CHAPA-DE INDIAN HEALTH PROGRAM, INC.

Credentialing Requirements

The following items required for credentialing purposes. Return these items to Human Resources as soon as possible.

Statement of Understanding and Release (attached) _____

Request for Clinical Privileges (attached) _____

Adverse Action/Liability Claims Questionnaire (attached) _____

Financial Conflict of Interest Disclosure (attached) _____

Chapa-De Employment Application (attached) _____

Curriculum Vitae _____

Copy of Diploma from medical school _____

Copy of internship and residency certificates _____

Copy of current Medical License _____

Copy of Controlled Substance License (if applicable) _____

NPI Form _____

BLS/ACLS Certification _____

Confidentiality form (attached) _____

Names and addresses of: (use attached sheet) _____

- Medical School
- Organization where internship and residency served
- Hospital affiliations
- Professional references (3)

Other:_____

_____

_____

Chapa-De Indian Health Program, Inc.

REQUEST FOR MEDICAL/CLINICAL PRIVILEGES
AMBULATORY PRIMARY CARE
FOR OPTOMETRIST

General Requirements: Clinical privileges at Chapa-De facilities shall be granted to contracted member of the Medical Staff who are board-certified, board-eligible, and/or State Board licensed in a primary care specialty. All medical providers are required to have BLS certification and ACLS is recommended. Specific privileges are requested below:

Instructions for form completion:

1) The Practitioner/Applicant will enter the appropriate code number in the requested location for each privilege requested.
2) Medical Director/Medical Committee Chairperson Recommendation: Reviews the requested privileges and checks if approved or enters code number if modified, signs and dates the forms.

Codes:
1 = Perform Unsupervised
2 = Perform with supervision/proctoring
3 = Not requested/approved due to lack of facility support
4 = Not requested/approved due to lack of expertise

LIST OF PRIVILEGES: R = Requested / A = Approved

R	A	PROCEDURE
[ ]	[ ]	Admitting privileges
[ ]	[ ]	Burns
[ ]	[ ]	Co-management of ocular conditions with other physicians
[ ]	[ ]	Comprehensive eye health and vision examination
[ ]	[ ]	Conjunctival/ocular irrigation
[ ]	[ ]	Corneal epithelial debridement
[ ]	[ ]	Corneal micropuncture for recurrent corneal erosion
[ ]	[ ]	Developmental and perceptual vision evaluation and treatment
[ ]	[ ]	Diagnosis and management of conditions of the visual system
[ ]	[ ]	Diagnosis, treatment and management of diseases and conditions of the eye, orbit, and adnexa (visual system)
[ ]	[ ]	Dilation and irrigation of lacrimal apparatus
[ ]	[ ]	Electrodiagnostic testing
[ ]	[ ]	Fluorescein angioscopy
[ ]	[ ]	Incision and drainage of abscess
[ ]	[ ]	Incision and drainage of lacrimal gland or sac
[ ]	[ ]	Low vision evaluation and related services
[ ]	[ ]	Medical laboratory tests: order and interpret
[ ]	[ ]	Minor procedures of the eye and adnexa
[ ]	[ ]	Ocular microbiology laboratory tests: order and interpret (specify) _____
[ ]	[ ]	Ophthalmic ultrasonography: A and B scans
[ ]	[ ]	Punctal occlusion
[ ]	[ ]	Radiological imaging tests

Chapa-De Indian Health Program, Inc.

REQUEST FOR MEDICAL/CLINICAL PRIVILEGES
AMBULATORY PRIMARY CARE
FOR OPTOMETRIST

R	A	PROCEDURE
[ ]	[ ]	Repair of superficial ocular laceration
[ ]	[ ]	Utilization of injectable ophthalmic therapeutic pharmaceutical agents
[ ]	[ ]	Utilization of oral legend drugs
[ ]	[ ]	Utilization of oral narcotic pharmaceutical agents
[ ]	[ ]	Utilization of topical ophthalmic pharmaceutical agents (specify) _____
[ ]	[ ]	Vision therapy/orthoptics related services (specify) _____

I have not requested privileges for any procedures for which I am not qualified to perform. Furthermore, I realize that certification by a board does not necessarily qualify me to perform certain procedures, and supervision/proctoring may be required.

Print Name _____ Signature _____ Date _____

PRIVILEGES RECOMMENDATION:

□ Recommend Approval as indicated.

□ Recommend Approval with modification: _____

□ Recommend Disapproval: _____

_____ _____

_____ _____

_____ _____
Medical Director/Medical Committee Chairperson Date

_____ _____
Chief Executive Officer Date

_____ _____
Chairperson, Board of Directors Date

STATEMENT OF UNDERSTANDING AND RELEASE

By receiving appointment to the Medical staff, I signify my willingness to appear for interviews in regard to my appointment and authorize Chapa–De Indian Health Program representatives to consult with administrators and members of Medical staffs of other institutions with which I have been associated and with others, including past and present Insurance carriers, who may have information bearing on my professional competence, character and ethical qualifications. I further consent to the disclosure to this facility's professional staff and/or representatives of all personnel, professional and personal medical records and documents, including alcohol and drug abuse records at other institutions, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested, as well as my moral and ethical qualification for staff membership. I further consent to the disclosure, by authorized Chapa–De representatives, of records of my professional service with Chapa–De relating to my personal character and professional qualifications and competence to carry out the clinical privileges granted to me by Chapa–De, to any subsequent practitioner(s), facility, state or country medical society or licensing board to whom or to which I may apply to clinical privileges, membership, or licensure. This may include information regarding drug and alcohol abuse or dependency.

I fully understand that a false statement, or the misrepresentation of information otherwise provided, may constitute cause for revocation of medical staff appointment and/or clinical privileges, and may be punishable by fine or imprisonment (U.S. Code, Title 18, and Section 1001).

I certify that the statement/documents I have provided for this appointment are true, complete, and correct to the best of my knowledge and belief and are made in good faith.

I hereby release from liability all representatives of Chapa–De Indian Health Program for their acts performed in good faith and without malice in connection with evaluating my credentials and qualifications, and hereby release from any liability any and all individuals and organizations who provide information to these representatives in good faith and without malice concerning my professional competence, ethics, character and other qualifications for the medical staff and any applicable clinical privileges.

I agree to abide by the bylaws, rules and regulations of the medical staff.

_____ _____

Signature Date

_____

Print Name

CHAPA-DE INDIAN HEALTH PROGRAM, INC.

ADVERSE ACTION/LIABILITY CLAIMS QUESTIONNAIRE

Clinician Name: _____

1. **Have liability claims been filed against you, or against a hospital, other health care entity, corporation, or government, based on a case under your care?**
   Yes: _____ No: _____

2. **Have judgments or settlements been made involving you or against a hospital, corporation, or government based on a case under your care?**
   Yes: _____ No: _____

3. **Have you ever had, or are you about to have, your professional liability insurance declined, canceled, issued on special terms, or refused for renewal?**
   Yes: _____ No: _____

4. **Has your professional license (certification or registration) to practice in any jurisdiction ever been limited, placed in probationary status, restricted, suspended, denied, revoked, voluntarily surrendered, or not renewed?**
   Yes: _____ No: _____

5. **Have you ever been censured or reprimanded by a licensing (certifying, etc) board, hospital medical staff, professional society, or other professional organization?**
   Yes: _____ No: _____

6. **Have any or all of your privileges at any health care facility ever been or are about to be limited, reduced, suspended, revoked, voluntarily surrendered in the course of an investigation, or not renewed? Have you resigned from a medical staff because of concern that your privileges might have been limited, suspended, or revoked? Have any other professional disciplinary actions been taken against you?**
   Yes: _____ No: _____

7. **Has your narcotics registration, federal or state, ever been denied, limited, suspended, voluntarily surrendered, not renewed, or revoked?**
   Yes: _____ No: _____

8. **Have you ever been denied membership, or renewal thereof, or been subject to disciplinary action in any professional society or organization?**
   Yes: _____ No: _____

9. **Have any civil or criminal charges ever been filed against you or are you under an investigation that might lead to such charges?**
   Yes: _____ No: _____

LIABILITY CLAIMS/ADVERSE ACTION QUESTIONNAIRE- page 2

10. Have you ever been sanctioned by Medicare or a Medicaid program, or by any other Federal agency?
Yes: _____ No: _____

11. Are you currently involved in or have knowledge of a pending investigation, review, or surveillance of your professional practice or conduct that could result in an adverse action concerning your ability to bill and collect from Medicare or Medicaid programs; your narcotics registration; your professional license registration or certification; or your medical staff membership or privileges?
Yes: _____ No: _____

Explain affirmative responses in detail:

_____

_____

_____

_____

_____

_____

_____

I agree to abide by all lawful standards, policies, and rules of Chapa-De Indian Health Program, Indian Health Service, and the Department of Health and Human Services as they apply to my responsibilities and practice as a member of this medical staff. I pledge to maintain an ethical practice and to provide for the continuous care of all my patients. I further agree to immediately disclose to the medical staff and/or administration more detailed information related to all "yes" responses if asked to do so. In addition, I agree to immediately report to the Clinical Administrator any new information concerning a "yes" response or concerning a response that becomes "yes" after filling out this questionnaire, either while medical staff privileges are pending or after they have been granted.

_____

Signature **Date**

Chapa-De Indian Health Program, Inc.
Financial Conflict of Interest Disclosure

Name:_____ Department: Medical

Reporting Period:_____ Date:_____

1. Are you directly or indirectly involved in placing Chapa-De business with any person or entity in which you or your immediate family has a significant financial interest?

☐ No
☐ Yes If yes, please provide the following:

Name of Business/Person/Entity
_____
General Description of Business Activity
_____

2. Have you accepted any gifts related to your position at Chapa-De from outside institutions, companies or individuals?

☐ No
☐ Yes (please explain) _____

_____

3. Have you accepted or arranged for a gift or contribution from an outside entity in return for facilitation a business relationship with Chapa-De?

☐ No
☐ Yes If yes, please provide the following:

Name of Business/Person/Entity
_____
General Description of Business Activity
_____

4. Do you have a significant financial interest in any entity that engages in a business relationship with Chapa-De?

☐ No

☐ Yes If yes, please provide the following:

Name of Business/Person/Entity _____ General Description of Business Activity _____

5. Do you have any significant financial interest in any health care provider and/or entity to which Chapa-De health care practitioners refer patients?

☐ No

☐ Yes If yes, please provide the following:

Name of Business/Person/Entity _____ General Description of Business Activity _____

_____

Signature

CHAPA-DE INDIAN HEALTH PROGRAM, INC.

EMPLOYEE CONFIDENTIALITY

Each employee is responsible for safeguarding confidential information obtained in connection with his or her employment. In the course of your work, you may have access to confidential information regarding the company, its suppliers, its clients/patients or even fellow employees. It is your responsibility not to reveal or divulge any such information unless it is necessary for you to do so in the performance of your duties. Access to confidential information is on a "need to know" basis and must be authorized by your supervisor. Any breach of this policy will not be tolerated and corrective action will be taken.

Do not discuss the client/patient or any information regarding the client/patient with:

- Fellow workers/Board members (unless they are directly involved with caring for that client/patient)
- Another client/patient
- Concerned friends or visitors
- Client/patient relatives
- Any member of the news media
- Any member of your family
- Any person in the community

I understand and agree that in the performance of my duties as an employee of Chapa-De Indian Health Program, I must hold client/patient/employee information in confidence. I understand that any violation of the confidentiality of information may result in immediate termination.

_____ _____

Employee (Signature) Supervisor/Human Resources

_____

Print Name

_____

Date