EYE SURGERY CENTER
OF MIDDLE TENNESSEE

Credentialing and getting Privileges at the Eye Surgery Center of Middle Tennessee is a process. Congratulations on the first step—Obtaining an Application Packet.

Below is the Provider Credentialing Checklist. **SECTION I** includes the gray sheets that are to be read, signed and dated, then returned along with the necessary documents you will provide in **SECTION II** . **SECTION III** is the verification process based on the information you provided in SECTION II, we will take care of this step.

Provider Credentialing List:

SECTION I:

_____ Application for Medical Staff Membership
_____ Delineation of Privileges – Place a "T" in "Credentialing Request " column.
_____ Medical Staff Health Statement (Physical & Mental)
_____ Authorization for Release of Information
_____ Confidentiality Statement
_____ Heb B/ Tuberculosis PPD Test
_____ Infection Control Practices
_____ Release of Liability

SECTION II:

_____ Current Curriculum Vitae
_____ Current State Medical License
_____ Current DEA Certificate
_____ Professional Malpractice Liability Insurance Certificate
_____ Explanation of any previous Litigation
_____ Board Certification orBoard Eligibility
_____ Professional school/diplomas, residency certificates, and Fellowship certificate
_____ 3 Professional References with Complete Name, Address and Phone Number
_____ Current CME's
_____ Current Drivers License
_____ Copy of current Years Flu Vaccination

We look forward to welcoming you to our Medical Staff. If you have any Questions or Concerns regarding this application process, please don't hesitate to give me a call at the office: (615) 964-5912, or on my cell: (615) 598-1373.

Regards,

Alyssa Somerfield, RN, BSN
Interim Administrator, Eye Surgery Center of Middle Tennessee
asomerfield@esc-mt.com

EYE SURGERY CENTER OF MIDDLE TN
APPLICATION FOR MEDICAL STAFF MEMBERSHIP
(If extra space is required, please attach additional papers)

IDENTIFYING INFORMATION			
Name:		Maiden Name:	SS #:
Place of Birth:	Citizenship:	Drivers License No./State:	DOB:
Office Address:		City, State, Zip:	Office Telephone:
Home Address: (if less than 3 years, list previous address)		City, State, Zip:	Home Telephone:
Previous Address:		City, State, Zip:	Mobile Telephone:
Email Address:			
Appointment Desired: ☐Active Attach list of privileges desired.		Practice Limited to:	

EDUCATION		
Pre-Medical College or University	Address/City/State:	Date Graduated/Degree:
Medical College or University ECFMG# if applicable	Address/City/State:	Date Graduated/Degree:
Internship - Name of Hospital/Institution:	Address/City/State:	Dates:
Residency - Name of Hospital/Institution:	Address/City/State:	Dates:
Fellowship - Name of Hospital/Institution:	Address/City/State:	Dates:

HOSPITAL AFFILIATIONS - LAST THREE YEARS			
Hospital:	Address/City/State:	Status:	Dates:

MILITARY HISTORY (if applicable)	
Experience:	Dates:

EYE SURGERY CENTER OF MIDDLE TN
APPLICATION FOR MEDICAL STAFF MEMBERSHIP - PAGE 2

BOARD CERTIFICATION

Name of Board:	Address:
☐ Board Candidate	Date of Board Certification:
☐ Board Certified	Date Scheduled for Boards: Date for Recertification:

LICENSING

Medical License Number(s):	State:	Expiration Date:
NPI Number:		
DEA Number(s):	State:	Expiration Date:

PROFESSIONAL LIABILITY INSURANCE
(Attach copy of Insurance Binder)

Current Malpractice Insurance Carrier/Agent:	Limits of Coverage:	Effective Dates:

MEDICAL COMPETENCY REFERENCES
(Provide at least 3 names of physicians in your specialty)

Name:	Address:	City, State, Zip:	Telephone:

GENERAL HEALTH STATUS

Date of Last Physical Exam	Examining Physician	Significant Findings

Have you been hospitalized in the last five years? ☐ Yes ☐ No	If yes, please explain:

PROFESSIONAL MEMBERSHIPS

Name	Office Held, if applicable

PHYSICIAN EMPLOYED ASSISTANTS TO BE CREDENTIALED BY THE FACILITY

Do you employ any of the following assistants? ☐ Yes ☐ No	If yes, please fill in their names.
☐ Certified Physician's Assistant	
☐ Certified Registered Nurse Anesthetist	
☐ Nurse Practitioner	
☐ Surgical Technician	
☐ Endoscopy Technician	
☐ Other	

EYE SURGERY CENTER OF MIDDLE TN
APPLICATION FOR MEDICAL STAFF MEMBERSHIP

CONTINUING MEDICAL EDUCATION

On a separate sheet, list all activities you have attended for which you have received credit in the past two years - please include name of activity, date(s) attended, and where attended

If the answer to any of the following questions is "Yes", please give full details on a separate sheet of paper.

IN THE PAST THREE YEARS:

1.	Have your clinical privileges at a hospital or other health care facility ever been denied, limited, suspended, revoked, not renewed, or subjected to probationary conditions?	☐ Yes ☐ No
2.	Have you been involved in proceedings brought by a hospital or other health care facility to deny, limit, suspend, not renew, revoke your privileges?	☐ Yes ☐ No
3.	Have you been asked to resign from the staff of a hospital or other health care facility?	☐ Yes ☐ No
4.	Has your license to practice medicine, or your permit to dispense of prescribed drugs ever been limited, suspended, revoked, denied, or subject to probationary conditions in any state?	☐ Yes ☐ No
5.	Has your specialty board certification or eligibility ever been denied, revoked, relinquished, not renewed, suspended or reduced?	☐ Yes ☐ No
6.	Has your Drug Enforcement Agency or other controlled substances authorization ever been denied, revoked, suspended, reduced, or not renewed?	☐ Yes ☐ No
7.	Are you currently, or have you ever been excluded from a federal healthcare program, i.e., Medicare, Medicaid, Champus, etc.?	☐ Yes ☐ No
8.	Have you ever voluntarily relinquished a medical staff membership, a clinical privilege, a medical organization or professional society membership, a professional license, or a narcotics registration?	☐ Yes ☐ No
9.	Have you ever been denied professional liability insurance or has your policy ever been canceled?	☐ Yes ☐ No
10.	Have you been notified to respond to or appear before any licensing or regulatory agency on a complaint of any nature, including, but not limited to, unprofessional or unethical conduct?	☐ Yes ☐ No
11.	Have disciplinary proceedings been instituted against you by a country or state medical society, hospital/facility board or committee, or Board of Medical Examiners?	☐ Yes ☐ No
12.	Has any judgment or settlement been made against you in any professional liability case? If yes, are there any claims pending? (include docket number of suit, place of filing)	☐Yes ☐ No ☐ Yes ☐ No
13.	Have you been charged with, or convicted of a felony or misdemeanor, other than traffic violations?	☐ Yes ☐ No
14.	Have you been treated or hospitalized for any mental or emotional disorders?	☐ Yes ☐ No
15.	Have you been treated or hospitalized for use of any of the following: Alcohol Narcotics Central nervous system stimulants or depressants	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
16.	Have you appeared before or met with any official or non-official committee or group at a hospital or other health care facility where you have privileges, that has reviewed any problem or potential situation which was a concern to the facility?	☐ Yes ☐ No

To the best of my knowledge, the above statements are the truth and I have not knowingly withheld any information.	Signature:

EYE SURGERY CENTER OF MIDDLE TN

APPLICATION FOR MEDICAL STAFF MEMBERSHIP - PAGE 4

In making application for appointment, I agree to abide by the facility's Medical Staff Bylaws and Rules and Regulations, and further agree to abide by such facility policies and procedures that may be in force and from time to time enacted. I am aware that the facility has a Compliance Program in effect, and I agree to abide by these policies and procedures. I am familiar with the principles and standards of the accrediting bodies, i.e. JCAHO and AAAHC, and the principles, standards, and ethics of the national, state, and local associations that apply to and govern my specialty and/or profession, and I agree to be bound by the terms thereof if I am granted membership or clinical privileges, and I further agree to be bound by the terms thereof without regard to whether or not I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment to the professional staff.

I hereby acknowledge that the Medical Staff Bylaws, Rules and Regulations are on file in the facility and I have received and reviewed a copy.

I understand that it is my responsibility to ask questions regarding any portion of the Medical Staff Bylaws and/or Rules and Regulations which I do not understand.

I understand that the Medical Staff Bylaws, Rules and Regulations provide for recourse to adverse rulings regarding Medical Staff membership. I agree to exhaust internal administrative remedies as delineated in the Medical Staff Bylaws, Rules and Regulations before litigating in the event an adverse ruling is made.

I agree to participate in Performance Improvement activities in accordance with my responsibilities as a member of the Medical Staff.

By applying for appointment to the professional staff, I hereby signify my willingness to appear for interviews in regard to my application and authorize the facility, its professional staff, and their representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to the inspection by the facility, its professional staff, and its representatives of all records and documents, including medical records, at other hospitals/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 qualifications for staff membership. I hereby release from all liability all representatives of the facility and its professional staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the facility, or its professional staff, in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I understand and agree to the credentialing process which will include, but is not limited to, verifying licensure, professional references and qualifications, previous and current hospital affiliations, education, history of professional discipline taken or pending, and inquiries into my physical/mental health. As a part of the credentialing process, and if deemed necessary by the Governing Body, I also agree to be interviewed by designated members of the medical staff.

Moreover, I specifically pledge that I will not receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services; and I fully understand that any significant misstatements in or omissions from this application constitute cause for summary dismissal from the Medical Staff. All information submitted by me in this application is true to my best knowledge and belief.

Any falsification of information contained in the application shall result in the automatic denial of the application. Denials on the basis of falsification of information shall not be entitled to any fair hearing rights as set forth in Article V of the Medical Staff Bylaws.

Applicant's Signature:	Date:

IN ADDITION TO COMPLETING THIS FORM, PLEASE ATTACH CURRICULUM VITAE IF AVAILABLE

EYE SURGERY CENTER OF MIDDLE TN
DELINEATION OF PRIVILEGES
OPHTHALMOLOGY - PAGE 1 OF 2

Applicant's Name:	**Specialty:**	**For Calendar Year(s):**

The granting, reviewing and changing of clinical privileges will be in accordance with the Medical Staff Bylaws. Assignment of such clinical privileges is based on education, clinical training, demonstrated skills and capacity to manage procedurally related complications.

Indicate procedures for which you wish to be credentialed. Return this form with your Application.

PROCEDURE	**Credentialing Request** T	**QAPI Committee Recommendation**		***Governing Body*** **Privilege Granted**
		YES	**NO**	
Perform/interpret x-rays performed within the facility				
Category A:				
Epilation of eyelashes				
Removal of superficial foreign body				
Blepharotomy - hordeolum				
Repair of minor lacerations of lids, conjunctivae				
Conjunctival biopsy				
Corneal curettage				
Chalazion surgery				
Category B:				
Lacrimal duct probing				
Punctum and canalicular surgery				
I & D lacrimal sac abscess				
Subconjunctival and retrobulbar injections				
Tarsorrhaphy				
Pterygium surgery				
Ectropion/entropian repair				
Category C:				
Repair of extensive lacerations of lids, conjunctivae, cornea, globe				
Iridectomy/iridotomy				
Anterior chamber irrigation				
Dacryocystorhinostomy				
Enucleation and evisceration				
Strabismus surgery				
Blepharptosis surgery				
Removal of intraocular and intraorbital foreign bodies				

EYE SURGERY CENTER OF MIDDLE TN
DELINEATION OF PRIVILEGES
OPHTHALMOLOGY - PAGE 2 OF 2

Procedure	Credentialing Request T	*QAPI Committee* Recommendation		*Governing Body* Privilege Granted
		Yes	No	
Category C (continued):				
Cataract surgery				
Intraocular lens implantation/removal				
Excision of ciliary body lesions				
Glaucoma filtering procedures				
Goniotomy				
Cyclodialysis				
Cyclocryotherapy				
Trabeculectomy/trabeculotomy				
Exteneration surgery				
Major plastic repair				
Keratoplasty				
Keratoprosthesis surgery				
Excision of iris lesions				
Retinal detachment surgery				
Phacoemulsification procedures				
LensX Laser				
*** Include documentation of continuing education/training**				
Other: Supervision of Anesthesia				
Local and Regional Injections				

Applicant's Signature	Date
Signature QAPI Chairperson	Date
Signature Governing Body Chairperson	Date

EYE SURGERY CENTER OF MIDDLE TN

MEDICAL STAFF HEALTH STATEMENT

As of this date:

☐ I certify that I believe I am physically and mentally capable of exercising the clinical privileges I am requesting.

☐ I certify that I am not taking any medications which could affect my ability to exercise the clinical privileges I am requesting.

☐ I certify that I do not abuse, nor am I impaired by the use of, alcohol or drugs.

Print or Type Full Name: _____

Applicant's Signature:_____ Date: _____

Applicant - please do not write below this line.

I confirm that I am the:

☐ Director of a Training Program
☐ Chief of Services in the applicable specialty or Chief of Staff in hospital where applicant holds privileges
☐ Currently licensed physician designated by the organization

FACILITY/HOSPITAL NAME _____

I have been given a copy of the Delineation of Privileges for which the aforementioned practitioner is applying at your facility. I confirm that as of this date the above named practitioner appears physically and mentally capable of practicing medicine in the specialty for which he/she has made application. I also confirm that I do not believe that the aforementioned practitioner abuses, nor is impaired by the use of, alcohol or drugs.

Please PRINT or TYPE name _____Title_____

AUTHORIZATION FOR RELEASE OF INFORMATION

By making application to the EYE SURGERY CENTER OF MIDDLE TN, I hereby authorize the facility to make inquiries as to my educational/professional background or qualifications of any of my references and institutions in which I have been enrolled or by whom I have been employed.

I further authorize EYE SURGERY CENTER OF MIDDLE TN to perform primary source verification, to make inquiries as to my professional/educational background, my qualifications of any of my references and institutions in which I have been enrolled or by whom I have been employed or extended privileges.

I further authorize any of the above persons or institutions to forward any and all information their records may contain and agree to hold them harmless from any action by me for any statements which they may make concerning me.

I agree that a photocopy of this release, which shall serve as the original, shall be sent to those references listed in this in this application, together with a request for information and a list of the privileges for which I am applying.

Please Print or Type Full Name: _____

Applicant's Signature _____ Date _____

CONFIDENTIALITY STATEMENT
EYE SURGERY CENTER OF MIDDLE TENNESSEE

The Eye Surgery Center of Middle Tennessee has a legal and ethical responsibility to safeguard the privacy of all patients and to protect and safeguard the confidentiality of health information. The ASC must assure the confidentiality of its patient, human resources, payroll, fiscal, computer systems, computer access, management information, and/or personal computer access codes (Confidential Information).

I agree not to directly or indirectly use or disclose Confidential Information without proper authority and specifically agree with the following:

1. In the course of my involvement at the ASC, I may come into possession of Confidential Information. I understand that such information must be maintained in the strictest confidence.
2. I agree not to use, disclose or discuss any Confidential Information with others, including other business clients, friends, or family who are not authorized or who do not have a need-to-know.
3. I agree not to access any information, or utilize equipment, other than what is required to perform my function in the facility.
4. I agree not to discuss Confidential Information where others can overhear the conversation. Discretion must be used when discussing Confidential Information in public areas even if the patient's name is not used, since it can raise doubts with patients and visitors about the facilities respect for their privacy.
5. I agree not to make any unauthorized transmissions, inquiries, modifications, or purging of data in the computer system. Such unauthorized transmissions include, but are not limited to; removing and/or transferring data from the ASC computer systems to unauthorized location (e.g., home).
6. If used, I agree to log-off prior to leaving any ASC computer or terminal unattended.

I have read and agree to the terms and conditions of this agreement and understand that any violations may result in termination of services and/or legal action.

_____ _____

Signature Date

_____

Print Name

HEPATITIS B AND TUBERCULOSIS VACCINATION OFFER AND DECLINATION

I have received information and training pertaining to Hepatitis B and the vaccine as well as Tuberculosis and PPD testing. I have had the opportunity to ask questions and they have been answered to my satisfaction.

I.) Please check one of the following regarding Hepatitis B:

_____**I decline the Hepatitis B Vaccination**
I understand that due to my occupational exposure to blood or other potentially infections materials, I may be at risk for acquiring Hepatitis B infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to me. However, I decline the Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk for acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infections materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at not charge to me.

_____I am currently in the process of receiving the vaccine series.

_____By my signature below, I certify that I have already completed the three or four injections series of Hepatitis B vaccine.

_____I have had Hepatitis B infection and do not require the vaccine.

_____**I accept the Hepatitis B Vaccination**
I understand the benefit and risks of the vaccine and I consent to receive the vaccine. I further understand that I am responsible for scheduling and keeping my appointment to receive the Hepatitis B vaccine in accordance with the recommended series (three vaccination series; second vaccine one month after the first vaccine; the third vaccine within five months of second vaccine).

II.) Please check one of the following regarding Tuberculosis Testing:

Eye Surgery Center of Middle Tennessee requires all employees and credentialed personnel to obtain an annual PPD test or submit current within the last 12 months results of this requirement. Those with a history of this infection or a previous positive PPD test must provide a chest x-ray results.

_____ I decline this test being offered at no charge to me from *Eye Surgery Center of Middle Tennessee* as I have received this required annual testing at another facility on _____(date). I further attest that the results of this skin test or the required x-rays indicate that I am free of this disease.

_____I accept this testing at this time either via the skin test or x-ray.

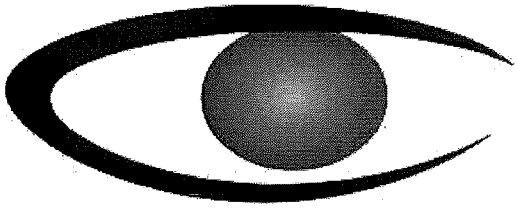
_____ I will provide a copy of the results for my file.

_____

Name

_____

Signature with Date



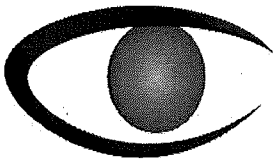
EYE SURGERY CENTER
OF MIDDLE TENNESSEE

INFECTION CONTROL PRACTICES

- ✓ Hand washing BEFORE and AFTER patient contact!
- ✓ Full hand washing with soap and water before 1st case of the day, and anytime hands are visibly soiled.
- ✓ Let hand rub dry before gowning and gloving!
- ✓ Wear appropriate PPE in OR: masks when patient's sterile field of instruments is present in room, gloves and gown when contact with sterile areas. Hats worn at all times in OR's.
- ✓ REMEMBER—Hand lotion is available in both OR and Pre-Op to help prevent irritation and dryness. Utilize this if needed!

Please sign to acknowledgement of this review of our best standards of practice:

Signature: _____ Date: _____



EYE SURGERY CENTER
OF MIDDLE TENNESSEE

RELEASE OF LIABILITY STATEMENT:

By applying for clinical privileges, I hereby signify my willingness to appear for interviews in regard to my application/re-application, and I authorize the organization, its medical staff and their representatives to consult with members of management and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to inspection by the Eye Surgery Center of Middle Tennessee, its medical staff, and its representatives, of all records and documents, including medical and credential records at other hospitals, which may be material to an evaluation of my qualifications for staff membership. I hereby release from liability all representatives of the Eye Surgery Center of Middle Tennessee and its medical staff, in their individual and collective capacities, for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all Individuals and organizations who provide information to the Eye Surgery Center of Middle Tennessee or to members of its medical staff in good faith and without malice concerning my professional competence, ethics and character, and other qualifications for staff appointment and clinical privileges. I hereby consent to the release of information by other hospitals, or other medical associations, and other authorized persons, on request, regarding any information the Eye Surgery Center of Middle Tennessee may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability and hold harmless the Eye Surgery Centerof Middle Tennessee and any other third party for so doing. I understand and agree that I, as an applicant for clinical privileges, have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics, and other qualifications and for the resolution and any doubts about such qualifications.

By accepting appointment and/or reappointment to the medical staff at the Eye Surgery Center of Middle Tennessee, I hereby acknowledge and represent that I have read and am familiar with the Bylaws, rules and regulations of the Eye Surgery Center of Middle Tennessee, as well as the principles, standards and ethics of the national, state, and local associations and state law and regulations that apply to and govern my specialty and/or profession, which are the "Governing Standards". I further agree to abide by such further Governing Standards as may be enacted from time to time.

In addition, I agree to notify the Eye Surgery Center of Middle Tennessee of any curcumstances that would change my status in licensure, DEA, Medicare participation, liability Insurance coverage or board certification status or hospital privileges.

I understand and agree that any significant misstatements or omissions from this application shall constitute cause for denial of appointment or re-appointment or cause for summary dismissal from the medical staff with no right of appeal. All information submitted by me in this application is true to the best of my knowledge and belief.

I further authorize a photocopy or facsimile of the requests, authorizations and releases to this application to serve as the original.

Signature of Applicant:_____ Date: _____

Print Name of Applicant: _____