Welcome to Ochsner Clinic Foundation

ON-LINE CREDENTIALS APPLICATION

The Professional Staff Services office has requested that you complete an application for privileges on the Medical Staff at Ochsner Clinic Foundation. We look forward to you joining our staff and would appreciate your completing the enclosed documents.

1. **A uniform on-line application**
2. **An Attestation statement**
3. **Delineation of clinical privileges forms**
4. **Copy of current Driver's License or Passport**
5. Please note that the delineation form for moderate and deep sedation is separate. The instructions and privilege form stipulates the guidelines that must be adhered to for this privilege. **NOTE**: Only print this form if you are requesting Sedation Privileges.
6. A separate health evaluation form is included for your completion. This form is to be placed in a sealed envelope and included with your completed application. The sealed envelope will not be opened until the Ochsner Clinic Foundation Credentials Committee has recommended your application for approval. Please be sure to place the completed evaluation form in a **SEALED ENVELOPE MARKED CONFIDENTIAL HEALTH STATEMENT**, so that it will remain confidential. Your application will be deemed incomplete if this document is not provided with your application.

Please return the forms immediately, and include the documentation requested on Page 1 of the Uniform Application. You may also wish to include copies of any other documents that would be pertinent to the Credentials Committee's consideration of your qualifications for membership and privileges. The application for privileges in your department is based on usual and customary practices of your specialty board. If you wish to apply for privileges beyond the scope of your specialty board (e.g., laser or laparoscopic surgery) then you must present evidence of training and experience in that area, and this must be approved by your department chairman (Section C of the Delineation of Clinical Privileges). On the other hand, if you do not desire certain privileges in your specialty area, please note this in Section B of the Delineation of Privileges.

Your licensure, education, training and previous hospital affiliations will be verified, and the National Practitioner Data Bank will be queried. Initial requests for verifying information will be made by the Medical Staff Office of Ochsner Clinic Foundation. If replies have not been received within a reasonable period of time, you will be notified, and it will be your responsibility to assure that references are forwarded so that your application will be complete.

Please bear in mind that medical staff privileges may not be granted prior to receiving a completed application, verification of all references, Credentials Committee approval, and final action by the Board of Directors of Ochsner Clinic Foundation. This credentialing procedure is not just for the Hospital. Ochsner Clinic, Ochsner Health Plan (Humana) and most of the PPO contracted groups delegate credentialing to us. In order for you to treat most insurer group patients, this credentialing process must be finalized.

After all references have been received, it will take approximately 30-60 days to route your credentials through the necessary committees for final action on your application. Questions regarding the credentialing procedure may be directed to the Medical Staff Office at 504-842-3619.

Ochsner Clinic Foundation Medical Staff Bylaws, Rules and Regulations and other related documents are on this website for review or you may print for your file.

You will be hearing from Medical Administration to provide further information to you concerning any forms or information you may need in connection with your employment with Ochsner Clinic Foundation.

Again, thank you for your interest in Ochsner.

Sincerely,

Angela Romance

Angela Romance
Credentialing, Medical Staff Services

PLEASE ATTACH PHOTOGRAPH HERE (REQUIRED)

1514 Jefferson Highway
New Orleans, Louisiana 70121
Medical Staff Services – Brent House Rm. 600
504-842-3619 FAX 504-842-3471

SELECT CAMPUS PREFERENCE:

☐ OCF - East Bank

☐ OCF - West Bank

PROVIDER APPLICATION FOR MEDICAL STAFF APPOINTMENT

Applicant's Name: ____

I. INSTRUCTIONS

This form should be typed or legibly printed. If more space is needed, attach additional sheets and reference the appropriate section and question. Current copies of the following documents **must be submitted with this application**:

- All Medical Licensure
- DEA Certificate
- Medical School Diploma
- Professional Liability face sheet
- Controlled Dangerous Substance Certificate
- All training certificates (internship, residency, fellowship)
- ECFMG (if applicable)
- Board Certificate(s) or Recertification
- Current CV
- Copy Driver's License

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:	Suffix:
Is there any other name which you have been known?: Name(s)			
Home Mailing Address:	City:	State, Zip:	
Home Telephone #:	Home Fax Number:	E-Mail Address:	
Pager Number:	Cell Phone:	Social Security Number:	
Date of Birth (mm/dd/yy):	Birthplace:	Citizenship:	
Gender:	Visa Status if not U.S. Citizen:	Race (optional):	
Applying for - Department:	Marital Status:	Spouse name:	
Sub Specialty:	Secondary Department	Secondary Specialty	
Staff Membership requested: [ ] Academic-Active [ ] Admitting Academic-Active [ ] Consulting-Teaching [ ] Courtesy [ ] Consulting [ ] Well Newborn Privileges, only [ ] Scientific [ ] Associate			

III. PRACTICE INFORMATION

Practice Name (if applicable):		
Primary Office Address:	City:	State, Zip:
Telephone Number:	Fax Number	
Office Manager:		

Secondary Office Address:		
City	State	Zip:
Telephone Number:	Fax Number	
Office Manager:		

Current Partners and Associates:

IV. MEDICAL LICENSURE/REGISTRATIONS

La. State Medical License Number:	Issue Date:	Expiration Date:
Other State Medical License:	Issue Date:	Expiration Date:
Other State Medical License:	Issue Date:	Expiration Date:
Drug Enforcement Administration (DEA) #:		Expiration Date:
Controlled Dangerous Substance Certificate (CDS) (if applicable):		Expiration Date:
Education Commission for Foreign Medical Graduates (ECFMG):		Date Issued: Valid Through:

Medicare UPIN:	NPI #:	Medicare #:	Medicaid #:

V. PROFESSIONAL LIABILITY

List all carriers for the past ten years :

Carrier:	Policy Number:		Original Eff. Date:
Mailing Address:	City/State:	Zip:	Telephone: Fax Number:
Per Claim Amount:	Aggregate Amount:		Expiration Date:

Carrier:	Policy Number:		Original Eff. Date:
Mailing Address:	City/State:	Zip:	Telephone: Fax Number:
Per Claim Amount:	Aggregate Amount:		Expiration Date:

Carrier:	Policy Number:		Original Eff. Date:
Mailing Address:	City/State:	Zip:	Telephone: Fax Number:
Per Claim Amount:	Aggregate Amount:		Expiration Date:

Are you a qualified provider under the Louisiana Patient's Compensation Fund? [ ] Yes [ ] No

Do you carry coverage in excess above your self-retention under the LPCF? [ ] Yes [ ] No

If so, how much? ____

Are you self-insured? [ ] Yes [ ] No

Provide full explanation on a separate page for any question answered "yes " below: (for claims - USE ADDENDUM FORM ATTACHED)

Question	Answer
Has any professional liability insurance carrier ever excluded any specific procedures from your coverage?	[ ] Yes [ ] No
Have you ever been denied professional liability coverage, refused renewal or had liability insurance terminated?	[ ] Yes [ ] No
Has any insurance company ever imposed a surcharge or additional premium upon you because of your claims history?	[ ] Yes [ ] No
Have any professional liability suits ever been filed against you?	[ ] Yes [ ] No
Have any professional liability suits been filed against you that are presently pending?	[ ] Yes [ ] No
Have any judgments been made against you, or have there been any settlements involving you, in professional liability cases?	[ ] Yes [ ] No
Has any medical review panel ever found that you have failed to meet the applicable standard of care as complained in the petition for review?	[ ] Yes [ ] No

VI. MEDICAL PROFESSIONAL EDUCATION

Medical School:	Degree Received:	Date of Graduation:
Mailing Address:		

Medical / Professional School:	Degree Received:	Date of Graduation:
Mailing Address:		

VII. INTERNSHIP/PGY 1

Institution:	Program Director	Telephone Number: **Fax Number:**
Mailing Address:		
Type of Internship:	Specialty:	

Dates Attended: From _________ Mo/Year To: _________ Mo/Year

Did you successfully complete the program? [ ] Yes [ ] No

VIII. RESIDENCIES

Institution:	Program Director	Telephone Number: Fax Number:
Mailing Address:		
Type of Residency:	Specialty:	

Dates Attended: From _________ Mo/Year To: _________ Mo/Year

Did you successfully complete the program? [ ] Yes [ ] No (If NO, please explain on separate sheet)

Institution:	Program Director	Telephone Number: Fax Number:
Mailing Address:		
Type of Residency:	Specialty:	

Dates Attended: From _________ Mo/Year To: _________ Mo/Year

Did you successfully complete the program? [ ] Yes [ ] No (If NO, please explain on separate sheet)

Did your program director recommend you for board certification? [ ] Yes [ ] No (If NO, please explain on separate sheet)

Institution:	Program Director	Telephone Number: Fax Number:
Mailing Address:		
Type of Residency:	Specialty:	

Dates Attended: From _________ Mo/Year To: _________ Mo/Year

Did you successfully complete the program? [ ] Yes [ ] No (If NO, please explain on separate sheet)

Did your program director recommend you for board certification? [ ] Yes [ ] No (If NO, please explain on separate sheet)

IX. FELLOWSHIPS

Institution:	Program Director	Telephone Number: Fax Number:
Mailing Address:		
Specialty:	Did your program director recommend you for board certification?	

Dates Attended: From _________ (Mo/Year) To: _________ (Mo/Year)

Did you successfully complete the program? [ ] Yes [ ] No (If NO, please explain on separate sheet)

Institution:	Program Director	Telephone Number: Fax Number:
Mailing Address:		
Specialty:	Did your program director recommend you for board certification?	

Dates Attended: From _________ (Mo/Year) To: _________ (Mo/Year)

Did you successfully complete the program? [ ] Yes [ ] No (If NO, please explain on separate sheet)

X. BOARD CERTIFICATION

Name of Issuing Board:	Specialty:	Date Certified/Recertified	Expiration Date:

Have you applied for board certification other than those indicated above? [ ] Yes [ ] No

Name of Board:____ Date Applied: ______________________

Have you ever been examined by any specialty board, but failed to pass the examination? [ ] Yes [ ] No
(if yes, provide full explanation of details on separate sheet)

If not certified, describe your intent for certification, if any, and date of eligibility for certification on separate sheet.

XI. OTHER CERTIFICATIONS (E.G. , CPR, ACLS, BCLS, PALS, NRP, Fluoroscopy, Radiography, etc.)

Type:	Number	Expiration Date:
Type:	Number	Expiration Date:
Type:	Number	Expiration Date:

XII. CURRENT HOSPITAL AFFILIATIONS AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in reverse chronological order (with current affiliation(s) first all institutions where you have (A) and have had (B) clinical privileges at least during the past ten years. This includes hospitals, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet.

A. CURRENT AFFILIATIONS

Name & Address of Primary Admitting Hospital: **Fax Number:**		
Department:	Status:	Dates of Affiliation:

Name & Address of other Hospital/Institution: **Fax Number:**		
Department:	Status:	Dates of Affiliation:

Name & Address of other Hospital/Institution: **Fax Number:**		
Department:	Status:	Dates of Affiliation:

Name & Address of other Hospital/Institution::		
Department:	Status:	Dates of Affiliation:

B. PREVIOUS HOSPITAL AND OTHER AFFILIATIONS

Name & Address of Hospital/Institution: **Fax Number:**		
From:	To:	Reason for leaving:

Name & Address of other Hospital/Institution: **Fax Number:**		
From:	To:	Reason for leaving:

Name & Address of other Hospital/Institution:: **Fax Number:**		
From:	To:	Reason for leaving:

C. PENDING APPLICATIONS

Name & Address of Hospital/Institution:
Name & Address of Institution:
Name & Address of Institution:

XIII. PEER REFERENCES

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges. NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

Name of Reference:	Title:	Telephone Number: **Fax Number:**
Mailing Address:		

Name of Reference:	Title:	Telephone Number: **Fax Number:**
Mailing Address:		

Name of Reference:	Title:	Telephone Number: **Fax Number:**
Mailing Address:		

XIV. WORK HISTORY

A five-year work history must be completed. Use the following codes and list all work history from the time you completed your medical training to present. MONTH AND YEAR MUST BE INCLUDED. **Any gaps in work history must be explained**:

CODES: **C** = Clinic/Group **S** = Solo Practice **H** = Civilian Hospital Medical Staff Appointment **T** = Academic/Teaching Appt
G = Gap in Practice **O** = Other **M** = Military Service (including hospital staff appointments)

CODE	NAME & ADDRESS OF ENTITY	DATE (include Mo/Year)

XV. CONTINUING MEDICAL EDUCATION

I attest that, as a licensed independent practitioner (LIP) privileged at Ochsner Clinic Foundation, I participate in continuing medical education (CME) that meets all requirements as defined by my specialty board certification and/or by the Louisiana State Board of Medical Examiners. I understand that CME is required to maintain clinical skills and current competence. I furthermore understand that CME is considered for reappointment to membership on the medical staff or renewal or revision of individual clinical privileges. It is my responsibility to maintain and submit proof of CME credits (if requested) when asked by Ochsner Clinic Foundation.

To the best of my knowledge and my belief, the following information provided in this declaration is accurate and true.

Signature: ____ Date_______________________

XVI. MILITARY SERVICE

List all medical and surgical experience in the armed service and/or public health service with dates and locations and branch of service.

DATE OF DISCHARGE	**HONORABLE [ ] YES [ ] NO**	**RESERVE STATUS**

XVII. PROFESSIONAL ASSOCIATIONS

List all professional fellowships and memberships and societies, past and present including state and county (parish):

Name of Society:	
Address:	
From	**To**
Name of Society:	
Address:	
From	**To**
Name of Society:	
Address:	
From	**To**

Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings, in any professional organization? [ ] Yes [ ] No
If "yes", please provide a full explanation of the details on a separate sheet and attach.

XVIII. MEDICAL PUBLICATIONS

List all medical publications or attach bibliography with CV:

Ochsner Clinic Foundation
Attestation Questions

Please answer the following questions "yes" or "no". If your answer to any of the following questions (with the exception of No. 20) is "yes", please provide full details on separate sheet. Explain a "No" answer to No. 20.

1. Has your license to practice medicine ever been suspended, revoked, modified, restricted, surrendered or voluntarily not renewed while under suspicion or investigation in any jurisdiction, country, state, county or parish? [ ] Yes [ ] No
2. Have any investigations or disciplinary actions ever been initiated by any state licensure agency or are there any currently pending? [ ] Yes [ ] No
3. Have you ever been asked to surrender your license in any state? [ ] Yes [ ] No
4. Have you ever been reprimanded or otherwise sanctioned by or had conditions placed on your license by any licensure agency? [ ] Yes [ ] No
5. Has your DEA registration or state controlled substance license ever been relinquished, limited, denied, suspended, or revoked, or have any conditions been placed on either of these licenses or your use of controlled substances, whether voluntarily or involuntarily? [ ] Yes [ ] No
6. Is your DEA certificate or state controlled substance license currently being investigated? [ ] Yes [ ] No
7. Have you ever voluntarily agreed not to exercise your prescriptive privilege for controlled substance at the request of a hospital, employer, state or federal agency? [ ] Yes [ ] No
8. Have you ever been suspended, sanctioned, excluded, or otherwise precluded from participating in Medicare, Medicaid, or any other federal, state or private health insurance program? [ ] Yes [ ] No
9. Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, state health insurance program? [ ] Yes [ ] No
10. Have you ever been arrested for or charged with any crime? [ ] Yes [ ] No
11. Have you ever been convicted of any misdemeanor relating to the practice of your profession, other health care related matters, third party imbursement, violence, or controlled substances violations? [ ] Yes [ ] No
12. Have you ever been convicted of, or pleaded nolo contendere to or are you currently under investigation for a federal, state, parish or county, or city felony (including but not limited to Medicare or Medicaid fraud) or other criminal charges or have you ever served a prison term? [ ] Yes [ ] No
13. Has your employment, medical staff appointment or clinical privileges, or status as a participating provider in a managed care organization ever been relinquished, withdrawn, suspended, reduced, revoked, denied, not renewed, or subject to probationary or other conditions at any hospital, health care facility, managed care organization, whether voluntarily or involuntarily? [ ] Yes [ ] No
14. Have you ever withdrawn your application for, or resigned from your appointment, reappointment, clinical privileges, or participating provider status in a managed care organization, or resigned before a decision was made by a governing board or credentials committee? [ ] Yes [ ] No
15. Have you ever been denied, withdrawn an application to, or refused membership/appointment on a medical staff, hospital, or professional organization, medical society or health plan? [ ] Yes [ ] No
16. Have you ever been the subject of any investigation at any hospital, health care facility, or managed care organization? [ ] Yes [ ] No
17. Have you ever, in association with any query, formal or informal investigation, or credentialing matter, voluntarily or involuntarily refrained from exercising or reduced your clinical privileges at any hospital, health care facility and/or managed care organization? [ ] Yes [ ] No
18. Are there presently any proceedings or investigations taking place at any hospital, health care facility, or managed care organization relating to your clinical competence or professional conduct? [ ] Yes [ ] No
19. Have you ever been the subject of focused individual monitoring relating to your clinical competence or professional conduct at any hospital, health care facility, or managed care organization? [ ] Yes [ ] No
20. **Are you able to safely and competently exercise the clinical privileges requested and perform the duties of appointment, without posing a threat to the health and safety of yourself, patients or co-workers? [ ] Yes [ ] No**
21. Are you presently abusing or addicted to, any illegal drugs, scheduled drugs or alcohol? [ ] Yes [ ] No
22. Are you actively involved in treatment for the use of or dependency of any drug, chemical, alcohol, or behavioral problem that could affect your ability to exercise clinical privileges, provide professional care, and/or perform the duties and essential functions related to your staff appointment? [ ] Yes[ ] No
23. Are you presently using any illegal drugs, alcohol or other substance that could potentially interfere with your ability to practice competently and safely? [ ] Yes [ ] No
24. Do you have any mental or physical condition that could potentially compromise your ability to provide safe and competent patient care in exercising all of the privileges requested? [ ] Yes [ ] No
25. If "yes" answers to questions 21-24, are there any reasonable accommodations which could be made to enable you to provide such care? [ ] Yes [ ] No

I hereby certify that all information contained in this application is true, complete, and accurate to the best of my knowledge and belief and is furnished in good faith. I understand that material, omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement/contract.

Printed Name: ______________________________

Original Signature: ______________________________ **Date:** __________
(Stamped Signature not acceptable)

CONDITIONS OF APPLICATION - RELEASE AND IMMUNITY

A. Conditions of Application

In return for my application being considered and processed, I agree to be legally bound by the following terms and conditions:

1. I understand that it is my responsibility to produce adequate information so that my application can be properly evaluated. In addition to the information provided in this application, I also agree to provide Ochsner Clinic Foundation (the Hospital) with any additional information that the Hospital or one of its authorized representatives may request. MY FAILURE TO PROVIDE ANY REQUESTED INFORMATION WILL CAUSE MY APPLICATION TO BE INCOMPLETE AND WILL PREVENT IT FROM BEING PROCESSED.
2. I also agree to keep this application current by informing the Hospital, through the Chief Executive Officer, or his or her designee, of any changes in the information provided, including, but not limited to, any investigations by a state licensure agency, any change in my professional liability insurance coverage, the filing of a professional liability lawsuit against me, any change in my status at any other hospital, any change in my eligibility for participation in the Medicare or Medicaid programs, and any changes in my ability to safely and competently exercise my clinical privileges because of health status issues, including impairment.
3. I will make myself available for interviews in regard to this application.
4. I agree to accept committee assignments, emergency service call obligations, if applicable, and such other reasonable medical staff duties and responsibilities as shall be assigned to me.
5. I agree to provide timely and continuous care for all my patients treated at Ochsner Clinic Foundation and the Ochsner Clinic Foundation Hospital.
6. My appointment to the medical staff and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, acceptable performance of all related responsibilities, as well as the other factors deemed relevant by the Hospital.
7. I have received and have had an opportunity to read a copy of the Medical Staff Bylaws, Rules and Regulations, Credentialing Policy and Organizational Manual. I specifically agree to abide by the bylaws, policies, rules and regulations, and directives that are in force during the time I am appointed to the medical staff.
8. I also agree, as a condition of appointment, to adhere to the Corporate Compliance Policy of the Ochsner Clinic Foundation and any laws, regulations, and standards of conduct applicable to my profession, participation in any federal health program, or activities at the Hospital, and to report any known or suspected violation of the same by me or by any officer, director, employee, non-physician practitioner or other medical staff member to the Chief Executive Officer or the Compliance Officer.
9. I represent that all of the information provided in or attached to this application is accurate and complete. I understand and agree that any misrepresentation, misstatement, or omission from this application, whether intentional or not, shall constitute cause for immediate cessation of the processing of the application and no further processing shall occur. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may be deemed to constitute automatic relinquishment of my clinical privileges and medical staff appointment. In either situation, I am not entitled to any hearing or appeal rights that are contained in the Credentialing Policy.

B. Release and Immunity

By applying for appointment and clinical privileges, I accept the following conditions and intend to be legally bound by them, regardless of whether or not I am granted appointment and/or clinical privileges. These conditions shall remain in effect for the duration of any term of appointment that I may be granted:

1. To the fullest extent permitted by law, I extend absolute immunity to, release from any and all liability, and agree not to sue Ochsner Clinic Foundation, its medical staff, their authorized representatives, and appropriate third parties for any matter relating to appointment, reappointment, clinical privileges, or my qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken, or received by the Hospital, the medical staff, their authorized representatives, or appropriate third parties.
2. I authorize Ochsner Clinic Foundation (OCF), its medical staff, and their authorized representatives (i) to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for initial and continued appointment to the medical staff, and (ii) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such questions. In addition, I specifically authorize these third parties to release the information to the Hospital, its medical staff, and their authorized representatives upon request.
3. I also authorize the Hospital, its medical staff, and their authorized representatives to release such information to other hospitals, health care facilities, managed care entities, and their agents, who solicit such information for the purpose of evaluating my qualifications pursuant to a request for appointment and clinical privileges, participating provider status, or other credentialing matter.
4. I agree that the hearing and appeal procedures set forth in the Ochsner Clinic Foundation Credentialing Policy shall be my sole and exclusive remedy with respect to any professional review action taken at the Hospital.
5. I understand that if I am granted only Ochsner Health Plan (OHP/Humana) medical staff membership and made a provider under contract with OHP, I will be eligible to treat OHP members upon receipt of a referral and I will be entitled to fees from OHP for services rendered at rates established by OHP. I understand, however, that membership on the OHP medical staff and a contract with OHP does not automatically entitle me to rights or privileges or medical staff membership at OCF.
6. I hereby authorize OCF to contact my professional liability insurance company or companies concerning coverage, claims, and loss experience. I furthermore authorize the endorsements to any policies which constitute a change as to coverage limits, duration, termination or cancellation. If called upon to do so, I will execute any and all documents necessary to grant the authority to my insurance company or companies to give such information and notices to OCF.
7. I understand and agree that the authorizations and releases given by me herein are irrevocable. I acknowledge that the investigation of information in this application and the release and exchange of information by these health care entities and OCF is done to achieve, maintain, and improve quality patient care. All information provided by me in this application is true and to the best of my knowledge and belief is without material omission. I understand and agree that any material misstatement in or omission from the application and supporting documents and addendums may constitute grounds for denial or termination of medical staff membership and privileges at OCF. I further acknowledge that I have read and understand the foregoing authorization and release. A photocopy of this authorization and release shall be as effective as the original.

Print Name: ____

Date: ______________________________ **Signature:** ____

(Stamped Signature not acceptable)

Do not write below this line

FOR OCHSNER CLINIC FOUNDATION USE ONLY

RECOMMENDATIONS AND ACTIONS

CHIEF OF SERVICE

APPOINTMENT: [ ] Recommend [ ] Not Recommend [ ] Deferred

Reasons for denial/deferral: ______________________________

____

STAFF CATEGORY ASSIGNED: [ ] Academic-Active [ ] Admitting Academic-Active [ ] Courtesy [ ] Consulting [ ] Associate
[ ] Consulting-Teaching [ ] Other ____________

Date	Section Head
Date	Section Head
Date	Department Chairperson
Date	Department Chairperson

Executive and Credentials Committee Recommendation

ACTION TAKEN: [ ] Application Accepted [ ] Application Denied [ ] Application Deferred

Reasons for denial/deferral: ______________________________

____

Date	Ochsner Clinic Foundation Medical Staff Secretary or designee

Ochsner Clinic Foundation Board of Directors Approval

ACTION TAKEN: [ ] Application Approved [ ] Application Denied [ ] Application Deferred

DATE APPROVED/:
Executive Order Issued:

Reasons for denial/deferral: ______________________________

____

Date	Ochsner Clinic Foundation Board of Directors Secretary (or designee)

ADDENDUM TO APPLICATION

MALPRACTICE CLAIMS INFORMATION:
Please complete this form if you reported any professional liability activity on your application. A separate sheet must be used for each professional liability incident.

Name of patient: ____

Allegation: ____

Your relationship to patient: (attending physician, consultant, etc.)
____

Your status: ___ Primary defendant ___ Other (specify): ___ Co-defendant

Enter the following dates in Month/Day/Year format

Date of incident: ____________ Reported: ____________ Claim or suit filed: __________

Location of incident: ____
County and state where filed: ____
Insurance Carrier: ____
Defense attorney (include Phone #) ____

Additional defendants: ____

Claims Status: ____ Open ____ Closed

If closed, indicate method of closing:

___ Dismissed Date: ____________________
___ Settled with prejudice Date: ____________________
___ Judgment for defendant Date: ____________________
___ Judgment for plaintiff Date: ____________________

Amount of settlement or judgment paid on your behalf: $ _________________

NARRATIVE IS REQUIRED – PLEASE COMPLETE THIS SECTION

Describe your care of the patient: (use attachment pages if needed)
Your narrative MUST provide the following:

Condition and diagnosis at time of incident.
Dates and description of treatment rendered.
Condition of patient subsequent to treatment.

____

____

____

____

____

I certify that the information in this document is true and correct.

Medical professional's signature: _________________________________Date: _______________

OCHSNER CLINIC FOUNDATION

**ACKNOWLEDGMENT
OF
RECEIPT OF NOTICE**

I, the undersigned, acknowledge that I have received and read the following Notice to Physicians by this hospital:

> "Notice to Physicians: Medicare/Champus payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws."

______________________________ ______________________________
(Date of Signature) (Signature of Physician)

Physician Name: ______________________________

Physician License Number: ______________________________

Confidential Health Status Questionnaire

In order to confirm whether you are capable of performing the duties and responsibilities of appointment and exercising the clinical privileges requested in a safe and competent manner, we request that the following information be provided to the Ochsner Clinic Foundation Medical Staff Office in order to process your application.

This information will not be reviewed until ***after*** the Credentials Committee has determined that you are professionally qualified for appointment to the Ochsner Clinic Foundation Medical Staff and the clinical privileges requested.

If you answer "yes" to any of the following questions, please submit a full explanation on an attached sheet describing how the condition may affect your ability to exercise the clinical privileges requested and to perform the duties and essential functions required of any staff appointment, and explain any proposed accommodations(s). Please place this form and any attachments in a <u>separate</u> envelope, seal it and return the sealed envelope with your application.

Health Status

1. Have you ever been aware of or been advised of any temporary or permanent physical or mental condition or impairment that could affect your ability to exercise the clinical privileges requested, or to perform the duties and essential functions of your staff appointment safely and competently with or without accommodations? [ ] Yes [ ] No

2. Are you currently under any limitations concerning your activities or workload? [ ] Yes [ ] No

3. Are you currently under the care of a physician for any illness or condition that may impair your ability to perform your privileges as requested? [ ] Yes [ ] No

4. Do you have a history of substance abuse or addiction during the last seven (7) years? [ ] Yes [ ] No

   If yes, are you in compliance with an aftercare plan? [ ] Yes [ ] No

Affirmation

I understand that my staff appointment and clinical privileges are conditional upon my demonstrating that I am capable of exercising my privileges safely and competently, and performing the duties and essential functions of staff appointment. Further, I understand that completion of this form is a necessary component of the application process and final action on my application will not be taken until this form is received and reviewed.

By my signature below, I hereby certify that all of the information provided above is true, complete, and correct. I agree to inform the Ochsner Clinic Foundation Medical Staff Office or the President of the Medical Staff should any statement of the information contained above, although true when made, become untrue due to a change in circumstances or discovery of new information.

__________________________________ ________________________
Applicant's Signature Date

____
Applicant's Legibly Printed Name

Instructions to Request Sedation Privileges

Note: Providers who deliver sedation/analgesia must recognize that different levels of sedation are possible since any drug (given a large enough dose) can cause a patient to lose consciousness. For the purposes of requesting privileges, please consider the intent/level of the sedation that you are planning to do on your patients.

Moderate Sedation/Analgesia ("conscious sedation") is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation (reflex withdrawal from a painful stimulus is not considered a purposeful response). No interventions other than positioning of head are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Titration of repeated doses of sedatives or titration to effect for procedures is considered MSA and is not anxiolysis. Administration of a combination of parenteral benzodiazepines and narcotic analgesic drugs for procedures is considered moderate sedation (MSA).

Deep Sedation/Analgesia is a drug induced depression of consciousness during which patients cannot be easily aroused but respond purposefully after repeated or painful stimuli. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. Agents such as propofol, ketamine, methohexital (Brevital), thiopental (Pentothal), and/or etomidate are deep sedation (DSA) medications.

You may choose to be privileged for Moderate Sedation alone or for Moderate and Deep Sedation.
[If moderate sedation alone is selected, you will not be able to intentionally perform deep sedation (i.e. you will not be able to use propofol, ketamine, etomidate, etc.)].

Moderate Sedation (alone):

Sedation Modules: Go to Ochweb and select the Applications Tab. Select "OH! Ochsner Healthstream" from the list and enter. Double click on the big yellow OH! In the upper left hand corner of the page and enter your user ID and password (both are the same) using the instructions at the top of the page. Go to the tab titled "my courses" where the modules should be listed as assigned to you (please allow a few days from the time that you requested privileges for the assignment to be made).

AND

Hand's On Training: Make an appointment with Anesthesia by calling ext. 62136 at least 24 hours in advance. Please leave a number where you can be reached. Attend the training at the appointed time in the OR. Anesthesia will complete the training certification form and send to the Healthstream system.

OR

ACLS/PALS/NRP – Attach copy of current certificate to the privilege request form or if need to take for the first time or due for a renewal, follow these instructions to register: Go to Ochweb and select the Applications Tab. Select "OH! Ochsner Healthstream" from the list and enter. Double click on the big yellow OH! in the upper left hand corner of the page and enter your user ID and password (both are the same) using the instructions at the top of the page. Go to the tab titled "my courses" where the class should be listed as assigned to you (please allow a few days from the time that you requested privileges for the assignment to be made). Double click on the class. A list of dates and times will appear. Choose the class that you want and click the "details" button first. Please read the note section and comply with the course prerequisites. Then, select the register button located to the right. Do the prerequisites and attend the class at the designated time.

When all requirements are completed, select the transcript tab in OH! Print a copy of your transcript and attach it to the privileging request form. Send the form into the Medical Staff office.

Moderate and Deep Sedation: **ALL THREE (3) ELEMENTS ARE REQUIRED**

Sedation Modules: Go to Ochweb and select the Applications Tab. Select "OH! Ochsner Healthstream" from the list and enter. Double click on the big yellow OH! In the upper left hand corner of the page and enter your user ID and password (both are the same) using the instructions at the top of the page. Go to the tab titled "my courses" where the module should be listed as assigned to you (please allow a few days from the time that you requested privileges for the assignment to be made).

AND

Hand's On Training: Make an appointment with Anesthesia by calling ext. 62136 at least 24 hours in advance. Please leave a number where you can be reached. Attend the training at the appointed time in the OR. Anesthesia will complete the training certification form and send to the Healthstream system.

AND

ACLS/PALS/NRP – Attach copy of current certificate to the privilege request form or if need to take for the first time or due for a renewal, follow these instructions to register: Go to Ochweb and select the Applications Tab. Select "OH! Ochsner Healthstream" from the list and enter. Double click on the big yellow OH! in the upper left hand corner of the page and enter your user ID and password (both are the same) using the instructions at the top of the page. Go to the tab titled "my courses" where the class should be listed as assigned to you (please allow a few days from the time that you requested privileges for the assignment to be made). Double click on the class. A list of dates and times will appear. Choose the class that you want and click the "details" button first. Please read the note section and comply with the course prerequisites. Then, select the register button located to the right. Do the prerequisites and attend the class at the designated time.

When all requirements are completed, select the transcript tab in OH! Print a copy of your transcript and attach it to the privileging request form. **Send the form into the Medical Staff office.**

Ochsner Clinic Foundation
Moderate/Deep Sedation
Delineation of Clinical Privilege Form

Practitioner Name: ____

☐ **Initial** ☐ **Reappointment**

Privileges Requested: ☐ **Moderate Sedation** ☐ **Deep Sedation**

*****PLEASE ATTACH ALL COMPETENCY DOCUMENTATION AND PROOF OF CERTIFICATION TO THIS FORM***

INITIAL APPLICANTS:

MODERATE SEDATION PRIVILEGE REQUIREMENTS

1. Review Sedation Module on Ochsner Healthstream Intranet System (OH) on Ochweb
   AND
2. **Select only one below:**
   - ☐ Hands-on Operating Room Airway Management Skills course offered by the OCF Anesthesia Dept. X 62136 (or 504/842-3000, extension 62136)
   - ☐ ACLS, ATLS, PALS, NRP Certification or American Board of Emergency Medicine
   - ☐ Provide documentation (list of patients) of competency that moderate sedation has been administered for at least 50 patients within the past 24 months

DEEP SEDATION PRIVILEGE REQUIREMENTS (ALL THREE ITEMS ARE REQUIRED)

ALL MUST BE COMPLETED:

- Review Sedation Modules on Ochsner Healthstream Intranet System (OH) on Ochweb
- Hands-on Operating Room Airway Management Skills course offered by the OCF Anesthesia Dept. X 62136 (or 504-842-3000, extension 62136)
- ACLS, ATLS, PALS, NRP Certification or American Board of Emergency Medicine

REAPPOINTMENT APPLICANTS:

MODERATE SEDATION PRIVILEGE REQUIREMENTS
Select only one below:

- ☐ Review Sedation Module on Ochsner Healthstream Intranet System (OH) on Ochweb
  AND
  Hands-on Operating Room Airway Management Skills course offered by the OCF Anesthesia Dept. X 62136 (or 504/842-3000, extension 62136)
- ☐ Review Sedation Module on Ochsner Healthstream Intranet System (OH) on Ochweb **AND**
  ACLS, ATLS, PALS, NRP Certification or American Board of Emergency Medicine
- ☐ Provide documentation (list of patients) of competency that moderate sedation has been administered for at least 50 patients within the past 24 months

DEEP SEDATION PRIVILEGE REQUIREMENTS
ALL MUST BE COMPLETED:

- Review Sedation Modules on Ochsner Healthstream Intranet System (OH) on Ochweb
- Hands-on Operating Room Airway Management Skills course offered by the OCF Anesthesia Dept. X 62136 (or 504/842-3000, extension 62136)
- ACLS, ATLS, PALS, NRP Certification or American Board of Emergency Medicine

By my signature below, I attest that I have successfully completed the Sedation Modules on Ochsner Healthstream Intranet System (OH) and I have met the requirements for the privileges requested as indicated above. I will follow the procedural guidelines set forth in the Ochsner Clinic Foundation Sedation/Analgesia policy:

______________________________ ______________________________
Signature **Date**

APPLICATION/REAPPOINTMENT CHECKLIST

MAKE SURE ALL OF THE FOLLOWING ARE INCLUDED:

- □ **SIGN ALL ASPECTS OF THE APPLICATION**
- □ **ATTACH LICENSURES & CERTIFICATES**
- □ **ATTACH COPY OF CURRENT DRIVER'S LICENSE**
- □ **GO TO** http://www.ochsner.org/medicalstaffservices **TO OBTAIN DELINEATION OF PRIVILEGE FORM**
- □ **FORWARD COMPLETED APPLICATION TO MEDICAL STAFF OFFICE:**

OCHSNER CLINIC FOUNDATION
MEDICAL STAFF OFFICE-6TH FLOOR BRENT HOUSE
1514 JEFFERSON HWY.
NEW ORLEANS, LA 70121

OR

FAX: 504-842-3471
OR E-MAIL:

AROMANCE@OCHSNER.ORG