Providence Hospital
of North Houston

Thank you for your interest in becoming a member of the Allied Health Staff of Providence Hospital of North Houston. The following documents must be included in the packet you return:

- **Photocopies of:**
    - Completed Texas Standardized Credentialing Application Form available online at: http://www.tdi.texas.gov/form9credential.html
    - State Medical License (copy)
    - Federal DEA Certificate (copy)
    - DPS Certificate (copy)
    - Government issued Photo Identification (Driver's License, Passport); you will need to show ID to administrator on your first day at the facility
    - Certificate of Malpractice Liability showing policy number, effective date and amounts of coverage (200,000-600,000)
    - Medical Claims History (should cover the past 5 years)
    - Continuing Medical Education (CME) in the previous two (2) years and/or course training documents
    - Education, Training Certificates, ECFMG (if applicable)
    - Curriculum Vitae
    - Current PALS and ACLS (if applicable)
    - DD214- Evidence of Military discharge and/or letter from commanding officer approving off duty employment (if currently active duty)
    - Board Certification Certificate or Board eligibility letter (if applicable)
- **Completion and signature of the following enclosed forms:**
    - Delineation of Privileges form
    - Medical Records/Pharmacy Signature form
    - Bylaws Acknowledgement form
    - Confidentiality Statement
    - Health Screening Attestation
    - Sponsoring/Supervising Physician form

Should you have any questions, please feel free to contact me at credentialing@phnh.net or 281-453-7232.
Thank you,

Arin J. Tijerina
Credentialing Manager

Providence Hospital
of North Houston

DEPARMENT OF MEDICAL RECORDS & PHARMACY

SIGNATURE VERIFICATION FORM

Please furnish us with a sample of your signature for verification and authentication of your signature in the medical record.

Please list all variations, including initials:

____

Signatures

____

Initials

PLEASE PRINT THE FOLLOWING:

____

Name with credentials as applicable

____

DEA Number (if applicable)

____

Date Submitted

Providence Hospital
of North Houston

MEDICAL STAFF BYLAWS, RULES AND REGULATIONS, POLICY AND PROCEDURE ACKNOWLEDGEMENT AND AGREEMENT

I hereby agree to comply with the Medical Staff Bylaws, Rules and Regulations and Policies and Procedures set forth by the Governing Board of Providence Hospital of North Houston.

I understand that copies of the Medical Staff Bylaws, Rules and Regulations are available at the facility for review upon my request.

____
Print Name

____ ______/_____/__________
Signature **Date**

Providence Hospital
of North Houston

CONFIDENTIALITY STATEMENT

Providence Hospital of North Houston considers all patient and business information maintained as confidential and proprietary. This Confidentiality Statement pertains to all information, whether access occurs on hospital property or remotely and is to be signed as part of the application process. It will be maintained in your file and will remain effective as long as you remain credentialed.

I. I agree that I will only access patient health information for the purposes of direct patient treatment or hospital operations (such as peer review activities to which I am assigned).

II. I will immediately report any known or suspected breach of the confidentiality of the system or records/data obtained from it to the Privacy Officer.

III. I will not access confidential information that I am not authorized to access including information for which I do not have a legitimate need to know such as information that is not related to my direct treatment relationship with a patient.

IV. I will not divulge copy, release, sell, loan, alter, revise or destroy any confidential information except as properly authorized within the policy of the hospital.

V. I will maintain confidentiality of all information that I access through the Systems, including protected health information of patients. When I access patient health information from a remote location, I will ensure that no unauthorized person can view the patient health information.

VI. I understand that access to patient health information is governed by federal and state laws and that there are significant fines and criminal action that can apply to me, as well as the hospital, if I violate these regulations.

I HEREBY ACKNOWLEDGE THAT I HAVE READ AND AGREE TO ABIDE BY THE ENTIRE CONTENTS OF THIS AGREEMENT.

____

Print Name

____ ________/_______/__________

Signature **Date**

PROFESSIONAL STAFF HEALTH SCREENING ATTESTATION

Various requirements from the Centers for Disease control (CDC), the Joint Commission (JC), Det Norske Veritas (DNV-GL), and the Occupational Safety and Health Administration (OSHA) require healthcare facilities to ensure that physicians and other licensed healthcare professionals working in the facility are screened for exposure and/or immunity to certain infectious diseases.

I. TB Screening

□ Yes □ No I have completed an evaluation for TB either through a negative TB skin test within the last 12 months –OR- absence of signs/symptoms of TB if I had a positive TB skin test with negative Chest X-ray.

□ Attached is a copy of a negative TB test

□ Attached is a copy of a completed TB questionnaire and a copy of a negative chest x-ray

□ PPD test may be administered at our facility (at no charge)

II. Vaccine Preventable Diseases

□ Yes □ No I have immunity to chicken pox/varicella, measles, mumps, and rubella through history of disease and/or vaccination.

If you answered no, please indicate the viral diseases you do not have a known immunity:

□ Chicken pox/varicella □ Measles □ Mumps □ Rubella

III. Hepatitis B Vaccination

□ **Decline** I have had the vaccination in the past or I do not wish to receive the vaccination. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge* to myself. I understand that due to my occupational exposure to blood and other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

*Not offered at all hospitals.

□ **Accept**, I request the Hepatitis B vaccine and will report to the designated department.

IV. Influenza Vaccination

□ **Decline** I have had the vaccination in the past 12 months.

□ **Accept** I understand that I will be given the opportunity to receive the influenza vaccination during between October and December of each year and that it is important for the safety of patients and other hospital staff that I receive the influenza vaccination.

I attest that the above information is correct.

____

Printed Name

____ _______/________/______

Signature **Date**

STATEMENT OF SPONSORING /SUPERVISING PHYSICIAN

I hereby verify that ____is in my employment or under my supervision in the capacity of _____________________________.
(Specialty)

The undersigned warrants and represents that this individual meets the qualifications in accordance with Hospital medical staff bylaws and policies and is competent to perform activities under my direction as delineated within the scope of services of the Hospital.

- Accept full legal and ethical responsibility for this individual's performance of the duties and acts authorized for him or her while under my supervision.
- Accept full responsibility for the proper conduct of the practitioner within the Hospital, for the observation of all bylaws, policies and rules and regulations of the hospital and medical staff, and for the correction of any problems that may arise.
- Agree to comply with prescriptive authority delegation requirements set forth by the licensing board(s) and State and Federal agencies, including but not limited to controlled substances and dangerous drugs.
- Ensure that the AHP is current with respect to relevant health screening, including but not limited to immunizations and PPD status.
- Comply with all regulations of the state licensing board/relevant licensing board and/or certifying board with respect to my supervision of the AHP, specifically including (but not limited to) such regulations as have been (any may, from time to time, be) adopted by said board with respect to (1) billing for services, and (2) requirements for supervision of said AHP with respect to the type and scope of services such AHP is approved to perform by the Board.
- Immediately notify the CEO of the Hospital in the event any of the following occur:
  a. My approval to supervise the allied health professional is revoked, limited, or otherwise altered by action of the Texas State Board of Medical Examiners, relevant licensing board, and/or certifying board.
  b. Notification is given to me of investigation of my supervision of the AHP by the TSBME, relevant licensing board and/or certifying board.
  c. Changes in authorized scope of practice or employment status.
  d. My professional liability coverage is changed insofar as coverage of the acts of the AHP is concerned.

____ ___________________________

Signature of Sponsoring/Supervising Physician **Date**

____

Print Name of Sponsoring/Supervising Physician