HEALTH CARE PROFESSIONALS
CREDENTIALING & PRIVILEGING APPLICATION

PERSONAL INFORMATION

Name: _____

Title: _____

Home Address _____

_____

Home Phone ( )_____ Cell Phone ( ) _____

E-mail Addess_____

Date of Birth _____Social Security Number (last four digits)_____

Current Practice Status: ☐ Active ☐ Retired

PRACTICE INFORMATION

☐ N/A

Practice Name _____

Practice Address_____

_____

Mailing address if different from above:

_____

_____

Phone ( ) _____ Fax ( ) _____

Practice Contact Name _____

Hospital/Institutional Membership(s)

For LIPs & Mid Level Providers
(List current memberships)

Facility Name_____

Address_____

Department/Service/Position_____

Dates of Appointment From_____ To_____

Facility Name_____

Address_____

Department/Service/Position_____

Dates of Appointment From_____ To_____

Affirmation, Authorization and Consent

In making this application:

- I acknowledge my obligation to fulfill my responsibilities to provide quality care to the patients of Mariam Clinic
- To maintain practice knowledge and skills current through continuing education opportunities; and
- To abide by the bylaws, rules and regulations, policies and procedures of the organization.

I Affirm that:

- I have never been convicted of a felony;
- I have never been charged with sexual harassment;
- I have not and will not provide patient care under the influence of drugs or alcohol;
- I do not have any communicable disease and if at anytime I should contract a communicable disease I will notify the Medical Director and/or Executive Director;
- I will adhere to patient confidentiality and privacy standards.

I agree to participate:

- In and cooperate fully with all Quality Assurance Programs for improving quality and reducing risk.

I hereby release from liability Mariam Clinic and all its representatives for their acts performed while evaluating my application, credentials and qualifications. I understand that an AMA profile and NPDB query will be obtained.

I hereby release from liability any and all individuals and organizations that provide information to Mariam Clinic or its representatives concerning my professional competence, character, ethics, and other qualifications for employment and/or privileges and I hereby consent to the release of such information.

As applicable, I hereby accept that I will abide by the requirements for medical malpractice coverage for the Federal Tort Claims Act Program. I will cooperate fully with any investigations and defense of liability claims.

I understand that I have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications. I fully understand that any misstatements or omissions in the application constitute cause for denial or termination of privileges and/or employment. All information submitted by me in this application is true to the best of my knowledge.

_____ _____

Signature of Applicant **Date**

_____

Printed Name & Title

PROFESSIONAL MALPRACTICE INSURANCE

Present Carrier's Name_____

CLAIMS INFORMATION

1. Have you ever been denied professional liability insurance or has your coverage ever been canceled? ☐ Yes ☐ No

If yes, please attach explanation

2. Are there currently pending or have there been any malpractice claims, judgments or settlements involving your professional practice in the last 10 years? ☐ Yes ☐ No

If yes, please attach explanation

REQUIRED COPIES & REFERENCES

Sponsoring FTCA clinics are required to have a copy of the following

- ☐ Identification (via government issued picture id-driver's license)
- ☐ Malpractice insurance carrier's current declaration statement
- ☐ DEA Registration, as applicable
- ☐ North Carolina Medical License
- ☐ Basic or Advanced Life Support Healthcare Providers card, as applicable
- ☐ Hepatitis B Immunization Record or Titer Results or as applicable, declination statement (contact the director for this form)

Please return this application and related documents to

Elaine Oakley BA, RN
Director Mariam Clinic
Phone: 919-824-4672 **Fax:** 919-439-3778
mariamclinicdirector@gmail.com

Mailing Address: 4441-106 Six Forks Rd #388 Raleigh NC 27609

Mariam Clinic Scope of Patient Services

Providers Scope of Practice Request

☐ **General Medicine**

Provide medical care, health maintenance, and preventive services for patients 18 years and older. Medical concerns are managed through diagnosis, treatment and prevention of common illnesses and chronic diseases. No pregnancy and delivery care is provided. Coordinate and manage patient care with other specialists. Perform joint aspirations and steroid injections.

☐ **Cardiology**

Provide diagnosis and non-surgical treatment of heart and vascular conditions of all ages, including those that require cardiologic methods of study and treatment.

☐ **Dental**

Provide exams, basic care and treatment to the teeth, jaws and mouth. Perform examinations, routine endodontic therapy and simple exodontias.

☐ **Dermatology**

Provide diagnosis and treatment of diseases and tumors of the skin and its appendages, including removal of skin lesions.

☐ **Endocrinology**

Provide medical care for disorders of the endocrine glands such as the thyroid and adrenal glands. Endocrinology also includes diabetes, metabolic and nutritional disorders, pituitary disease and other metabolic disorders. May perform thyroid nodule aspirates.

☐ **Gastroenterology**

Provide clinical services related to diseases of the digestive tract, liver and pancreas, including chronic gastrointestinal disorders such as acid peptic disease, ulcerative colitis, Crohn's disease, reflux esophagitis, esophageal stricture management, hepatic diseases and motor disorders of the gastrointestinal tract.

☐ **Gynecology**

Provide well woman and preventive care as well as diagnosis and treatment of most conditions of the reproductive organs. Some of these conditions may include treating abnormal pap smears, sexually transmitted diseases, or pain in the pelvis or urethra. Care does not include managing pregnancy, labor and delivery or post delivery. Office based procedures are usually performed to diagnose or treat certain conditions resulting from an abnormal pap smear, biopsy or irregular bleeding .Procedures performed in the clinic may include colposcopy and endometrial biopsy.

☐ **Podiatry**

Provide medical care for arthritic, diabetic, and other medical problems associated with the feet and lower extremities, including the use of devices fitted in shoes orthotic devices or modification of shoe(s) for enhancing mobility. Other procedures include cutting of nails, removing of callus and corns, and in-grown toenail surgical intervention.

☐ **Psychiatry**

Provide differential diagnosis and treatment of mental illness. Treatment can involve medication, psychotherapy and psychosocial interventions.

☐ **Internal medicine**

Provide diagnosis and non-surgical treatment of diseases in adults.

☐ **Ophthalmology**

Provide medical care for the eyes and visual system and prevention of eye disease.

☐ **Physician Assistant**

Provide basic health care for adults, including performing physical exams, diagnosis and treatment of acute and chronic common illnesses, ordering diagnostic tests, performing procedures, and prescribing and dispensing certain medications under the supervision of a medical doctor

☐ **Nurse Practitioner**

Provide basic health care for adults, including performing physical exams, diagnosis and treatment of acute and chronic common illnesses, ordering diagnostic tests, performing procedures, and prescribing and dispensing certain medications under the supervision of a medical doctor.

Requesting Provider's Name: _____ **Date:** _____

Requesting Provider's Signature: _____

Federal Tort Claims Act Coverage

Dear Provider,

I am pleased to introduce you to the Federal Tort Claims Act (FTCA) and thank you for your support of the Mariam Clinic. We realize that the time you afford our clinic is a precious gift and if not for professionals like yourself many people within our community may not receive health care assistance.

Congress has enacted the FTCA medical malpractice protection for volunteer free clinic health care professionals which will offer you immunity from medical malpractice lawsuits while volunteering at the Mariam Clinic

All free clinics who participate must assure the Bureau of Primary Health Care that they conduct complete and thorough credentialing and privileging of their health care professionals, including querying of the National Practitioner's Data Bank (NPDB). This process is probably not new to you, as this is the same process that hospitals require. In order to meet this requirement there is information and authorization that will need to be obtained to complete the credentialing process.

It is our intention to make this process as simple and unobtrusive as possible. If you have a practice manager a corresponding letter is being sent to your practice manager explaining the specific information needed for the credentialing process. The credentialing process will be conducted with complete confidentiality. A copy of the FTCA program information notice is also being sent for your review. If you have any questions regarding the FTCA program please don't hesitate to contact me. A form is attached so that you may respond as to your interest in pursuing the FTCA medical malpractice protection.

As stated we are glad to be able to offer this program and hope you will elect to take advantage of this opportunity. We look forward to your continued support.

Sincerely,

Elaine Oakley BA, RN
Director Mariam Clinic
Phone: 919-824-4672
Fax: 919-439-3778
mariamclinicdirector@gmail.com

Overview of Free Clinics FTCA Program Information Notice For Health Care Professionals

I. PURPOSE:

This Program Information Notice (PIN) provides detailed information regarding the implementation of the *Free Clinics Federal Tort Clinic Acts (FTCA) Medical Malpractice Program* as described in Section 194 of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

II. OVERVIEW:

Congress enacted FTCA for volunteer free clinic health care professionals. If a volunteer health care professional meets all the requirements of the Program, the related free clinic can sponsor him/her to be a "deemed" federal employee for the purpose of FTCA medical malpractice coverage. FTCA deemed status provides the volunteer with immunity from medical malpractice lawsuits resulting from his/her subsequent performance of medical, surgical, dental related functions within the scope of his/her work at the free clinic. Claimants alleging acts of medical malpractice against a deemed volunteer would have to file their claims against the United States according to FTCA requirements. Free clinics must submit and annual FTCA deeming application on behalf of their volunteer professionals to the Department of Health and Human Services' (HHS) Health Resources and Services Administration, Bureau of Primary Health Care (HRSA, BPHC) that administers the program.

III. WHO IS COVERED?

HHS will deem a volunteer free clinic health care professional to be a federal employee for the purposes of FTCA coverage for medical malpractice claims of the free clinic and health professionals meet certain requirements.

A free clinic is a health care facility operated by a nonprofit private entity that:

1. Does not accept reimbursements for any third party payer.
2. Does not impose charges on patients whom they service.
3. May accept patients voluntary donations for health services
4. Is licensed or certified to provide health care in accordance with applicable law

A volunteer free clinic health care professional must:

1. Provide services to patients at a free clinic or offsite program or events carried out by the free clinic.
2. Is sponsored by the free clinic.
3. Provides qualifying health service (i.e., any medical assistance required or authorized to be provided under the Title XIX of the Social Security Act (42 U.S.C 1396 et. seq) without regard to whether the medical assistance is included in the plan submitted by the State in which the health care practitioner provides the service;
4. Does not require compensation for provided services from patients directly or from any third-part payer;
5. Is licensed or certified to provide health care services at the time of services provision in accordance with applicable law; and
6. Provides patients with written notification before service provision of the extent to which his/her associated free clinic has not already provided such notification.

IV. WHAT SERVICES ARE COVERED?

FTCA deemed volunteers are eligible for medical malpractice coverage for health care services acts or omissions that:

Arise from the provision of medical, surgical, dental or related services at the free clinic site or through offsite programs or events carried out by the free clinic; and occur on or after the effective date that the HHS secretary approved the FTCA deemed application submitted by the free clinic on behalf of its volunteer professionals.

V. WHAT ARE THE PROGRAM REQUIREMENTS?

Free clinic and their FTCA deemed volunteers must satisfy the following program requirements.

1. Credentialing and Privileging
   - i. Credentialing is the process of associating and confirming the qualifications of licensure, certification and/or registration of a licensed or certified health care practitioner.
   - ii. Privileging is the process of authorizing the specific scope and content of patient care services of a licensed or certified practitioner

   Free clinics must satisfy these requirements by utilizing:
   - *i.* Primary source verification: verification by the original source or an approved agent. A local hospital where a practitioner is credentialed can serve as a credentials verification organizations (CVO). *We will contact them, with your permission.*
   - ii. Secondary source verification: verification by methods like viewing the original documents or a notarized copy of a credential.

The following information must be obtained for each health care practitioner desiring to become deemed through the FTCA. Examples include:

1. Current licensure
2. Relevant education, training or experience
3. Health fitness statement, ability to perform the requested privileges
4. Government issued photo identification, diver's licensed
5. DEA registration, as applicable
6. Hospital admitting privileges, as applicable
7. Immunization (Hep. B) & PPD (TB Skin Test) status
8. CPR training. As applicable
9. Quarrying the National Practitioner Data Bank (Clinic may perform)
10. Completion for the application for HHS.

RESPONSE TO FTCA COVERAGE

To: Mariam Clinic

Date: _____

☐ **YES,** I am interested in the Federal Tort Claims Act (FTCA) medical malpractice protection while volunteering at Mariam Clinic.

Name: _____ **Phone:** _____

E Mail address: _____

Applicant Signature: _____

Practice Manager Name: _____ ☐ **NA**

Phone: _____ **Email address:** _____

☐ **NO,** I am not interested in pursuing the Federal Tort Claims Act (FTCA) medical malpractice protection. I will provide my own malpractice coverage when I volunteer at the Mariam Clinic and I have enclosed a copy. If your policy covers volunteer work in the case of a malpractice event, your policy would be subject to **subrogation**. Simply stated this means the claim would go against your policy first.

Name: _____ **Phone:** _____

E Mail address: _____

Applicant Signature: _____

Mariam Clinic Health Care Professional
Medical Questionnaire

Date: _____

I, _____ **verify that the information below is truthful and honest to the best of my knowledge.**

PPD (TB Skin Test) Status

Date of most recent PPD: _____

Do you have a history of a positive PPD (TB Skin Test)? ☐**Yes** ☐**No**
If yes, date of last CXR_____

Immunization Status

Please provide copy of Immunization history to include (HEP. B) Vaccines, titer results. Contact the director for a declination statement.

☐ **NKDA**

Allergies: _____

Are you allergic to Latex? ☐ **Yes** ☐ **No**
If yes, describe reaction _____
_____
_____

Do you have any medical history or conditions that could cause you problems while working at the Mariam Clinic? ☐ **Yes** ☐ **No**

If yes, please explain: _____
_____
_____

Emergency Contact

Name: _____ **Phone:** _____
Relationship: _____
Address: _____

Applicant signature: _____

Mariam Clinic Health Fitness Statement

Applicant/Practitioner Name: _____

Title _____ Date of Birth _____

I _____ (applicant's/practitioner's name) attest that I am fit to perform the care, treatment and other services provided at Mariam Clinic. Further, the substantiation of this fitness may be confirmed by the Clinic's medical director, the hospital's chief of staff where I'm privileged or any other physician designated by the organization.

I further attest that I meet ongoing continuing education requirements not only to maintain any licensure or certification, but also to maintain practice skills and knowledge in the specific scope/content of patient care services I provide to patient's at Mariam Clinic.

_____ _____

Applicant/Practitioner Signature Date

STOP - Leave area below line blank

****

I confirm that the above stated applicant/practitioner is:

- ☐ Fit to provide services at Mariam Clinic without limitation
- ☐ Fit to provide services at Mariam Clinic under the following conditions:

_____

_____

_____

Signature of Confirming Physician Print Name & Title Date

_____

Address City State Zip

www.mariamclinic.org
Phone: 919-824-4672
Fax: 919-439-3777

Mariam Clinic Letter of Reference

To Mariam Clinic,

As a peer of _____, I find him/her to be competent, ethical and to meet professional obligation with the practice of _____ and endorse him/her as a licensed independent practitioner within this discipline of medicine.

If you have any questions are remarks regarding this request, please don't hesitate to contact me at _____.

_____ _____

Name **Date**

_____

Signature

REX HEALTHCARE, INC.
ELECTRONIC SIGNATURE REQUEST
HEALTH INFORMATION MANAGEMENT

Fax: 919-784-3343 Attn: _____

Required to request approval to use electronic signature for authenticating patient documents at Rex Healthcare.

To facilitate the care of their patients at Rex Healthcare (Rex), physicians with practice privilege at Rex ("Rex Medical Staff") may be granted approval to submit patient documents that have been authenticated by them via an Electronic Signature in their physician office system. To ensure protection of patient information as required by Rex and Federal, State and Regulatory requirements, the physician must agree to the following:

I am requesting approval to submit patient documents with the following types of authentication (check all that apply):

____ Electronic Signature generated from a system used in my Practice

Electronic Signature
Initial
here **____ I agree to take all necessary physical and technical precautions to safeguard my systems that will be used to generate electronically authenticated patient documents for Rex Healthcare. I take full responsibility to ensure that the security measures in place for protection of such systems will be maintained at a level necessary to meet Federal, State and Regulatory requirements, including but not limited to HIPPA and JCAHO requirements.**

I understand that usage of my Electronic Signature for authenticating any document submitted to Rex is legally binding and I will be held accountable for all documents submitted with my Electronic Signature

_____
Physician Name (please print)

_____ _____
Signature of Physician Date Signature of HIM Director Date

Please sign your name again in the blank area below.

CONFIDENTIALITY AGREEMENT

This Confidentiality Agreement ("Agreement") is made effective as of _____ between **Generations Family Practice** ("Practice"), and **[Staff Member Name]** ("Staff").

Staff acknowledges that being a member of the workforce of Practice, they could/will/might be processing and working with information dealing with a wide range of attributes. Staff hereby accepts that job roles and duties for all workforce members are subject to change as Practice sees fit.

Staff will protect any and all information that they receive or may encounter whether health-related information or other individually identifiable information, and will also protect with the same vigor Practice business information. Staff will also comply with the HIPAA Rules related to Privacy and Security and further details set forth by Practice. Under these requirements, Staff is to protect against the impermissible disclosure of any patient's Protected Health Information to an unauthorized third party.

Practice has requested that Staff will protect the confidential material and information which may be disclosed between Practice and Staff. Therefore, the parties agree as follows:

1. CONFIDENTIAL INFORMATION. The term "Confidential Information" means any information or material which is proprietary to Practice, whether or not owned or developed by Practice, and which Staff may obtain through any direct or indirect contact with Practice. Confidential Information includes without limitation:
   a. Protect Health Information of patients and employees
   b. Practice records and plans
   c. financial statements
   d. patient lists and records
   e. technical information
   f. computer programs and listings
   g. source code and/or object code
   h. copyrights and other intellectual property
   i. other proprietary information

2. PROTECTION OF THE CONFIDENTIAL INFORMATION. Staff understands and acknowledges that the Confidential Information, including but not limited to passwords, access codes and keys, has been developed or obtained by Practice by the investment of significant time, effort and expense, and that the Confidential Information is a valuable, special and unique asset of Practice which will affect the

Practice if improperly disclosed. Staff agrees to secure any equipment or information prior to leaving it unattended by methods such as: locking a door, logging off a computer, etc. In consideration for the disclosure of the Confidential Information, Staff agrees to hold in confidence and not to disclose the Confidential Information to any person or entity without the prior written consent of Practice. In addition, Staff agrees that:

a. No Copying/Modifying. Staff will not copy or modify any Confidential Information without the prior written consent of Practice.

b. Unauthorized Disclosure of Information. If it appears that Staff has disclosed or has threatened to disclose Confidential Information in violation of this Agreement, Practice shall be entitled to an injunction to restrain Staff from disclosing, in whole or in part, the Confidential Information. Practice shall not be prohibited by this provision from pursuing other remedies, including a claim for losses and damages.

3. RETURN OF CONFIDENTIAL INFORMATION. Upon the written request of Practice, Staff shall return to Practice all written materials containing the Confidential Information. Staff shall also deliver to Practice written statements signed by Staff certifying that all materials have been returned within five (5) days of receipt of the request. Staff will continue confidentiality obligations to Practice after the termination of employment or contract.

4. PROTECTED HEALTH INFORMATION. Protected Health Information, or PHI, means individually identifiable health information. 'Identifiable' refers not only to data that is explicitly linked to a particular individual but also includes health information with data items which reasonably could be expected to allow individual identification.

'Health Information' relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual that is transmitted or stored in any form.

PHI may be disclosed to only those parties that have proper authority and only for those purposes for which Practice has authority to disclose it:

a. Do not disclose PHI to a group administrator unless either (1) the group is fully compliant with HIPAA Privacy regulations as an "Involved Sponsor" or (2) Patient or dependent has signed a written authorization to release the information.
b. PHI may be disclosed to any Covered Entity (provider or health plan) or Business Associate of a Covered Entity with whom Practice is directly or indirectly contracted.
c. PHI may only be disclosed for purposes related to Treatment, Payment or Health Care Operations and in those situations should only disclose the minimum

necessary information to accomplish the intended use.

d. Other specific uses and prohibitions may arise – Staff should check with their supervisor for additional direction.

5. DOCUMENTING BREACHES. Under regulatory and contractual obligation, Practice is required to report any unauthorized disclosure of Protected Health Information to the various regulatory agencies (e.g. U.S. Department of Health & Human Services, U.S. Department of Labor). As a result, Staff is to immediately notify supervisors of a breach.

6. DISCIPLINARY ACTION FOR BREACHES. Since Practice is required to report these breaches and Staff acknowledges that any breach will result in some impact on Practice, Staff must be aware that a breach of privacy obligations will be documented in their files and that corrective action may be taken as a result. The range of possible corrective actions include but are not limited to reprimand, oral and/or written warning, suspension, termination of employment, or cessation of ongoing business relationship.

7. MINIMIZING THE IMPACT OF A BREACH. Practice is required to take corrective action immediately to mitigate or reduce the impact of the breach to any patient. Staff understands that they have an obligation to assist in that effort which will include providing all known information about the breach, including but not limited to the individual(s) impacted, the nature of the breach, individual(s) who may have had the opportunity to obtain the information, how to best communicate with all parties to resolve the breach and how to prevent future breaches of similar nature.

8. RETALIATORY ACTION. To ensure receiving all information necessary to minimize the impact on Practice and patients and to allow reporting in a timely fashion, Staff is encouraged to report any known breach to the proper individuals within the Practice. Intimidation, coercion, threats, discrimination or retaliatory actions against individuals who report breaches or are involved in a breach of privacy obligations is prohibited and appropriate measures will be taken to protect against the identification by someone who is being accused of breaching privacy obligations.

9. SECURITY. Practice is committed to protecting against the disclosure of patient data that may be contained in physical or electronic form and will take all reasonable administrative, physical and technical measures to provide security over that information. Practice will safeguard and protect Protected Health Information maintained or transmitted in electronic form and maintained in physical form within their control. Staff must take similar measures, including but not limited to Staff member's home, non-co-located office, personal possessions or your motor vehicle(s).

   Practice will meet regulatory and contractual obligations regarding security as follows:

a. All reasonable means to protect the confidentiality, integrity and availability of all electronic PHI which is received, created, maintained or transmitted;
b. Defend against any reasonably anticipated threats or hazards to the security and integrity of information over which there is control;
c. Defend against any reasonably anticipated uses or disclosures of information that are not permitted or required under various regulatory or contractual obligations; and
d. Ensure that Staff understand and follow these rules and guidelines and if they fail to do so, then appropriate measures will be taken to correct the violation, as well as, any disciplinary action necessary.

10. GENERAL PROVISIONS. This Agreement sets forth the entire understanding of the parties regarding confidentiality. Any amendments must be in writing and signed by both parties. This Agreement shall be construed under the laws of the State of North Carolina. This Agreement shall not be assignable by either party, and neither party may delegate its duties under this Agreement, without prior written consent of the other party. The confidentiality provisions of this Agreement shall remain in full force and effect after the effective date of this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement and affixed their respective seals as of the day and year first above written.

GENERATIONS FAMILY PRACTICE ("Practice")

By: _____ _____
Authorized person in Practice Printed Name/ Title

I have read the Agreement and agree to comply with all of its terms as a condition of my continued business relationship with the Practice.

STAFF MEMBER

_____
Signature

_____
Printed Name