STAFF APPOINTMENT: REQUIRED MATERIALS WORKSHEET **DOH:_______**

Applicant name:____

Section I: _____Application_____Reference 1_____Reference 2_____Current CV

_____Authorization_____Confidentiality Policy_____Job Description

II: _____Surgical Center Delineation of Privileges

III: ______State License_____CDS_____DEA_____Malpractice Insurance

(CDS and DEA must have matching business address)

IV: _____Board Certification/Letter_____New Provider Training/Orientation

_____Podiatrists Only: Must provide Profile Plus Verification from ABPM

V: (WASC Staff): _____OIG_____SAM_____NPDB_____AMA

VI: _____Medical Diploma_____Residency_____Special Training_____Basic Life Support/CPR

_____ECFMG

VII: _____Letter of Affiliation from hospital 30 minutes from facility Exp_____

_____Delineation of Privileges from same hospital (obtain from medical staff office)

VIII: _____Executive Board/Medical Director Review and Approval

IX: _____Appointment/Reappoinment Letter

X:_____Photo ID: State Driver's License or _____Passport

Office Contact for Credentialing Materials:____

FOR ANESTHESIA PROVIDERS: _____BLS_______ACLS______PALS

CONFIDENTIAL MEDICAL FILE

___Personal Phys. Certificate ___Health Assessment ___Hep Vacc Decline ___Emergency contact

Titers: ___Rubeola ___Rubella ___Mumps ___Varicella ___Hep B ___TB survey ___Covid Vacc Card

___Flu Vacc

New applicants: _____2 step PPD or___ current and 1 year prev test ***OR*** ___Current Gold Test

IF POSITIVE: ___Documentation of Treatment ___CXR

***TB surveys, Flu Vacc or Refusal, and Health Assessment Forms are required annually

**State required BLS may be done in person or online (any site)

Kindly email trish@waysurgicalcenter.com, or fax 973-709-9730 (secure) any license and BLS updates

PHYSICIAN JOB DESCRIPTION

Reports to Medical Director and Board of Directors

Position Summary: The surgeon should be an obvious, working physician, representing the center to the medical community and the public. The physician should participate in and understand the center's budget. He/she should work in a collegiate way with the Administrator and the Director of Nursing to affect efficient and profitable operations with providing best patient care.

Qualifications: A physician shall be a physician who has successfully completed a residency program accredited by the Accreditation Council for Graduate Medical Education or approved by the American Osteopathic, or successfully achieved Podiatry Licensure who is a member of the Medical Staff as a licensed independent practitioner with active medical privileges appropriate to the center and keeps abreast of national and federal regulations.

Responsibilities:

1.Participates in orientation and required educational activities

2.Participates in the peer review program

3.Assures quality care is rendered in the facility

4.Participates in the Infection Control Program

5.Reports and documents information accurately and in a timely manner

6.Communicates a positive and caring attitude towards patient care toward patients, peers, staff, and other contacts

7.Seeks guidance, directions, and assistance where needed

8.Maintains confidentiality of all patient and center communications/documents

9.Gains knowledge of all equipment and supplies and is familiar with their location, especially emergency drugs, supplies and equipment

Work Environment and Hazards: Hazards include risk of exposure to communicable diseases and materials and the risk of physical injury from moving/lifting patients and equipment as well as operation of equipment. Work may be stressful at times, interaction with others is constant and interruptive. Contact may involve with dealing with sick and/or persons under high stress/anxiety. May occasionally exposed to fumes or airborne particles and or toxic or caustic chemicals. The noise level in the environment is usually moderate.

Special Physical Demands: The physical demands described here are representative of those thay may be met by an exposure by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is regularly required to stand, use hands, talk,and hear. The provider may occasionally climb, stoop, balance, kneel, sit, walk, use hands to finger, handle or feel objects tools or controls, reach with hands and arms. The provider must occasionally lift 50 or more pounds and sometimes move/lift more than 100 ponds. Specific vision abilities required by this job include close, distance, and peripheral vision, and the ability to adjust focus.

The above statements reflect the general outline considered necessary to describe the principal functions of this job. It shall not be construed as a detailed description of all work requirements of the job.

Physician:______________________________ Date:______________________

APPLICATION FOR PRIVILEGES

Last Name:________________________________First Name:________________________MI:__

Degree: MD DO OD DDS DMD PA-C Other:___ DOB:___ Sex:___

Specialty:____________________________

Social Security:__________________________NJ LIC:____________________________________

Medicare ID:____________________________CDS:_____________________________________

UPIN:_________________________________DEA:_____________________________________

NPI:__________________________________Tax ID:___________________________________

Home Address:____

City:__________________________________ State:______________Zip:__________________

Home Phone:__________________________Cell Phone:________________________________

Home Email:____________________________

Name of Practice:____

Adress:____

City:______________________________________State:_____________Zip:_________________

Phone:__________________________________Fax:_______________________________________

Office Manager:_____________________________Email:________________________________

Office Scheduler:_____________________________Phone:______________________________

Email:_______________________________

Hospital Affiliations:

Name:____

Appointmant Dates:____________________________________Status:__________________________

Name:____

Appointment Dates:____________________________________Status:__________________________

Name:____

Appointment Dates:____________________________________Status:__________________________

Have you ever voluntarily or involuntary been dismissed from any facility? ___YES ___NO

Please explain:____

____

Professional Liability

Carrier Name:____

Address:____

Policy #:____Exp date:____________________

Per Occurrence:________________________Per Aggregate:__________________________

Has your professional liability insurance coverage ever been denied, canceled, reduced, limited, not renewed, or terminated by an action of an insurance company? ___YES ___NO.

1.Have any professional liability suits been filed against you? ___Yes ___No

2.Have any judgements or settlements been made against you professional liability cases ___Yes ___No

3. Are there any claims pending? ___Yes ___No

If yes to any questions, please provide an explanation.

Health Status

1. I certify that I am in good health and have no physical or mental limitations which may impair my ability to render patient care? ___Yes ___No
2. Have you ever been hospitalized at any time during the past 5 years for a condition, drug or alcohol abuse which impaired your ability to render patient care? ___Yes ___No
3. When was your last complete physical exam?________________________________
4. Are you currently taking medication that may affect either your clinical judgement or ability to otherwise render patient care? ___Yes ___No

If yes to any questions, please provide an explanation

Disciplinary Actions

1. Has any action ever been taken against your licenses in any state or jurisdiction including but not limited to denial, suspension, revocation, restriction, probation, or reprimand or have you ever voluntarily or involuntarily relinquish these licenses ? ___Yes ___No
2. Has any application for privileges or your existing privileges ant any facility ever been denied, suspended, revoked, or have you ever voluntarily or involuntarily relinquished privileges in leiu of disciplinary or peer review action or investigation ? ___Yes ___No
3. Have you ever agreed to have your privileges or medical staff appointment to be reduced, limited, or terminated ? ___Yes ___No

4. Are you aware of any investigation by state or governmental authority concerning your licenses?
___Yes ___No
5. Have you ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state insurance program (i.e. Medicare, Medicaid, HMO,or PPO,etc)
___Yes ___No
6. Have you ever been reported to the National Practitioner Data Bank for any reason?
___Yes ___No
7. Have you ever been censured by a medical society or other professional society or national board or association? ___Yes ___No
8. Have you ever been required to pay civil monetary penalties under Medicare or Medicaid?
___Yes ___No
9. Have you ever been convicted of a criminal offense other than minor traffic violations?
___Yes ___No
10. Have any facility ever, as a disciplinary action, ever required a peer to evaluate or be physically present with you for any patient before , during, or after procedures, treatment, or testing And/or initiated any action against you by formal notice to your representitives ? ___Yes ___No
11. Are you a habitual user of narcotics, barbituates, hypnotic, amphetimines, concaine, benzodiazepines, or other substances or addicted to alcoholic beverages? ___Yes ___No

If yes to any questions, please provide an explanation

Education

Medical or Graduate School______________________________

Address:______________________________

Dates Attended:______________________________Degree:______________________________

School:______________________________

Address:______________________________

Dates Attended:______________________________Degree:______________________________

Residency

School:______________________________

Dates Attended:______________________________Type:______________________________

School:______________________________

Dates Attended:______________________________Type:______________________________

Fellowship

Institution:______________________________

Dates
Attended:_______________________________Specialty:_________________________________

Board Certification

Specialty:___________________________Board:____

Sub-Specialty:___________________________Board:______________________________________

Qualifying Exam

___ECFMG ___USMLE ___FLEX Other:____

Do Any Of The Following Apply?

1. Dismissed from any training program? ___Yes ___No
2. On probation from any training program? ___Yes ___No
3. Disciplinary action taken against you in any program? ___Yes ___No
4. Resigned voluntary from any training program? ___Yes ___No

If yes to any questions, please provide and explanation

Attestation Statement

I hereby agree to abide by the bylaws and regulations of WASC Holding and release the organization from any liability in connection with credentialing decisions. I further agree and accept professional obligations therin reflected along with accepting privileges to provide for continuous patient care for patients. By signing this application I attest that my mental and physical capabilities are sound and unchanged since my appointment. The information provided in this application is true, complete, and accurate to the best of my knowledge.

Signature of Applicant:____Date:____________________

CONFIDENTIALITY POLICY

POLICY

The surgical center shall provide healthcare services to it's patients while protecting the patients rights to confidential treatment of information.

PURPOSE: to ensure that only parties with legitimate interest have access to healthcare information and there is a conscious effort by all employees to constantly protect patient information through their work habits, computer and fax transmissions, conversation, and handling of patient paperwork.

Patient information will be maintained in secured areas.

Patient's identifiable information will be protected will be protected from inadvertent viewing by persons not directly involved in the patient's care.

Patient information will be accessed and discussed on a "need to know" basis.

Necessary patient discussions will be in a low tone with awareness to othersin the immediate area.

Phone conversations with, to, or about patients will be conducted in a low tone.

Computer and fax transmission of patient information will be conducted in a secure manner.

The original medical record are not to be removed from the center except by the subpoena or proper court order.

Employees will sign a confidentiality statement that will be maintained on an employee file, and agree to abide by its contents without exception.

Disciplinary action will be taken if a patient confidentiality is breached in any manner.

EMPLOYEE CONFIDENTIALITY STATEMENT

I have read and understood the above policy on patient confidentiality and agree to abide by it's contents without exception.

Signature____Date____________________________

PRACTITIONER DATA RECORD / AUTHORIZATION AND RELEASE FORM

General Provisions:

In order to evaluate my application, I agree to the following terms and conditions:

1. That the information contained in the practitioner data record is true and accurate and that information important to my application has not been falsified and/or omitted intentionally. I fully understand that any misstatements or omissions from this application constitute cause for denial of appointment.
   I understand that this is an application process and does not constitute acceptance or approval by a credentialing committee. I also acknowledge that my cooperation by consenting to the production of such information about medoes not guarantee that WASC Holding, LLC and its affiliates will contract me as a provider of services. I further understand that the burden of providing the necessary to process my application is upon me (the applicant).
2. I give full permission and authorization to collect, research, and verify any and all references, licenses, certificates, insurance related matted matters that relate to consideration of my application. This permission extends to and includes the current application and periodic checks as required by the credentialing institution, State of New Jersey, HRS, AHCA, AAAHC, NCQA, and AAAASF and for re-credentialing. The aforementioned shall be in effect as long as the applicant is affiliated with the credentialing institution.
3. I hereby release from liability and hold harmless all employees, previous employees, staff, authorized representative, management and affiliates, individuals and groups for all acts and statements made in connection with collection, verification, review, and evaluation of my credentials and qualifications. These institutions, individuals, anfd groups include, but are not limited to:

WASC Holding Company, LLC	Educational Institutions
Governmental and Non-Governmental Agencies	
Insurance companies	Previous employees
Interviews	Public or private record providers

   The foregoing of immunities from liability shall be in addition to those provided by law.
4. I the undersigned agree to waive any written notice from any present or past organization, individual or employer that prohibits release of information important to my application.
5. I the undersigned agree to accept a faxed or photocopy of this authorization to be accepted with the same authority as the original.

____

Applicant Signature

____

Applicant Printed Name

____

Date

PEER REFERENCE FORM

Name of Applicant:________________________

The above named practitioner has applied for appointment to the professional staff of WASC Holding, LLC (Wayne and /or Elite Surgical Centers). It is our understanding that you have knowledge about this practitioner. In order to appraise the practitioner's professional competence for the purpose of appointment, please assist us by completing the questions below to the best of your knowledge. If any answer dictates the need for explanation, please do so on the reverse side of this questionnaire. This information is considered confidential and privileged to the fullest extent protected by law.

Please Check	**Favorable**	**Unfavorable**
Professional Judgement	_____	_____
Sense of responsibility	_____	_____
Technical Proficiency	_____	_____
Clinical Knowledge	_____	_____
Ethical Conduct	_____	_____
Surgical Staff/ Management relationship	_____	_____
Physician/ Patient relationship	_____	_____
Quality/ Timeliness of recordkeeping	_____	_____
Participation in Medical Staff affairs	_____	_____

1. Is the practitioner's quality of patient care routinely measured through quality assurance mechanisms, and are the results consistent with the level of patient care established by your institution? _____Yes _____No
2. To your knowledge, has the practitioner been subjected to disciplinary action, reduction, suspension, or revocation by a hospital, surgery center, or licensing body? _____Yes _____No
3. Has the practitioner displayed possible physical or mental health problems or chemical dependence which might affect his/ her ability to perform in a competent manner? _____Yes _____No
4. To your knowledge, has the practitioner been named in a possible or filed professional liability cases in the past 12 months? _____Yes _____No
5. If yes, have these claims been reviewed through quality assurance mechanisms? _____Yes _____No

Completed by:____ Date:__________________

Print:____

Adress:____

PEER REFERENCE FORM

Name of Applicant:______________________

The above named practitioner has applied for appointment to the professional staff of WASC Holding, LLC (Wayne and /or Elite Surgical Centers). It is our understanding that you have knowledge about this practitioner. In order to appraise the practitioner's professional competence for the purpose of appointment, please assist us by completing the questions below to the best of your knowledge. If any answer dictates the need for explanation, please do so on the reverse side of this questionnaire. This information is considered confidential and privileged to the fullest extent protected by law.

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Professional Judgement	_____	_____
Sense of responsibility	_____	_____
Technical Proficiency	_____	_____
Clinical Knowledge	_____	_____
Ethical Conduct	_____	_____
Surgical Staff/ Management relationship	_____	_____
Physician/ Patient relationship	_____	_____
Quality/ Timeliness of recordkeeping	_____	_____
Participation in Medical Staff affairs	_____	_____

1. Is the practitioner's quality of patient care routinely measured through quality assurance mechanisms, and are the results consistent with the level of patient care established by your institution? _____Yes _____No
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3. Has the practitioner displayed possible physical or mental health problems or chemical dependence which might affect his/ her ability to perform in a competent manner? _____Yes _____No
4. To your knowledge, has the practitioner been named in a possible or filed professional liability cases in the past 12 months? _____Yes _____No
5. If yes, have these claims been reviewed through quality assurance mechanisms? _____Yes _____No

Completed by:______________________________Date:______________

Print:______________________________

Adress:______________________________

MEDICAL STAFF NEW PROVIDER TRAINING

I have received instruction, explanation, and review of the following subjects prior to my first case performed.

_____Tour of the center, including exit doors

_____Emergency/Disaster Preparedness/Fire Safety

_____Infection Prevention Training,(hand hygiene, SSIprevention, Monthly Tracking)

_____Patients Rights and Responsibilities

_____Pharmacy/Single Dose Vials

_____Pain Management

_____Patient Rights, Complaint Procedure

_____HIPPA

_____Bloodborne Pathogen Precautions, Exposure, and Eyewash Stations

_____Domestic Abuse

_____Cultural Diversity

_____Human Trafficking

____

Provider Signature   Date

WAYNE SURGICAL CENTER

PERSONAL PHYSICIAN'S CERTIFICATE

Name of Applicant______________________________________

Name of personal physician_______________________________

Street Address of personal physician____

City___________________________**State**__________________**Zip**__________

Telephone_________________________**Fax**_____________________________

I.CERTIFICATION

This is to certify that I am a physician duly licensed to practice medicine in the State of New Jersey, that I am unrelated to the applicant named above, and that I have taken a full history and performed a complete physical examination upon that person. On the basis of that history and physical examination, I formed a professional opinion concerning his or her health as indicated by my signature below.

II.STATEMENT OF OPINION

PLEASE CHECK AND SIGN ONE OF THE FOLLOWING IN ACCORDANCE WITH YOUR OPINION.

_____The applicant named herein does not suffer from any ailment which might prevent him/ or her from practicing medicine or surgery at your facility. I am in the opinion that he/she is free from any impairments that are a potential risk to a patient, or which might interfere with the performance of his/her duties as a member of the medical staff, including the habituation of addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter his/her behavior.

Signature: ______________________________________ Date: _______________

_____The health of the applicant herein is described in a separate statement which is enclosed.

Signature: ______________________________________ Date: _______________

WASC HEALTH SELF-ASSESSMENT FORM

Employee Name: ______________________________ Title: MD DO PA RN CST OTHER: ____

Department: ____

1.Has there been a major change in your healthcare status during the past year? ___YES ___NO

If yes, please state: ____

2. Have you had any hospitalizations, illnesses, accidents, operations or injuries in the past 12 months? ___YES ___NO

If yes, please state: ____

3. Are you currently taking any medications on a regular basis, including over the counter medications and herbal supplements? ___YES ___NO please list:____

____

4. Have you experienced any new rashes, skin irritations, respiratory problems, associated with latex or other PPE?____

5. Do you require any specific medical accommodation to assist you in performing your duties?

____

6. *For N-95 mask users only: Do you smoke or have you smoked any tobacco or other products in the last month?*____

*Practitioners with a positive PPD: a review of symptoms of active Tuberculosis include persistent cough, coughing up blood, loss of appetite, unexplained weight loss, night sweats, fever, chills, prolonged fatigue. If any of these symptoms occur, please contact your primary care provider for an evaluation. ***If you have a positive PPD, please initial here to acknowledge awareness of TB symptoms.*

This evaluation is for the purpose of determining your ability to perform your duties and is not considered a substitute for your total medical care by your private healthcare provider.

I certify I have disclosed all known current health impairments which may be potential risk to patients or coworkers, or which may interfere with performance of my duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter my behavior. I understand that failure to disclose information or giving false or misleading answers would be sufficient cause for dismissal.

Employee signature______________________________ Date:________________

WAYNE SURGICAL CENTER

RESPIRATORY ASSESSMENT FOR TUBERCULOSIS

SURVEILLENCE PROGRAM

In compliance with state regulations, you must be screened for potential exposure to the Tuberculosis Bacillus annually. Completion of this questionnaire is mandatory and must be returned to the Employee Health Office yearly to comply with NJDHSS regulations and OSHA guidelines.

PLEAE CHECK IF YOU HAVE HAD ANY OF THE SYMPTOMS IN THE PAST 12 MONTHS:

___cough lasting longer than three weeks

___coughing up blood

___chest pain

___fever and / or chills

___night sweats

___easily fatigued or tired

___loss of appetite or unplanned weight loss

IF YOU ANSWERED YES TO ANY OF THESE SYMPTOMS ABOVE, PLEASE EXPLAIN:

1.When did the symptoms start?____

2.How long did the symptoms last ?______________________________________

3.Are you currently experiencing any of these symptoms?_______________________

4. Have you consulted your doctor?______________________________________

5. What is your diagnosis?____

Signature______________________________Printed name_________________________

Date_______________

WASC HOLDING LLC EMERGENCY CONTACT LIST

NAME:____

Dob:__________________

In the event of an emergency, I authorize WASC Holding to contact **OR** provide the following emergency contact to police/EMS ;

Name:__________________________________relationship:_______________

Ph #1:___________________________Ph #2:______________________________

Name:__________________________________relationship:_______________

Ph #1:___________________________Ph #2:______________________________

List any medications or medical diagnosis you would like EMS to know:

____

____

____

Signature____

Printed name____

Date____

HEPATITIS B VACCINE

DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated, however, I decline the Hepatitis B vaccine at this time. In the future I continue to have occupational exposure, I can receive the vaccination series at no charge to me. I do not need to be offered this vaccine again.

Employee Signature____

Date:____