

**YALE-NEW HAVEN HOSPITAL
MEDICAL STAFF
POLICY & PROCEDURE
TEMPORARY PRIVILEGES**

Purpose: Identify when temporary privileges may be issued to Medical Staff Members and Affiliates

Scope:

- (1) New applicants with a complete application
- (2) Current Medical Staff members undergoing re-appointment whose applications either (a) are complete and await Medical Board/Medical Board Administrative Committee approval or (b) are needed on staff for patient care purposes.
- (3) Current Medical Staff Requesting additional privileges
- (4) Medical Staff Guests

Policy: Temporary privileges are issued in accordance with the procedure, and under the circumstances, described below. New applicants may only be granted temporary privileges when their application is complete and has been fully processed in accordance with the Appointment Procedure.

Procedure:

1. New Applicants

The application must be complete, all documentation signed, verifications and queries obtained as outlined in the Appointment Procedure. Temporary Privileges are granted following approval by the Credentials Sub-Committee or Credentials Committee. Temporary Privileges will be in place pending final approval by the Patient Safety & Clinical Quality Committee of the Board of Trustees.

2. Re-Appointment Applicants

Medical Staff Members undergoing re-appointment may be granted Temporary Privileges when their application is complete and has been approved by the relevant Department/Section Chief or Associate Chief and is awaiting final approval by the Credentials Committee, Medical Board/Medical Board Administrative Committee and Patient Safety & Clinical Quality Committee of the Board of Trustees.

3. Requests for Additional Privileges

Members of the Medical Staff may apply for additional privileges between re-appointment cycles. Temporary privileges may be granted once the following are complete: (a) sufficient evidence provided by the applicant to fulfill any initial credentialing criteria, (b) current competence validated, (c) all required hospital, license and NPDB verifications obtained and (d) the relevant Department/Section Chief or Associate Chief has recommended approval. The recommendation of the Department/Section Chief or Associate Chief will be forwarded to the next scheduled meetings of the Credentials Committee, Medical Board/Medical Board Administrative Committee and Patient Safety & Clinical Quality Committee of the Board of Trustees for action and final approval.

3. Medical Staff Guests

Participating in Patient Care:

Physicians or dentists who have been invited to participate in the delivery of care at Yale-New Haven Hospital for a limited period of time or to assist in the care of a specific patient and who would otherwise have no need to obtain full Medical Staff privileges (due to geography or other reasons) may apply for Temporary/Guest Privileges. Such individuals may include visiting professors or others who come to the Hospital to perform or assist an existing Medical Staff member in a select procedure or serve in a role of definitive scope.

Guests are typically involved in the care of a specific patient for a specific procedure or admission and must work under the direction of, or in collaboration with, a current member of the Active Medical Staff.

The Department to which the physician will be assigned must make a request by completing the Temporary/Guest Privilege Request Form and specifying that the physician will be a "Guest". The request must be approved by the appropriate Chief/Associate Chief and Section Chiefs (when relevant) and the Chief of Staff.

Guest appointments are reported at the next Medical Board / Medical Board Administrative Committee meeting.

Requests must be made with a minimum of five (5) business days notice. Sufficient notice is required to allow for adequate time for processing. Applications submitted without enough notice may be denied.

Refer to the "Yale-New Haven Hospital Department of Physician Services Policy and Procedure regarding Medical Staff Guests and Observers" for specific requirements relative to Guest appointments.

Note: As outlined in Article VI, Section K of the "Medical Staff Bylaws," the Department Chief and Associate Chief, upon whose request Temporary Privileges are granted, are responsible for the supervision of the physician. In addition, the Temporary Privileges of any physician are subject to all of the other conditions and requirements as described in Article VI, Section K.

Upon approval, Guests are provided with a letter which serves as their identification while on YNHH premises and outlines restrictions related to their activity. In certain circumstances, Guests may be provided with a temporary YNHH identification badge. As applicable, the Medical and Nursing Directors of the Operating Room are notified of any Guests who have been approved to be in YNHH Operating Rooms.

Observers:

Physician or dentists who have been invited strictly to Y-NHH strictly to *observe* patient care are permitted to do so under the direct supervision of a member of the Active Medical Staff. Such individuals are not subject to the requirements for Guest Privileges as set forth above, however, Medical Staff members who wish to bring in physician observers must notify the Department of Physician Services with a minimum of five (5) business days notice.

The Medical Staff member must agree, in writing, to be responsible for the observer and must attest that the observer will not engage in any of the following activities:

- Speaking with patients
- Examining patients
- Writing in or accessing patient charts
- Advising members of the medical staff regarding patient care or treatment
- Participating in patient care in any manner

Additionally, observers in Y-NHH Operating Rooms are to remain "unscrubbed" at all times.

Depending upon the nature and duration of the observation period, physician observers may be provided with a temporary YNHH identification badge.

Updated: 06/14/02

Updated: 03/16/04

Updated: 08/18/04

Reviewed: 02/06/08

Updated: 03/04/08

Updated: 06/10/11

Updated: 10/24/12

Approved: March 6, 2013 Medical Board

Approved: March 21, 2013 PSCQ

Yale-New Haven Hospital
Application for Physician Guests

NAME _____

CURRENT HOSPITAL _____

DEPARTMENT _____

LICENSE STATE AND NUMBER _____

SOCIAL SECURITY NUMBER _____

BIRTHPLACE _____

DATE OF BIRTH _____

MALPRACTICE INSURANCE COMPANY _____

MALPRACTICE COVERAGE AMOUNT _____

MEDICAL SCHOOL _____

DEGREE _____ DATE _____

INTERNSHIP _____ DATE _____

RESIDENCY _____ DATE _____

FELLOWSHIP _____ DATE _____

Name _____
(please print legibly)

I. Practice History Information

If you answer "yes" to any of the following questions, you must supply full details on a separate sheet.

1. Regarding your license to practice your profession in any jurisdiction:
 - a. Has your application ever been denied? yes no
 - b. Has your license ever been limited, suspended or revoked? yes no
 - c. Has the relevant licensing board ever censured you for matters having to do with professional practice? yes no
 - d. Have you ever entered into a consent order, practice agreement, reinstatement order (or equivalent thereof) with any licensing board? yes no
 - e. Have you ever been fined by a medical licensing board? yes no

 2. Have you ever been, or are you currently, under investigation or involved in any proceeding involving your practice before any state licensing board? yes no

 3. Have you ever been denied a state or federal certificate of authority to prescribe controlled substances or is your state or federal certificate of authority to prescribe controlled substances currently under investigation? yes no

 4. Has your state or federal authority to prescribe controlled substances ever been voluntarily or involuntarily...
 - a. limited by the agency? yes no
 - b. suspended? yes no
 - c. revoked? yes no
 - d. denied renewal? yes no

 5. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action by any medical organization? yes no

 6. Have you ever been sanctioned by a specialty board or has your specialty or sub-specialty certification ever been suspended or revoked? yes no

 7. Has your eligibility to participate in the Medicare or Medicaid program ever been suspended or terminated in any state or have you ever been threatened with exclusion or debarment from either program? yes no

 8. Have you ever been charged by any local, state or federal authority, official or agency, plead guilty to or been convicted of any of the following:
 - a. crimes or offenses related to the delivery of service under Medicare/Medicaid? yes no
 - b. crimes or offenses related to the abuse or neglect of patients in connection with the delivery of health care? yes no
 - c. crimes or offenses involving fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of health care or involving any act or omission in a program financed in whole or in part by any federal, state or local government? yes no
 - d. obstruction of justice? yes no
 - e. crimes or offenses related to the manufacture, distribution, prescription or dispensing of any controlled substance? yes no
 - f. other crimes or offenses (including motor vehicle charges other than parking tickets)? yes no
-

Name _____
(please print legibly)

9. Have you ever been assessed a civil penalty by anyone for false or fraudulent submittal of claims for payment, or other violation of billing practice standards? [] yes [] no
10. Have you ever been denied privileges or medical staff membership at any hospital or other health care facility? [] yes [] no
11. Have you ever been the subject of disciplinary action and/or a hearing under any set of medical staff bylaws? [] yes [] no
12. Have your hospital or other health care facility privileges or medical staff membership ever been voluntarily or involuntarily cancelled, challenged, reduced, surrendered, limited, suspended, not renewed, revoked or withdrawn? [] yes [] no
13. Are you dependent upon any controlled substance or alcohol? [] yes [] no
14. Are you currently engaged in illegal drug use? [] yes [] no
15. Do you have any physical, mental or emotional condition that would compromise your ability to practice medicine with reasonable skill and safety? [] yes [] no
16. Have formal allegations ever been made against you related to any form of impairment, disruptive behavior or unprofessional conduct or have you ever been asked to seek an evaluation or counseling for such behavior? [] yes [] no
17. Have you ever been reported to the National Practitioner Databank by any individual or organization for any reason? [] yes [] no
18. Has any malpractice or professional liability claim been brought against you within the past ten (10) years? [] yes [] no

*If yes, please complete the "Claim/Suit Report" for each case and describe The case indicating the following:

- a. date and details of the incident(s)
- b. your role in the incident(s)
- c. current status of the claim
- d. if settled, amount paid
- e. if pending, amount being sought
- f. professional liability insurer involved

19. Have you ever been denied professional liability coverage? [] yes [] no

*Please note that Yale-New Haven Hospital requires minimum insurance limits for the Medical Staff of \$1 million per occurrence and \$3 million in the aggregate (proof of insurance coverage is required).

Date

Signature of Applicant

Printed Name of Applicant

**YALE-NEW HAVEN HOSPITAL
IMMUNIZATION TESTING RECORD**

NAME: _____ SS#: _____
 DEPARTMENT: _____ DATE: _____

DOCUMENTATION OF IMMUNIZATIONS/TITERS		
	<u>DATE</u>	<u>RESULT</u>
RUBEOLA VACCINE		
RUBEOLA TITER (if no vaccine)		
RUBELLA VACCINE		
RUBELLA TITER (if no vaccine)		
MMR VACCINE		
Have you had the chickenpox? YES _____ NO _____		
VARICELLA TITER (if done)		
VARICELLA VACCINATION (if done but not required)		
PPD, MANTOUX (within the last year, if PPD-Negative)		

If **PPD** positive, did you have a chest x-ray:

YES _____ **NO** _____

If **PPD** positive, did you receive prophylactic anti-tuberculous therapy:

YES _____ **NO** _____

Have you received the **Hepatitis B** Vaccine series:

YES _____ **NO** _____

What was the result of your **Hepatitis B** surface antibody test following the vaccine series:

POSITIVE _____ **NEGATIVE** _____

Dear Colleague:

Based upon current standards of OSHA/AHA/JCAHO and Hospital policy, applicants to the Medical Staff and Clinical Fellows are requested to forward their immunization/test records to the Department of Physician Services. For your convenience, a standardized reporting form is enclosed. Specifically, documentation of the following is required:

- ◆ **MEASLES** (for those whose DATE OF BIRTH is 1/1/57 or later), statement of history of illness is not acceptable:
 - A statement of date of positive antibody titer
 - Or
 - Date of Immunization (done after 1/1/69)

- ◆ **RUBELLA** (for those whose DATE OF BIRTH is 1/1/57 or later), statement of history of illness is not acceptable:
 - A statement of date of positive antibody titer
 - Or
 - Date of Immunization

- ◆ **HEPATITIS B**
 - A statement of date of positive antibody titer
 - Or
 - Date of completion of Immunization series
 - Or
 - Signed attached waiver

- ◆ **VARICELLA-ZOSTER VIRUS**
 - A statement of history of illness (chicken pox, shingles, or varicella-zoster)
 - IF NEGATIVE HISTORY, THEN, result of antibody titer.

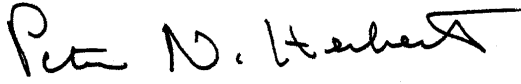
- ◆ **TB SKIN TEST**
 - A statement of result of Montoux skin test, done since 7/1/98.
 - Negative result will require annual TB skin testing; if positive, please provide reason {exposure or BCG vaccination}, date of evaluation, summary of treatment and chest x-ray report since first becoming positive.

Any applicant, who, as a member of the Yale-New Haven Hospital Housestaff had immunizations/testing performed during their training, will need to **PERSONALLY REQUEST** that the Occupational Health Services (203-688-2232), forward a copy of the immunization records to the Department of Physician Services, Hunter 4.

To become compliant if your records are unavailable, please arrange testing and reporting with your personal provider.

Thank you for your cooperation in providing documentation regarding this important matter.

Sincerely yours,

A handwritten signature in black ink that reads "Peter N. Herbert". The signature is written in a cursive style with a long horizontal stroke at the end.

Peter N. Herbert, M.D.
Chief of Staff

Yale-New Haven Hospital Authorization to Release Records and Information

By applying for appointment as a Guest at Yale-New Haven Hospital, I hereby authorize Yale-New Haven Hospital, its representatives, employees, agents and members to consult with prior associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, and ability to work cooperatively with others.

I hereby release from liability all representatives, employees, agents and Medical Staff members of Yale-New Haven Hospital, for their acts performed and statements made in connection with evaluating my credentials and qualifications.

I hereby release from liability any and all individuals and organizations who provide information to Yale-New Haven Hospital, its representatives, employees, agents and members concerning my professional competence, ethics, character, and other qualifications for membership.

I agree to indemnify Yale-New Haven Hospital, its representatives, employees, agents and Medical Staff members in the event that any false or misleading information or failure to provide complete data later exposes the Hospital to professional liability.

I authorize Yale-New Haven Hospital and its employees and agents to allow Accrediting Bodies access to my credentialing file as requested and to permit Accrediting Bodies to review said file.

I agree to abide by the Bylaws and the Rules & Regulations of the Medical Staff of Yale-New Haven Hospital. (Copies of the Bylaws and Rules & Regulations are available upon request or via the Y-NHH Clinical Workstations.) I further agree to abide by the Policies applicable to my activities. Additionally, I agree to practice within the limitations of my guest privileges as delineated.

I further attest that I have read, understand and will abide by the enclosed Y-NHH policy regarding Infection Control and Safety Precautions.

I declare under penalty of law, that all statements, answers, and information contained in this application are true, correct and complete to the best of my knowledge. I understand that falsification, misrepresentation or omission of any fact(s) will be sufficient cause for denial of this application and/or subsequent termination of any participating privileges granted upon the basis of this application. I agree to inform Yale-New Haven Hospital in writing within fifteen (15) days, of any changes in the information provided and the answers to questions on the application as a result of new information or developments subsequent to my signing of the application.

I understand and agree that acceptance of this application does not constitute approval of membership in the Yale-New Haven Hospital Medical Staff and grants me no rights or privileges of membership beyond guest privileges as specifically defined.

I agree that photocopies of this document will be as binding as the original and attest to the fact that the signature below is my own.

(Date)

(Signature of Applicant)

(Printed Name)

YALE-NEW HAVEN HOSPITAL
REQUEST FOR TEMPORARY/GUEST PRIVILEGES

Name:			
Department:		Section:	
Social Security #:		Dates:	

Complete this Section for Medical Staff Applicants:

The Applicant:	
<input type="checkbox"/>	Meets criteria to request Temporary Privileges
<input type="checkbox"/>	Has completed/clean application with the Medical Staff Office

Complete this Section for Guests:

The proposed Guest:	
<input type="checkbox"/>	Is licensed in the State of Connecticut or other State as appropriate
<input type="checkbox"/>	Has malpractice coverage (minimum insurance limits for Medical Staff are \$1million per occurrence/\$3million in the aggregate)
<input type="checkbox"/>	NPDB performed
<input type="checkbox"/>	Hospital Verification performed
Types of Privileges requested:	

Available information supports the fact that this practitioner's qualifications are consistent with those required for Medical Staff appointment.

Signature of Chief/Section Chief

Signature of Associate Chief

Date:

Date:

Approved () _____

Disapproved () _____

Date Date Chief of Staff

Yale New Haven Hospital
Application for Physician Observers*

Date:	
Medical Staff Sponsor's Name:	
Department / Section:	
Observer's Name:	
Dates of Observation:	
Purpose of Observation Visit:	

Attestation

The individual listed above is requesting to visit Yale New Haven Hospital (YNHH) strictly as an observer for the period of time indicated. I agree that I will be responsible for this individual and he/she will be accompanied at all times by a member of the Medical Staff while he/she is on YNHH premises.

We agree and understand that, if approved as an observer, the applicant is permitted to observe patient care only and that he/she will have no patient contact. To this end, he/she will be prohibited from engaging in any of the following: speaking with or examining patients, providing opinions or consultation about any patient hospitalized at YNHH or reading or writing in patient medical records. If approved as an observer in the Operating Rooms or other procedural areas, the applicant understands that he/she must remain unscrubbed at all times.

The applicant agrees:

- to display appropriate identification while on YNHH premises
- to complete the attached immunization testing record and fulfill documentation requirements as stipulated in the attached letter
- sign and return the

Medical Staff Member's Signature		Observer's Signature	
Date		Date	

PLEASE FAX COMPLETED DOCUMENTS TO: 203-688-5343

*Note: Physicians who are not members of the YNHH Medical Staff and wish to participate in patient care may apply as a "Guest." Applications are available by contacting the Department of Physician Services at 203-688-2615.

Department of Physician Services

Reviewed by: _____
Date: _____

Comments: _____

**YALE-NEW HAVEN HOSPITAL
IMMUNIZATION TESTING RECORD**

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 DEPARTMENT: _____ DATE: _____

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	<u>DATE</u>	<u>RESULT</u>
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RUBEOLA TITER (if no vaccine)		
RUBELLA VACCINE		
RUBELLA VACCINE		
RUBELLA TITER (if no vaccine)		
MMR VACCINE		
MMR VACCINE		
Have you had the chickenpox? YES _____ NO _____		
VARICELLA TITER (if done)		
VARICELLA VACCINATION (if done but not required)		
PPD, MANTOUX (within the last year, if PPD-Negative)		
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If **PPD** positive, did you have a chest x-ray:

YES _____ NO _____

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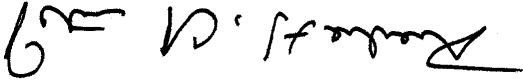
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Peter N. Herbert, M.D.

Chief of Staff