevant by the hospital.

If appointed and/or granted clinical privileges, I specifically agree to:

1. refrain from fee splitting or other inducements relating to patient referral;
2. refrain from delegating responsibility for diagnoses or care of hospitalized/surgery center patients to any other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised;
3. refrain from deceiving patients as to the identity of any practitioner providing treatment or services;
4. seek consultation whenever necessary or required;
5. abide by generally recognized ethical principles applicable to my profession;
6. provide continuous safe/quality care and supervision as needed to all patients in the hospital/surgery center for whom I have responsibility;
7. accept committee assignments, other duties and responsibilities as assigned to me by the Governing Boards of the Hospital and Medical Staff;
8. follow recommended practices to prevent diseases transmission, to comply with federal and state regulations regarding patient confidentiality and to comply with the patient safety initiatives;
9. I fully understand that any significant misstatement in or omissions from this application constitute cause for summary dismissal from the Medical Staff;
10. If appointed and/or granted clinical privileges, I specifically agree to: Work cooperatively with others so as not to adversely affect patient care and the efficient administration of the hospital/surgery center/alliance regional health network.
11. I agree to abide by the Medical Staff, and Governing Board's bylaws, policies, rules and regulations, directives, guideline for sedation, patient safety goals, universal standards, state and federal regulations regarding patient confidentiality that are in force during the time I am affiliated with the Medical Staff.

Signature: _____ **Date:** _____



Northwest Texas Surgery Center
Alliance Regional Health Network
Request for Appointment and Release

By my signature below, I request appointment to the Medical Staff and granting of Clinical Privileges at Northwest Texas Healthcare System, Inc. (NWTHS) and/or Northwest Texas Northwest Texas Surgery Center (SC) and Alliance Regional Health Network (ARHN) and in return for processing and considering my application for appointment and other valuable consideration, I hereby agree as follows:

1. The term "NWTHS"; "the hospital"; or "SC," or "ARHN" will include Northwest Texas Healthcare System, and/or Northwest Texas Northwest Texas Surgery Center, and Alliance Regional Health Network and their governing boards, medical staff, directors and managers, officers, employees, attorneys and agents.

2. All information submitted by me will be truthful and will not contain material misstatements or omissions. Submissions of false information or omissions will be grounds for denial of my application and/or summary suspension.

3. NWTHS/SC/ARHN are authorized to conduct whatever investigation of me it deems appropriate, including without limitation conducting interviews or obtaining documentation regarding: my education, training, credentials, character, experience, behavior, licensure, affiliation with other hospitals, physical and mental health, instances of substance abuse, malpractice claims, references, professional, moral, and ethical qualifications, and any other matter that may directly or indirectly affect my professional competence, patient care at NWTHS, and/or the SC or the orderly operation of NWTHS, ARHN, and/or SC. I will keep my application current by advising the Medical Staff Office of any changes in application data, including problems related to my mental or physical health. I understand that appointment and granting of clinical privileges are not a right and are contingent upon demonstration of professional competence, appropriate conduct, and the ability to act in the best interest of patient care at NWTHS, and/or SC. I directed and authorized all persons and entities, including other hospitals, insurance companies, past and present malpractice carriers to fully cooperate with any investigation of my application by NWTHS, and/or SC, and release such persons or entities from any liability for claims I may have related to their acts or omissions in cooperating with or releasing data or documents to NWTHS, and/or SC.

4. I release NWTHS, ARHN, and/or SC of, and from, any and all liability on claims that I now have or may have in the future relating to my request for appointment and granting of clinical privileges, and do promise not to sue any of them for any such claim. This release includes, but is not limited to: any investigation of me, the receipt and use of information about me for appointment purposes, disclosure or reporting of information as required or permitted by applicable federal or state law; and any actions regarding my request for appointment and granting of privileges.

5. Information obtained by NWTHS, for the purpose of credentialing for Alliance Regional Health Plans and/or SC will be kept in accordance with the Medical Staff Confidentiality Policy and may only be released as allowed by law, including, without limitation, the Health Care Quality Improvement Act of 1986, the Texas Medical Practice Act, or on signed release from me.

6. I will be bound by the bylaws, rules and regulations, policies and procedures adopted by the Medical Staff and by the governing body of Northwest Texas Healthcare System, Inc, Alliance Regional Health Plans and/or Surgery Center.

7. Furthermore, I agree to comply with Federal and State Regulations regarding patient confidentiality and patient safety initiatives.

 Signature: _____ Date: _____

DOCUMENTATION CHECKLIST

Please enclose the following documents with your application copy of:

- ___ Texas Standardized Application and the NWTBS Pre-Application. <http://www.tdi.texas.gov/forms/lhlhmo/lhl234.pdf>
- ___ CV
- ___ Medical/Dental Degree (Include translation copy if not in English)
- ___ ECFMG
- ___ Internship/Residency training certificate(s) if residency training was completed within the last two years, please provide a copy of procedures performed during training
- ___ Fellowship or special training certificate(s)
- ___ Texas license ___ copy of temporary license or faculty permit
- ___ Board certification certificate
- ___ Current federal narcotic registration (DEA)
- ___ Current Texas narcotic registration (DPS)
- ___ Professional liability (malpractice) policy
- ___ **ATLS required for all General Surgeon only**
- ___ Military discharge DD214 Form
- ___ **Copy of drivers license or passport-the picture must be visible**
- ___ Copy of National Provider Identifier (NPI#)
- ___ Delineation of Privileges Please make sure name is on all forms
- ___ Pharmacy Signature Card
- ___ Signature sheet from Physician Orientation Manual
- ___ Medical Record (Medicare/Medicaid/Tricare) physician signature document
- ___ Emergency Department Questionnaire
- ___ Documentation of current **TB skin test**, required **Immunizations** and **Flu Vaccine** (note attached letter)

TO AVOID DELAY IN PROCESSING-Please use the documentation checklist as a guide for all the required documents that need to be returned. Make sure the application is complete with full names, addresses, and zip codes for all training institutions, peer references, and hospital affiliation, and the address information must be current. It is important we receive all required documents, if required documents are not enclosed, the application may be returned and processing of the application may be delayed.

NORTHWEST TEXAS HEALTHCARE SYSTEM
Northwest Texas Surgery Center

MEDICAL RECORD SERVICES
RECORD OF PHYSICIAN SIGNATURE

PHYSICIAN NAME/ADDRESS:

ACKNOWLEDGEMENT OF PENALTY NOTICE (FEDERAL REQUIREMENT TO BE COMPLETED)*

NOTICE TO PHYSICIAN

"**MEDICARE/MEDICAID/TRICARE** 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."

THIS STATEMENT REMAINS IN EFFECT AS LONG AS THE PHYSICIAN HAS ADMITTING PRIVILEGES AT NORTHWEST TEXAS HEALTHCARE SYSTEM/Northwest Texas Surgery Center.

 **SIGNATURE OF PHYSICIAN:**

DATE:

*PLEASE SIGN IN THE SAME MANNER IN WHICH YOU SIGN THE MEDICAL RECORD. INITIALS ARE NOT ACCEPTABLE

**NORTHWEST TEXAS HEALTHCARE SYSTEM, INC.
EMERGENCY DEPARTMENT
PHYSICIAN CATEGORY QUESTIONNAIRE**

Name:

Please Complete and Return to Facilitate Contacting or Referring to You:

Address:

Office Phone:

Fax:

A. Private Patients:

Check one:

- Call me after ED physician evaluation**
- Call me after ED physician evaluation and only if patient needs to be admitted**
- Call me only if ED staff thinks I need to be contacted**
- Call me prior to ED evaluation; acuity permitting**

B. After Office Hours

Call me at these numbers in this order:

- 1. _____ () answering service () pager () cell phone () home
- 2. _____ () answering service () pager () cell phone () home
- 3. _____ () answering service () pager () cell phone () home
- 4. _____ () answering service () pager () cell phone () home

C. Referrals:

- Call me for referrals**
- Refer without calling**

- Call me for admits**
- Hospitalist will admit my patients**

Northwest Texas Healthcare System Communication Sheet

Physician:

In order to provide efficient communication, please provide your communication preference.

Email Address: _____

Office Manager Name and Email Address: _____

Cell Phone:

Pager: _____

Please indicate your communication preference

Text messages: YES NO

Email: YES NO

MEMORANDUM

TO: NWTTHS Medical Staff Members

FROM: Nathan Goldstein III, M.D., Chief Medical Officer

SUBJECT: Immunization Documentation

During the 82nd session of the Texas Legislature, legislators passed Senate Bill 7, which contained a provision requiring that all hospitals develop and implement a policy specifying required vaccines health care workers must have to protect their patients from vaccine-preventable diseases. These policies must be in place by September 1, 2012.

All Physicians and Allied Healthcare providers applying for privileges at Northwest **will be required to provide documented immunity for the following vaccine preventable diseases: Hepatitis B, Measles, Mumps, Rubella, Pertussis, and Varicella.**

Documentation of **annual TB testing and Influenza vaccination are also required.** Those with medical exceptions will be required to wear a surgical mask whenever they come within six (6) feet of a patient during designated flu season.

Options for compliance are: documentation of the vaccine, or laboratory evidence of immunity.

Exemptions to immunizations may be granted for medical contraindications and precautions based on the most current recommendations from the Advisory Committee on Immunization Practices (ACIP) published by the Centers for Disease Control and Prevention. Individuals requesting exemption must submit a “Medical Exemption Statement for Healthcare Personnel.”

All healthcare workers will be required to strictly adhere to respiratory and hand hygiene practices as well as isolation precautions. Anyone who exhibits signs and symptoms of any vaccine-preventable disease will be excluded from duty per the current CDC guidelines.

If you do not have current documentation for the above required vaccinations’ the Occupational Health department of Northwest Texas Healthcare System is available to provide this service for you; please contact them at 354-1907.

If you need a series of immunizations, such as the Hepatitis B vaccine, you do not have to have the series completed, but you must have the series in process. If you have any questions regarding the above please contact me at 354-1112.