NuHealth
Together through life.

Nassau University Medical Center
A. Holly Patterson Extended Care Facility
Family Health Centers

APPLICATION FOR INITIAL APPOINTMENT

Enclosed you will find an Initial Application for Medical Staff privileges at NuHealth. Please review the checklist below and complete and submit all required documents within 15 days from receipt of this letter to ensure that appropriate time is allotted for processing the application.

☐ Processing fee of $200 with check made payable to "Secretary Treasurer of Medical and Dental Staff at NuHealth."

☐ Application, completed, signed and dated with all disclosure questions answered, signed and dated. All disclosure questions answered as "yes" require a written explanation.

☐ Delineation of Privileges & Disclaimer, completed, signed and dated.

☐ Health form completed (record of immunizations and PPD or chest x-ray) and signed by your Health Care provider. **If you require fit testing for N95 respirator mask, please contact Occupational Health at 516—572-6308 to arrange for fit testing.**

☐ New York State License and other state licenses if applicable.

☐ Copy of current New York State Registration (signed).

☐ Copy of current malpractice insurance certificate with limits no less than 1.3 million/3.9 million (if you are not applying for a salaried position, you must provide proof of malpractice coverage with limits of liability included). For all providers, please complete the application section for malpractice and include your last 10 years of coverage.

☐ Professional school degree/diploma (i.e. internship. residency or fellowship certificates).

☐ Copy of Board Certificate.

☐ Three (3) peer recommendations (forms enclosed).

☐ Federal or state license with signature and photo ID (**notarized** copy of driver's license, passport, NYS Provider ID card). If notarized copy not provided, you must bring your ID to the Medical Staff Office for verification.

☐ Two (2) passport size photos.

☐ Attestation form for continuing medical education (CME), signed and dated, and copies of certificates from education completed within the last two years (50 CME credits required).

☐ Form of Acceptance, signed and dated.

☐ Infection Control Training Certificate.

☐ Current Curriculum Vitae (month/year format) with the last 5 years of work history included.

☐ Malpractice Claims Attestation Form for explanation of malpractice claims history completed, signed and dated.

☐ ACLS, PALS, ATLS certificates (if required as per privileges).

☐ NPI# (National Provider Identifier). If you do not have an NPI number, please apply on line at https://nppes.cms.hhs.gov/NPPES/Welcome.do

☐ NPI# confirmation receipt.

☐ Copy of ECFMG certificate (if applicable).

☐ Acknowledgement Statement, signed and dated.

☐ Impairment Education Attestation.

☐ Palliative Care Attestation.

Please send all materials with your application to the Medical Staff Office. If you have any questions, feel free to contact me at (516) 572-6131.

Sincerely,

Dianna Ruppel
Dianna Ruppel, CPMSM, CPCS
Manager, Medical Staff Services
NuHealth

Medical Staff Office . 2201 Hempstead Turnpike . East Meadow, NY 11554 . (516) 572-6131 . Fax (516) 572-6153

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Nassau University Medical Center
A. Holly Patterson Extended Care Facility
Family Health Centers

MEDICAL STAFF APPOINTMENT APPLICATION

(Practitioner Credentialing Application Form)

2201 Hempstead Turnpike
East Meadow, New York 11554
(516) 572-6131 phone
(516) 572-6153 fax

Please choose facilities to which you are applying:

☐ Nassau University Medical Center ☐ A. Holly Patterson Extended Facility

☐ Family Health Centers ☐ Nassau County Correctional Center

Seeking Appointment Status As:

Employment Status: ☐ Full Time ☐ Part Time ☐ Sessional ☐ Contracted ☐ Voluntary

Category of Appointment: ☐ Active ☐ Affiliate Referring ☐ Courtesy Admitting ☐ Courtesy Teaching

☐ Visiting ☐ Emeritus ☐ House Staff ☐ Clinical Fellows ☐ Allied Health Professions

Last Name: _____ First Name: _____ Middle Name: _____

Degree: _____ Maiden Name: _____ Sex: ☐ Male ☐ Female

Date of Birth: _____ Place of Birth: _____ Country of Citizenship: _____

Social Security #: _____ NPI #: _____

Medicare Provider #: _____ Medicaid Provider #: _____

UPIN #: _____ Workers Compensation #: _____

Languages: _____ ☐ Read ☐ Write ☐ Speak _____ ☐ Read ☐ Write ☐ Speak

Do you know American Sign Language? ☐ Yes ☐ No

Home Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Pager: _____

PRIMARY PRACTICE INFORMATION

Group/Corporation Name as it appears on W9: _____

Address: _____ City, State, Zip: _____

Phone #: _____ Fax #: _____

Office Manager/Contact: _____ Email Address: _____

APPLICANT NAME: _____

SECONDARY PRACTICE INFORMATION
Group/Corporation Name as it appears on W9: _____

Address: _____ City, State, Zip: _____

Phone #: _____ Fax #: _____

Office Manager/Contact: _____ Email Address: _____

Primary Specialty: _____ Secondary Specialty: _____

Tertiary Specialty: _____

STATE MEDICAL LICENSE(S): (Submit copies of all current licenses and New York State Registration)

Do you have any limitations or restrictions on your license? ☐ Yes ☐ No
If yes, please explain: _____

DEA: (Submit copy of current DEA certificate)

Registration #: _____ Expiration Date: _____

Schedules: ☐ 1 ☐ 2 ☐ 2N ☐ 3 ☐ 3N ☐ 5

Do you have any limitations or restrictions on your license? ☐ Yes ☐ No
If yes, please explain: _____

BLS: ☐ Yes ☐ No Expiration Date: _____ **ACLS**: ☐ Yes ☐ No Expiration Date: _____
ATLS: ☐ Yes ☐ No Expiration Date: _____ **PALS**: ☐ Yes ☐ No Expiration Date: _____

EDUCATION:
Are you an International Medical Graduate? ☐ Yes ☐ No If yes, ECFMG #: _____

Undergraduate Education:
School Name: _____
Address: _____
Start Date: _____ Date of Graduation: _____
Degree Earned: _____

Medical/Dental/Professional Education:
School Name: _____
Address: _____
Start Date: _____ Date of Graduation: _____
Degree Earned: _____

APPLICANT NAME: _____

POST-GRADUATE RELATED TRAINING:

Internship:
Institution Name: _____
Address: _____
Dates Attended: From: _____ To: _____ Program Director: _____
Did you successfully complete this program? ☐ Yes ☐ No Phone: _____ Fax: _____

Residency:
Institution Name: _____
Address: _____
Dates Attended: From: _____ To: _____ Program Director: _____
Specialty: _____ PGY Level: _____
Did you successfully complete this program? ☐ Yes ☐ No Phone: _____ Fax: _____

Residency:
Institution Name: _____
Address: _____
Dates Attended: From: _____ To: _____ Program Director: _____
Specialty: _____ PGY Level: _____
Did you successfully complete this program? ☐ Yes ☐ No Phone: _____ Fax: _____

Did you leave any residency program prior to the end of the program? ☐ Yes ☐ No
If yes, please explain: _____

Fellowship:
Institution Name: _____
Address: _____
Dates Attended: From: _____ To: _____ Program Director: _____
Specialty: _____ PGY Level: _____
Did you successfully complete this program? ☐ Yes ☐ No Phone: _____ Fax: _____

Fellowship:
Institution Name: _____
Address: _____
Dates Attended: From: _____ To: _____ Program Director: _____
Specialty: _____ PGY Level: _____
Did you successfully complete this program? ☐ Yes ☐ No Phone: _____ Fax: _____

Did you leave a Fellowship program prior to the end of the program? ☐ Yes ☐ No
If yes, please explain: _____

*****For any gaps in time, please provide a detailed explanation on a separate sheet of paper.*****
_____
_____
_____
_____

APPLICANT NAME: _____

HOSPITAL AFFILIATIONS/APPOINTMENTS:
(List in chronological order with the most recent affiliation first. Use additional sheets if necessary)

Name of Facility (Department): _____
Address: _____
Affiliation/Appointment: From: _____ To: _____
Reason for Termination of Affiliation/Appointment: _____

Name of Facility (Department): _____
Address: _____
Affiliation/Appointment: From: _____ To: _____
Reason for Termination of Affiliation/Appointment: _____

Name of Facility (Department): _____
Address: _____
Affiliation/Appointment: From: _____ To: _____
Reason for Termination of Affiliation/Appointment: _____

Name of Facility (Department): _____
Address: _____
Affiliation/Appointment: From: _____ To: _____
Reason for Termination of Affiliation/Appointment: _____

SPECIALTY BOARD STATUS: ** (Please note your Specialty Board must be approved by the ABMS or AOA in accordance with NuHealth Medical Staff Bylaws) **

Primary Certification

Name of Board	Certified	Year Issued	Date Expired	Certificate Number
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Name of Board	Year Issued	Date Expired
_____	_____	_____
_____	_____	_____
_____	_____	_____

Recertification

ACADEMIC APPOINTMENTS
(List in chronological order with most recent appointment first for the past 10 years).

Name of College/University: _____
Address: _____
Academic Title: _____
Telephone #: _____ Fax #: _____
Appointment Date: From: _____ To: _____
Reason for Leaving: _____

APPLICANT NAME: _____

Name of College/University: _____
Address: _____
Academic Title: _____
Telephone #: _____ Fax #: _____
Appointment Date: From: _____ To: _____
Reason for Leaving: _____

Name of College/University: _____
Address: _____
Academic Title: _____
Telephone #: _____ Fax #: _____
Appointment Date: From: _____ To: _____
Reason for Leaving: _____

MEMBERSHIP IN PROFESSIONAL SOCIETIES/ASSOCIATIONS:
(List all professional societies and associations. Use additional sheets of paper if necessary.)

_____ _____
_____ _____
_____ _____
_____ _____

PROFESSIONAL LIABILITY INSURANCE:
(List the name(s) of your professional liability insurance carrier(s). Please use additional sheets if necessary.)
Present Primary Insurance Carrier Name: _____
Policy Number: _____
Policy Limits: From: _____ To: _____
Inception Date: _____ Expiration Date: _____
Type of Coverage: ☐ Claims Made ☐ Occurrence ☐ Self-insured through hospital policy

Present Excess Insurance Carrier Name: _____
Policy Number: _____
Policy Limits: From: _____ To: _____
Inception Date: _____ Expiration Date: _____
Type of Coverage: ☐ Claims Made ☐ Occurrence ☐ Self-insured through hospital policy

Previous Insurance Carrier Name: _____
Policy Number: _____
Policy Limits: From: _____ To: _____
Inception Date: _____ Expiration Date: _____
Type of Coverage: ☐ Claims Made ☐ Occurrence ☐ Self-insured through hospital policy

Previous Insurance Carrier Name: _____
Policy Number: _____
Policy Limits: From: _____ To: _____
Inception Date: _____ Expiration Date: _____
Type of Coverage: ☐ Claims Made ☐ Occurrence ☐ Self-insured through hospital policy

APPLICANT NAME: _____

Please provide explanation for change in insurance company:
_____
_____
_____
_____

PROFESSIONAL REFERENCES:
List three (3) references, two of whom are from your specialty who 1) have had extensive recent experience directly observing your professional and clinical performance, 2) will provide opinions on actual performance, clinical judgment, technical skills as well as available information on the nature or types of care provided and outcomes, and 3) attest to your professional competence and ethics.

Name: _____ Title: _____
Organization: _____
Address: _____
Telephone #: _____ Fax #: _____

Name: _____ Title: _____
Organization: _____
Address: _____
Telephone #: _____ Fax #: _____

Name: _____ Title: _____
Organization: _____
Address: _____
Telephone #: _____ Fax #: _____

HEALTH STATUS:

Do you have a physical or mental condition that could affect your ability to exercise the clinical privileges requested? ☐ Yes ☐ No

If yes, please explain: _____
_____
_____

SPECIAL PRIVILEGES:

I WISH TO REQUEST THE FOLLOWING SPECIAL PRIVILEGES:
(an education packet will be forwarded to you for each of the following privileges requested)

Please choose special privileges requested:

☐ Moderate Sedation ☐ Total Parenteral Nutrition ☐ Fluoroscopy ☐ Ventilation Setting Adjustment

APPLICANT NAME: _____

CERTIFICATION:

I certify that all of the information contained in this application is complete and accurate. I further agree that I am obligated to promptly notify NuHealth if the information provided above changes at any time.

Signature: _____

Print Name: _____

Date: _____

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Nassau University Medical Center
A. Holly Patterson Extended Care Facility
Family Health Centers

Application for Appointment or Reappointment to the Medical Staff
Waiver of Confidentiality and Authorization to Release Information

All information submitted by me in connection with this application in turn is true and correct to the best of my knowledge and belief and I fully understand that any significant misstatement or omission of information from this application may constitute course for denial of appointment or privileges and may warrant dismissal from the medical staff.

By applying for appointment to the Medical Staff of the NuHealth System, I hereby signify my willingness to supply information and/or appear for an interview in regard to my application and authorize the NuHealth System, its Medical Staff and their representatives to consult with the administrative members of the Medical Staff, New York State Medical Society and health related facilities with which I have been associated and with others who may have information bearing on my professional competence, character and ethical qualifications.

I hereby further consent to the inspection by the NuHealth System and its Medical Staff of all records and documents at other hospitals that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested, as well as my ethical qualifications for staff membership.

I hereby authorize NuHealth and its representatives to consult with administrators and members of the medical staffs of hospitals, medical schools or other institutions with which I have been associated and with others, including past and present malpractice insurance carriers and governmental agencies who may have information bearing on my professional competence, status, character and ethical qualifications. I hereby further authorize and request such organizations and/or individuals to release to NuHealth and its representatives all documents that may be material to an evaluation of my professional status, qualifications and competence.

I grant authorization and consent to NuHealth and its representatives to conduct a background check, including, a criminal record check, conviction records check, abuse registry check, and driving record check.

I hereby release from liability NuHealth and those acting in good faith on its behalf in evaluating my application, credentials, qualifications and performance on an ongoing basis. I also release from liability any and all individuals and organizations that provide information to NuHealth concerning my professional competence, ethics, character, health status and other qualifications for staff appointment and clinical privileges. I also release from liability NuHealth and those acting on its behalf and authorize them to release and exchange information relating to my professional qualifications and/or relating to practices, competence, status, character, disciplinary action and/or medical staff privileges to other hospitals where I have or may apply for staff privileges.

I understand and agree that I, as an applicant for Medical Staff membership or privileges, 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

In making this application, I acknowledge that I have the responsibility to be bound to the Medical Staff Bylaws, Rules and Regulations and policies of NuHealth and agree to conduct my practice in accordance with high ethical standards.

_____ _____

Signature **Date**

_____

Print Name

REFUSAL TO UNDERGO A BACKGROUND CHECK

I ***refuse*** to undergo a background check and I understand this may directly affect my appointment or reappointment to the Medical Staff.

_____ _____

Signature **Date**

_____

Print Name

NAME: _____

If your answer to any question below is yes, you must provide a detailed explanation on a separate sheet. Explanations must include the reason the action was taken against you.

	Yes	No
1) Have you previously applied for staff privileges at NuHealth?		
2) Are there any professional misconduct proceedings pending against you in New York or another state or jurisdiction?		
3) Have you ever been reprimanded, disciplined or counseled by any agency with respect to your license to practice?		
4) Has your license to practice as a health professional in any jurisdiction ever been limited, suspended or revoked, or have you ever been reprimanded, fired or otherwise disciplined by a licensing board or similar agency in any jurisdiction?		
5) Have you ever pled guilty, no *lo contendere*/no contest, or been convicted of any crime (include all misdemeanors or felonies) or named in a civil suit (excluding divorce proceedings) or administrative action under New York State law, Federal Law or law of another jurisdiction? Include any litigation (clause, pre-suit notice, lawsuits), related in any way to your practice. For each felony or misdemeanor, list date, type of crime, specific charge and location. For each lawsuit or administrative action, list other party/parties, date, nature of action and resolution. Additional details may be requested.		
6) Have you ever voluntarily restricted or not renewed your license to practice a health profession in any state or your State Controlled Substance or DEA license?		
7) Has your license, certification or other authorization to prescribe or dispense medications ever been limited, suspended or revoked (includes DEA, state controlled substance license etc)?		
8) Have you ever been placed on probation or subject to other disciplinary action in any training program?		
9) Has your membership or your privileges at any group practice, academic institution, hospital or other health care facility or at any health plan ever been denied, suspended, restricted, otherwise limited, revoked or not renewed?		
10) Have you ever voluntarily restricted or withdrawn your privileges from any hospital or other health facility or limited or terminated your employment with any such institution or with any affiliated academic institution or group practice?		
11) Have you ever been reprimanded censured, excluded, suspended (even in the action was stayed), or disqualified from participating in Medicare, Medicaid or any other governmental or quasi-government health-related programs or any other third party payer?		
12) Were you ever convicted of driving while impaired or under the influence of any other substances?		
13) Has any formal or informal disciplinary action ever been imposed on you by any group practice, academic institution, hospital (including a clinical department), other health care facility (including a clinical department), health plan, professional society or licensing agency?		
14) Has a malpractice judgment been made against you or settled out of court in the past 10 years, or is a malpractice claim anticipated or pending?		
15) Have you ever opted out of Medicare?		
16) Are you currently addicted to drugs or alcohol? Have you used purchased or sold illegal drugs or abused prescription drugs within the last two years?		
17) Have you ever been asked to resign, withdraw or terminate your position in a medical partnership, professional association, health maintenance organization or medical practice?		
18) Have there been any felony criminal charges brought against you?		
19) Have you ever been denied professional liability insurance coverage or had your professional liability insurance coverage canceled?		
20) Are you habituated or addicted to the use of alcohol or any other drug or substance that will affect your ability to treat and/or render professional care to patients coming under your care?		
21) Have you had or is there any existing physical or mental health condition that would affect your ability to satisfactorily treat and/or render professional care to patients coming under your responsibility?		
22) Have there been any actions taken against you resulting from a violation by you of a patient's rights in any health care facility (i.e., findings arising out of complaints by patients about the care and services provided by you)? If yes, please provide a full explanation (including the substance of the allegations and findings) of each incident on a separate sheet of paper.)		

_____ _____

Provider Signature Date

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CENTERS OF CARE
Nassau University Medical Center
A. Holly Patterson Extended Care Facility
Family Health Centers
Elmont • Westbury • Hempstead • Roosevelt

For Physician or Nurse Practitioner

The following was contained in a letter dated February 8, 2011 from the Deputy Commissioner of the New York State Department of Health to our Chief Executive Officer:

"As of February 9, 2011, under Chapter 331 of the Laws of 2010 (commonly known as the Palliative Care Information Act), physicians and nurse practitioners are required to offer to provide terminally-ill patients with information and counseling concerning palliative care and end-of-life options. A patient has a terminal illness or condition, under the law, if the illness or condition is "reasonably expected to cause death within six months, whether or not treatment is provided." Palliative care, as defined by the law, is "health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life, including hospice care."

The law is intended to ensure that patients are fully informed of the options available to them when they are faced with a terminal illness or condition, so that they are empowered to make choices consistent with their goals for care and wishes and beliefs, and to optimize their quality of life. The law is not intended to limit the options available to terminally-ill patients. Nor is it intended to discourage conversations about palliative care with patients whose life expectancy exceeds six months. It is often appropriate to discuss palliative care with patients earlier in the disease progression."

By my signature below I acknowledge that I am aware of the requirements stated above.

Print Name _____

Signature _____

Title _____

Department _____

Today's Date _____

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A. Holly Patterson Extended Care Facility
Family Health Centers

NuHealth

MALPRACTICE CLAIM FORM

(Complete one form per claim)

This form MUST be returned. If you have no claims, check the box, sign, date and return the form. **You must list all pending, settled, dismissed, discontinued or closed malpractice actions in and out of New York State for the past 10 years.**

☐ **To the best of my knowledge, I have no malpractice claims against me nor have I been named in any cases.**

PRACTITIONER NAME: _____

NAME OF PATIENT: _____

NAME OF CASE AS IT APPEARS ON SUMMONS: _____

INSURANCE COMPANY PROVIDING COVERAGE FOR THIS CLAIM:
_____

EXCESS INSURANCE: _____

DATE OF OCCURRENCE OF CLAIM: _____

STATUS OF CLAIM: Case Dismissed: _____

Case Open: _____ Case Closed: _____

Case Settled: _____ Settlement Amount: _____

For Open Claims, **DESCRIBE ALL ACTIVITY ON THIS CLAIM WITH THE LAST 12 MONTHS**
(i.e. testified at an EBT, verdict on appeal, etc).
_____

_____

Date of Occurrence Giving Rise to this Claim:
_____

Location of Treatment: ☐ Office ☐ Hospital or Health Related Facility ☐ Other

Brief Statement of Fact and Allegation:
_____
_____
_____
_____

Comments you may wish to make:
_____

_____

I, _____, declare that all the information contained in this
(Practitioner Name)
Malpractice Claim Form is true and accurate.

Signature: _____ **Date:** _____

MS WG approved 10-28-09

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A. Holly Patterson Extended Care Facility
Family Health Centers

FORM OF ACCEPTANCE OF APPOINTMENT
TO THE MEDICAL STAFF OF THE
NASSAU HEALTH CARE CORPORATION

Board of Directors
NuHealth
2201 Hempstead Turnpike, Box 42
East Meadow, New York 11554

Ladies and Gentlemen:

By accepting the honor and responsibility as a member of the Medical Staff of the NuHealth, I hereby agree:

1. To be bound by the terms of the Medical Staff Bylaws and Rules and Regulations of NuHealth;

2. To comply with all NuHealth policies and procedures; federal, state, and local laws, regulations and guidelines; and professional standards and ethics;

3. To manifest to the best of my ability a constructive interest in NuHealth;

4. To ensure that all patients admitted to my care and treatment in any of the facilities, departments or services of NuHealth shall receive appropriate care and that one level of care is provided to all patients;

5. To immediately notify the Medical Staff Office of any suspension, sanction, or other action against me by a federal, state, or local licensing or regulatory body, governmental agency, or insurance program; any criminal action brought against me; or any civil action brought against me that relates to the practice of my profession;

6. To cooperate fully with all medical malpractice matters and investigations, including discovery and defense, and all other investigations by any federal, state, or local licensing or regulatory body, governmental agency, or insurance program, which arise during my tenure with NuHealth both during and following my affiliation and/or employment;

7. To be truthful in all matters related to the above and in all dealings with NuHealth, the violation of which may lead to my suspension and/or dismissal from the Medical Staff for which I agree to waive any appeal rights granted under the NuHealth Medical Staff Bylaws and Rules and Regulations..

Print: _____

Signature: _____ Date: _____

Please return to:
Medical Staff Office – 2201 Hempstead Tpke, Box 42, East Meadow, N.Y. 11554

WG approved 10-28-09

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Nassau University Medical Center
A. Holly Patterson Extended Care Facility
Family Health Centers

ANNUAL ACKNOWLEDGEMENT STATEMENT TO PRACTITIONERS STATE OF NEW YORK

Notice to Practitioners:

Payment to hospitals for inpatient services is based, in part, on each patient's principal and secondary diagnoses and the major procedures performed on the patient; for neonates, upon birth weight or admission weight as well. This data must be documented by the patient's medical record. Anyone who misrepresents, falsifies, or conceals this information may be subject to fine, imprisonment, or civil penalty under applicable Federal and New York State Laws.

This "Notice" conforms to Section 2803 of the Public Health Law, Paragraph 3(e) of Section 405.3 of Part 405 of Chapter V of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York. Effective 9/14/94, you are required to read, sign and date the following notice annually. This signed notice will become part of your Medical Staff Credentials file.

By my signature on this form, I acknowledge that I have received a copy of the above statement from NuHealth.

_____ _____

Practitioner's Full Signature Date

_____

Practitioner's Full Name (Please Print)

H 373
MS WG approved 10/28/09

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A. Holly Patterson Extended Care Facility
Family Health Centers

APPOINTMENT TO THE MEDICAL STAFF
EMPLOYMENT/AFFILIATION HEALTH ASSESSMENT

_____ _____
Name of Practitioner Department

This is to certify that I have:
☐ **completed a physical examination on _____/_____/_____**
or **date**
☐ **reviewed the health assessment dated _____/_____/_____**
date
on the above named practitioner and that documentation of the same is maintained in a medical record in my office or in the Medical Record Department at NuHealth.

I certify, to the best of my knowledge, that the above named practitioner is free from any apparent health impairment which is a potential risk to patients or might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drug substances which may alter the individual's behavior.

(Part 405.3(b) (10), Title 10, Chapter V, Article 2 of the Compilation of Codes, Rules and Regulations of the state of New York)

TST: Planted: _____/_____/_____ Read: _____/_____/_____ Result: _____mm
date **date**
If patient is TST positive:
Date of last chest x-ray: _____/_____/_____ Result: _____
date
I attest that the patient is free of symptoms of active tuberculosis (persistent cough, fever, chills, unexplained weight loss, night sweats, coughing up blood, loss of appetite, prolonged fatigue).

I certify that, according to the medical records, the practitioner is immune to:
❑Rubella ❑Hepatitis-B ❑Measles
❑Mumps ❑Varicella

I certify that the above named practitioner has the ability to perform his/her delineated functions.

Examination/Assessment completed/reviewed by:

_____ _____/_____/_____
Signature of Licensed Practitioner date

_____
Printed or Stamped Name

_____
NYS License #

_____
Address

_____
Telephone

K:employee health form 11-09

NEW TECHNOLOGY POLICY MS-012 page 4/4

New Technology/Procedure Briefing

Physician Name: _____

Date: _____

What new technology/procedure do you plan to use?

_____

Will the nursing staff or other staff need any special or additional education?

_____

Will use of this technology/procedure require an operating room set-up that is different from the norm?

_____

Please give us the name of three (3) hospitals that use this technology/procedure.

1. _____
2. _____
3. _____

When would you like to begin using this technology/procedure?

_____

Will this technology/procedure require the attendance of any continuing medical education courses prior to its use? _____

_____

Please outline the qualifications needed by a physician to use this technology/procedure safely.

_____

_____

_____

If you have any of the following information, please submit them with your Medical Staff Application.

a. Research concerning the proposed technology/procedure
b. Course materials
c. Manufacturer's materials
d. FDA approvals (if any)

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Nassau University Medical Center
A. Holly Patterson Extended Care Facility
Family Health Centers

MEDICAL STAFF OFFICE BOX # 42
2201 Hempstead Turnpike
East Meadow, NY 11554
(516) 572-6131 phone
(516) 572-6153 fax

PEER RECOMMENDATION FORM

PRACTITIONER NAME: _____ DEPARTMENT: _____

SPECIALTY: _____

1. How many years have you known the practitioner? _____
2. What is your relationship to the practitioner? _____

Please evaluate the practitioner based on the requested privileges (see attached) and demonstrated competency by virtue of training, education and performance to that reasonably expected of a practitioner at his/her level of training, experience and background.

	Poor	Fair	Good	Superior
Patient Care				
-Availability and thoroughness of patient care				
-Technical skills				
Medical/Clinical Knowledge				
-Medical/clinical knowledge				
-Clinical judgment				
Practice-Based Learning & Improvement				
-Utilizes current best practice (e.g. core measures, IHI indicator compliance				
Interpersonal & Communication Skills				
-Ability to work with members of healthcare team				
-Rapport with patients and families				
Professionalism				
-Commitment to continuous professional development (as evidenced by CM participation in medical staff or professional association activities				
-Demonstration of ethical standards in treatment				
Systems-Based Practice				
-Practices cost-effective health care and resource allocation that does not compromise quality of care				
-Advocates for quality patient care and assists patients in dealing with syster complexities				
-Use of medical consults				

PRACTITITONER NAME: _____

3. Comments: Please indicate any notable strengths and weaknesses or explanation of above answers and indicate the basis of your responses (e.g. direct observation, accumulated information/reports)

_____

_____

4. Recommendations: _____

_____

_____

I have reviewed the requested privileges in light of the practitioner's training and experience and make the following recommendation:

□ Recommended
□ Recommend with some reservation
□ Do not recommend

Signature: _____ Date: _____

Print Name: _____

Title: _____

Address: _____

_____

_____

Telephone: _____

NuHealth
Together through life.

Nassau University Medical Center
A. Holly Patterson Extended Care Facility
Family Health Centers

MEDICAL STAFF OFFICE BOX # 42
2201 Hempstead Turnpike
East Meadow, NY 11554
(516) 572-6131 phone
(516) 572-6153 fax

PEER RECOMMENDATION FORM

PRACTITIONER NAME: _____ DEPARTMENT: _____

SPECIALTY: _____

1. How many years have you known the practitioner? _____
2. What is your relationship to the practitioner? _____

Please evaluate the practitioner based on the requested privileges (see attached) and demonstrated competency by virtue of training, education and performance to that reasonably expected of a practitioner at his/her level of training, experience and background.

	Poor	Fair	Good	Superior
Patient Care				
-Availability and thoroughness of patient care				
-Technical skills				
Medical/Clinical Knowledge				
-Medical/clinical knowledge				
-Clinical judgment				
Practice-Based Learning & Improvement				
-Utilizes current best practice (e.g. core measures, IHI indicator compliance				
Interpersonal & Communication Skills				
-Ability to work with members of healthcare team				
-Rapport with patients and families				
Professionalism				
-Commitment to continuous professional development (as evidenced by CM participation in medical staff or professional association activities				
-Demonstration of ethical standards in treatment				
Systems-Based Practice				
-Practices cost-effective health care and resource allocation that does not compromise quality of care				
-Advocates for quality patient care and assists patients in dealing with syster complexities				
-Use of medical consults				

PRACTITITONER NAME: _____

3. Comments: Please indicate any notable strengths and weaknesses or explanation of above answers and indicate the basis of your responses (e.g. direct observation, accumulated information/reports)

_____

_____

4. Recommendations: _____

_____

_____

I have reviewed the requested privileges in light of the practitioner's training and experience and make the following recommendation:

□ Recommended
□ Recommend with some reservation
□ Do not recommend

Signature: _____ Date: _____

Print Name: _____

Title: _____

Address: _____

_____

_____

Telephone: _____

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ATTESTATION FOR CONTINUING EDUCATION

I, _____ certify that I have completed _____ *(number of hours) of continuing professional education for the previous two years.

I understand that my records can be audited at any time by the Medical Staff. I understand that if I cannot produce evidence of the above continuing education credits, I can lose my staff privileges with NuHealth.

Signature: _____

Department: _____

Date: _____

Membership on the Medical Staff requires a minimum of *50 HOURS* ***of category 1 AMA or ADA continuing Medical Education during the two-year period prior to the date of your application. At least one-half (1/2) of the CME will be related to privileges requested. Additional Category 1 hours may be required at the discretion of the Department Chair.***

All Allied Health Professionals must complete the minimum number of hours of Professional Education required for licensure/registration during the two-year period prior to the date of your application.

K:appointment/CME attestation 11-23-09
Approved 10-28-09 MSWG

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A. Holly Patterson Extended Care Facility
Family Health Centers

PRACTITIONER EDUCATION
ILLNESS AND IMPAIRMENT ISSUES

ATTESTATION

NAME: _____

I certify that I have reviewed the information and annual education provided to me by NuHealth regarding Licensed Independent Practitioner Illness and Impairment.

Signature: _____

Date: _____

Please fax this form to the NuHealth Medical Staff Office at (516) 572-6153