Providence Hospital
of North Houston

Thank you for your interest in becoming a member of the Medical 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)
  - ✓ **Surgery Preference Card (Very Important)**
  - ✓ 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
  - ✓ 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, Infection Control Education, Hospital Orientation, and Pain Management Education Acknowledgement(s);
  - ✓ Confidentiality Statement;
  - ✓ Health Screening Attestation; and
  - ✓ Positive PPD Results Questionnaire.

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
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DEPARTMENT 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

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PHYSICIAN 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 your privileges are in good standing or a member in good standing of the medical staff.

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 to through the information management system, including protected health and sensitive 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 law 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.

Physician Name (please print) _____

Signature _____Date _____

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MEDICAL STAFF HEALTH SCREENING ATTESTATION

Various requirements from the Centers for Disease control (CDC), DNV 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.

PHYSICIAN SIGNATURE **Printed Name/Date**

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POSITIVE PPD RESULTS QUESTIONNAIRE

In order to meet federal and state regulations, Providence Hospital of North Houston is required to have information on members of the Medical and Allied Health Staff in regard to their Tuberculin Skin Test.

To that effect, please provide us with the following information:

Tuberculin Skin Test (5TU PPD) Date Administered: _____/_____/_____

Date Read: _____/_____/_____

Administered / Read by: _____ _____
(Print Name) (Signature)

Please check the appropriate result:

☐ Negative ☐ 1st Positive **(See No. 1)** ☐ Previously Positive **(See No. 2)**

1. If your PPD skin test was previously negative and now it is positive, please provide a current chest x-ray and statement regarding prolonged symptoms of respiratory illness.
2. If your PPD skin test was previously positive and retesting is not indicated **OR** if you have not obtained a PPD skin test within the last 12 months, please answer the following questions regarding prolonged symptoms of respiratory illness.

Do you have any of the following symptoms?

Prolonged Cough	☐ No	☐ Yes
Malaise	☐ No	☐ Yes
Sputum Production	☐ No	☐ Yes
Weight Loss	☐ No	☐ Yes
Night Sweats	☐ No	☐ Yes
Previous Negative Chest X-Ray	☐ No	☐ Yes

All information indicated above is correct and complete to the best of my knowledge and belief.

_____
PHYSICIAN APPLICANT NAME (PLEASE PRINT)

_____ _____/_____/_____
PHYSICIAN SIGNATURE **DATE**