University Hospital & Clinics
Lafayette General Health

2390 West Congress Street Lafayette, LA 70506
PHONE: (337) 261-6329 or 337-266-4820 FAX: (337) 261-6334

TO: Incoming UHC Residents

FROM: Debbie Chiasson & Caroline Louviere Credentialing Coordinators

DATE: March 16, 2016

RE: Resident Appointment Application for UHC

The following documents are needed to process your application for residency at University Hospital & Clinics. A check off list has been provided for your convenience:

☐	Complete the attached application
☐	Photocopy of Driver's license
☐	Current colored photo
☐	Photocopy of current Louisiana Medical License or Permit
☐	Current TB Skin Test results. Or Chest x-ray or lab work if previous positive
☐	Proof of latest Flu Shot or Declination form
☐	Photocopy of ECFMG certificate (foreign medical graduates only)
☐	Photocopy of Current Certifications (ACLS, ATLS, BLS, PALS, NALS, etc.)
☐	Photocopy of current DEA license (if applicable)
☐	Photocopy of current CDS license (if applicable)
☐	Photocopy of current Board Certification (if applicable)

PLEASE PRINT YOUR NAME ON THE BOTTOM OF EACH PAGE AND COMPLETE THE APPLICATION LEGIBLY.

Applicant: _____

University Hospital & Clinics
Lafayette General Health

APPLICATION FOR APPOINTMENT

PERSONAL DATA:

Full Name: _____
LAST FIRST MIDDLE

Permanent Address: _____

Telephone Number: _____SS#:_____

Date of Birth: _____ Place of Birth: _____ Citizenship_____

Gender___ Marital Status: ____ email address: _____

Name, Address & Relationship of Next of Kin: Relationship: _____

Name: _____Phone:_____

Address:_____

_____

PROGRAM & LEVEL:

Type of Program:

_____

PGY Level: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 (Circle one)

Begin Rotation: _____ End Rotation: _____

Applicant: _____

University Hospital & Clinics
Lafayette General Health

EDUCATION:

College: _____Graduation Date:_____

Address: _____ Degree:_____

Medical School: _____ Graduation Date:_____

Address: _____ Degree: _____

Post-Grad Training:

_____

Previous Residencies: YES _____ NO _____

If yes, how many years completed: _____

Locations _____Date:_____

Locations _____Date:_____

EDUCATION postgraduate

Please list all previous internships, residencies, and fellowships.

Hospital	Date of Service	Chief of Service

Applicant: _____

University Hospital & Clinics
Lafayette General Health

LICENSES:

ECFMG Certification number: _____

ECFMG Certification Date (If applicable): _____

NPI: _____

LA Medical License Number: _____

LA Narcotic Number: _____

Federal DEA Number:
_____

Signature: _____ Date: _____

Applicant: _____

University Hospital & Clinics
Lafayette General Health

If the answer to any of questions 1 to 7 is "yes," please give full details on a separate sheet of paper.		
	YES	**NO**
1. Other than for delinquent medical records, have your privileges at any hospital ever been suspended, diminished, denied or revoked? Is any such action pending, or have you voluntarily or involuntarily relinquished such privileges?	◯	◯
2. Have you ever been denied medical staff membership, been subject to disciplinary action in any medical organization, or is any such action pending?	◯	◯
3. Has any licensure (state, district, DEA) issued to you ever been limited, suspended, denied or revoked. Is any such licensure currently being challenged, or is action pending? Have you voluntarily or involuntarily relinquished such licensure?	◯	◯
4. Have you ever been sanctioned or are you currently being investigated by any of the following: (a) a hospital (b) a health care organization or professional organization; © the La. State Board of Medical Examiners; or (d) the Health Care Financing Administration (Medicare or Medicaid) or the La. Health Care Review?	◯	◯
5. Have judgments or settlements been made against you in professional liability cases or are any such cases pending?	◯	◯
6. Have you ever been denied professional liability insurance coverage?	◯	◯
7. Have you ever been convicted of a felony?	◯	◯

Signature: _____ Date_____

Applicant: _____

University Hospital & Clinics
Lafayette General Health

Statement of Acknowledgment and Agreement

I UNDERSTAND that the medical staff of University Hospital & Clinics is responsible for the evaluation of my professional competence and qualifications. By filing an application, I acknowledge that I have received and read the bylaws of the medical staff and agree to be bound by its bylaws, rules, and regulations. I am familiar with the principles, standards, and ethics of the national, state and local associations that govern my specialty and/or profession, and I agree to be bound by the terms thereof. A copy of the current bylaws is available in the Medical Library for reference.

I AGREE that it is my duty and ethical responsibility as an individual physician and as a member of the medical staff of this hospital to cooperate with and assist the medical staff in evaluating not only my professional qualifications but also those of my colleagues. I agree to appear before medical staff officers and committees for interviews or inquiries at reasonable times and places. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records.

I SHALL BE AFFORDED a fair procedure in the event that action on this application, or with respect to my privileges, is adverse. Such procedure shall include reasonable notice of the reasons for such action and opportunity for rebuttal and impartial determination, as is more specifically set forth in the bylaws of the medical staff.

I ACKNOWLEDGE that my appointment shall be temporary. Provisional and the granting of clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my attendance at and participation in the affairs of the medical staff, my general support of the hospital, as evidenced by admission, treatment, and care of my patients and acceptable performance of all responsibilities related thereto as well as other factors.

I ACKNOWLEDGE my obligation to provide continuous care and supervision to all patients in the hospital for whom I am responsible.

I ACKNOWLEDGE my obligation to the medical staff to practice ethically. I will not accept or offer payment to another physician for a patient referral. I will not accept payment of any kind, in any form, from any source, such as a pharmaceutical company or pharmacist, an optical company or the manufacturer of medical appliances or devices, for prescribing or referring a patient to said source for the purchase of drugs, glasses, or appliances.

I HEREBY AFFIRM that the information furnished by me to the medical staff is true to the best of my knowledge and is furnished in good faith. During the time this application is being processed, I agree to update the application should there be any change of information provided which may be relevant to its consideration. I understand that willful and substantial omissions or misrepresentations may result in denial, modification, or revocation of my medical staff membership and/or clinical privileges.

I HEREBY AFFIRM that I have read and understand the University Hospital & Clinics Code of Conduct Policy attached to this document.

Signed: _____Date: _____

Applicant: _____

University Hospital & Clinics
Lafayette General Health

University Hospital & Clinics
Non-Disclosure Agreement

IMPORTANT: Please read all sections below. If you have any questions regarding this Agreement, please ask your supervisor.

Disclosure of Patient/Provider Information:
I recognize and acknowledge that the services the University Hospital & Clinics (hereinafter referred to as the "Facility") performs for its patients/providers are confidential and that to enable the facility to perform those services, its patient/providers furnish to the Facility confidential information concerning their affairs; that the good will of the Facility depends, among other things, upon its keeping such services and information confidential; and that by reason of my duties, I may come into possession of information concerning the services performed by the Facility for its patients/providers, even though I do not take any direct part in or furnish the services performed for those patients/providers. I accordingly agree that, except as directed by the Facility, I will not at any time during or after my stay at the Facility, disclose any of such services or information to any person whatsoever, or permit any person whatsoever to examine or make copies of any reports or other documents prepared to me or coming into my possession under my control, that have in any way to do with the patients/providers of the Facility. I recognize that the disclosure of information may give rise to irreparable injury to the Facility or to the owner of such information and that accordingly, the Facility or the owner of such information may seek any legal remedies against me which may be available.
I agree that I will at all times comply with all security regulations in effect from time to time at the Facility premises, and externally for all materials belonging to the Facility.

File Confidentiality:
I certify that I will retain all information belonging to any vendor with whom the Facility has a negotiated contract, and any information belonging to the Facility in strictest confidence, and will not release such information or material to anyone who has not signed a written Agreement expressly binding himself/herself not to use or disclose it. I recognize that irreparable harm can be occasioned to the Facility by disclosure of information relating to its business and, accordingly, that the Facility or the owner of such information may seek any legal remedies against me which may be available.

I have read all of the above Sections of this Agreement and I understand them.

Signed: _____ Date:_____

Applicant: _____

University Hospital & Clinics
Lafayette General Health

ACKNOWLEDGMENT OF RECEIPT OF NOTICE MEDICARE/CHAMPUS

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

Medicare/Champus payment to hospitals is based in part on each patient's principal and secondary diagnosis 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.

Your full signature (NO INITIALS) acknowledge receipt of this notice which will be kept on file at the hospital and made available to HCFA upon request and MUST have been completed prior to submission of claims. This same signature should also be used on the attestation statement on the medical records.

Physician's Name (print clearly): _____

Physician's Signature: _____

Date: _____

Louisiana Medical License Number: _____

Applicant: _____

University Hospital & Clinics
Lafayette General Health

CERTIFICATION OF SIGNATURE CONFIDENTIALITY AGREEMENT
BOTH WRITTEN AND ELECTRONIC

I certify that the signature below is my professional signature to be used by the Pharmacy at University Hospital & Clinics per the Joint Commission regulations. I furthermore certify that my Identification Number & Password also represent my signature and as such carry all the ethical & legal implications of a written signature. I will not disclose my Electronic Signature Password to any other person or permit another to use it. I understand that patient information is confidential and agree to follow University Hospital & Clinics Policies & Procedures, as well as the rules and regulations of the medical staff pertaining to Patient Confidentiality. I understand that failure to maintain patient confidentiality as well as the confidentiality of my Electronic Signature/Password will result in the forfeit of my rights to use the Electronic Signature Function. According to CMS, 482.24(c)(1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electric form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. Interpretive Guidelines 482.24(c) (1) According to CMS CR6698.3-For medical review, purposes, Medicare requires that services provided/ordered by authenticated by the author. The method used shall be a hand written or an electronic signature. Stamp signatures are not acceptable. Medicare requires that healthcare providers ordering or documenting the medical necessity for items or services received by Medicare beneficiaries must be identifiable. Therefore, practitioners are encouraged to review their documentation before submission to ensure that all records for services and orders are signed, dated and timed appropriately. I have read and understand the statements listed above and my signature below is an agreement to execute all of the requirements as stated above.

Signature:	
Louisiana Medical License Number:	
State Narcotics Number:	
Federal DEA Number:	
NPI:	
Medicaid & Medicare Provider numbers:	
Service:	

Applicant: _____

University Hospital & Clinics
Lafayette General Health

PHYSICIAN HEALTH STATUS

1. Do you have any physical, mental, or emotional condition that would affect your ability to perform the privileges requested or otherwise affect your practice in any way?		◯ YES	◯ NO
2. Which of the following best describes your health status?	◯ GOOD	◯ FAIR	◯ POOR
3. Do you believe your present health status would affect your ability to perform the privileges requested?		◯ YES	◯ NO
4. Are you currently using illegal drugs or illegally abusing legal drugs? ("Drug means a controlled substance as defined (In Schedule I-V of section 202 of the Controlled Substances Act, 21 U.S.C. 812).		◯ YES	◯ NO
5. Are you currently under any medication that may affect either your clinical judgment or motor skills, and thereby, your ability to perform the privileges requested?		◯ YES	◯ NO
6. Are you currently under any limitations regarding your activity or work load which would affect your ability to perform the privileges requested, including, without limitation, your ability to fulfill your obligations to provide call coverage for the Emergency Department of the hospital?		◯ YES	◯ NO
7. Are you currently under the care of a physician or psychologist for a condition that could, if not treated, impair your ability to provide care in a safe and competent manner, or have you, during the past five (5) years, participated in or been referred to any physician recovery program established pursuant to state law?		◯ YES	◯ NO

If the answer to any of the above questions is YES, please provide a detailed explanation on a separate sheet.

Applicant Signature:		**Date:**	
Department Chairperson Signature:			

NOTE: Regardless of how the above questions are answered, this application will be processed in the usual manner. If you have answered these questions affirmatively and are found to be professionally qualified for medical staff appointment or reappointment and the granting of clinical privileges requested, all attempts will be made to provide necessary or feasible accommodations as determined to allow you to practice safely.

Applicant: _____

University Hospital & Clinics
Lafayette General Health

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby consent to the release to University Hospital & Clinics, its Medical Staff and its representatives, records and documents, including, but not limited to quality assurance actions, malpractice actions, disciplinary actions or concerns, and substance abuse records that might be material to an evaluation of my professional competence, judgment, ethics, and other qualifications for staff reappointment and clinical privileges requested.

I hereby release from liability University Hospital & Clinics, and it's Medical Staff and its representatives for their acts performed in good faith in connection with the solicitation and evaluation of the above records and documents bearing on my application and my credentials and other qualifications for staff appointment and clinical privileges requested.

I hereby also release from liability any and all individuals and organizations that provide to University Hospital & Clinics, or its medical staff in good faith information and material concerning my professional competence, judgment, ethics, and other qualifications for staff reappointment and clinical privileges requested.

SIGNATURE:_____ Date:_____

Printed Name:_____

Applicant: _____

University Hospital & Clinics
Lafayette General Health

Date: April 18, 2012

To: All Staff and Residents

From: James B. Falterman, Jr., MD
Medical Director

Re: Use of Hospital DEA License

LSU Health, University Medical Center has been advised that the hospital Federal DEA license can only be utilized by physicians in prescribing medication(s) within the hospital. If a physician wishes to prescribe, in the hospital, to an out-patient or to a patient being discharged, an individual registration is required.

If you are fully licensed in the state of Louisiana, you cannot use the Hospital DEA and are urged to apply for your own DEA license. If in the scope of your practice, you do not prescribe controlled drugs, you need to sign a waiver to that effect. (See attached).

EXEMPTION is provided for Interns (HO1's) and foreign medical graduates in the code of Federal Regulations for such individuals to dispense, administer, and prescribe controlled substances under the institution's controlled substances permit.

DEA licensure is not obligatory. However, a practitioner who chooses not to obtain licensure must maintain, in his/her credentials file, a waiver to that effect. (See attached). Your cooperation in assuring that this mandate is met by our facility is expected.

JBFJr: dr

Attachment: waiver form

Applicant: _____

University Hospital & Clinics
Lafayette General Health

WAIVER OF FEDERAL DEA LICENSURE

- I, _____ have been advised of federal/state regulations which mandate that practitioners/residents may not utilize hospital DEA license to prescribe controlled substances to an out-patient or to a patient being discharged unless I fall into the category of EXEMPTION as listed on the attached letter.

- I, _____ choose not to obtain DEA licensure since it is not obligatory.

Knowing this information, I hereby voluntarily waive DEA/Narcotics licensure at this time. I understand the limitations which will be imposed upon me because of this waiver. I further understand that I have the opportunity to revoke the waiver at any time upon application/receipt of DEA registration. If obtained, I will notify the credentialing department with a copy of my DEA registration.

Signature:_____ Date:_____

Department Head Signature:_____ Date_____

Applicant: _____

University Hospital & Clinics
Lafayette General Health

COMPLIANCE ATTESTATION

Physicians at Teaching Hospitals Billing Policy

Please refer to the following link and login to view policy:

https://lgh.ellucid.com/userLogin?guestLGMC=cfbb323b7acdb73751f9b5c9bd107928

Username: **guestUHC**

Password: **policy**

I have reviewed the Physicians at Teaching Hospitals Billing Policy and agree to comply with the contents of that policy. I understand that I am responsible for reading and being familiar with the contents of this policy and if I have any questions concerning the policy, that I may contact the Compliance Officer for clarification. I understand that I am responsible for adherence to this policy. I also understand that I am responsible for reporting any suspected fraud and abuse practices within this program to the Compliance Officer.

Provider Signature:_____ Date: _____

Provider Printed Name: _____

University Hospital and Clinics
Corporate Compliance Department
Phone: 337-261-8532
Fax: 337-261-6058

*Original to be kept in the Medical Staff file of the signing provider

Applicant: _____

University Hospital & Clinics
Lafayette General Health

Patient Photographs and Videotaping Policy
Attestation Statement

Please refer to the following link and login to view policy:
https://lgh.ellucid.com/userLogin?guestLGMC=cfbb323b7acdb73751f9b5c9bd107928
Username: guestUHC
Password: policy

I have received, read, understand, and agree to follow the Patient Photographs and Videotaping Policy of this facility. I understand that if I violate these regulations it can result in disciplinary action.
If I have questions regarding compliance, I am to contact the Compliance Manager as soon as possible for clarification.

Signature_____ Date_____

Please print name:_____

University Hospital and Clinics
Corporate Compliance Department
Phone: 337-261-8532
Fax: 337-261-6058

Applicant: _____

University Hospital & Clinics
Lafayette General Health

EDUCATION ATTESTATION

I have reviewed the Provider Education packet at the following link:

https://portal.lgmc.com/common/physicianeducation.pdf

I understand that if I have any questions concerning this information, I should contact the Quality Department for clarification.

I attest that I understand and agree to comply with the education received on the following topics:

- Informed Consent
- Clinical Alarm Management
- Early Recognition of Changes in Patients' Condition/Rapid Response
- Pain Assessment & Management
- Restraints & Seclusion
- Abuse & Neglect
- Cerner Downtime Procedures
- Infection Prevention & Control
- Environment of Care
- Emergency Management

_____ _____ _____

Provider Signature Date Time

_____

Printed Name

Applicant: _____

University Hospital & Clinics
Lafayette General Health

Sedation & Analgesia Privilege Requirements

As a resident/fellow at University Hospital & Clinics, you are required to review University Hospital & Clinics' Sedation & Analgesia Education Module and pass the Sedation & Analgesia Module Test in order to receive the sedation & analgesia privileges delineated within the clinical duties of your residency/fellowship program.

- The Sedation & Analgesia Module is accessed through the following link:

  https://portal.lgmc.com/common/Sedation_AnalgesiaEducationModule.pdf

- The Sedation & Analgesia Module Test is accessed through the following link:

  https://portal.lgmc.com/common/Sedation_AnalgesiaModuleTest.pdf

Please return your completed Sedation & Analgesia Module Answer Sheet (found on the next page) with your completed packet.

NOTE: In addition to satisfactory completion of the Sedation & Analgesia Module Test, you **MUST** also be ACLS certified to administer sedation & analgesia to adult patients at UHC, and you **MUST** also be PALS certified to administer sedation & analgesia to pediatric patients at UHC. Copies of your current certification card(s) **MUST** be presented to the Credentials Coordinator/Medical Staff Office

Applicant: _____

University Hospital & Clinics
Lafayette General Health

Sedation & Analgesia Module Answer Sheet

Print Name: _____ Date/Time: _____

Directions: Circle the letter that corresponds with the correct answer

1. a b c d
2. a b c d
3. a b c d
4. a b c d
5. a b c d
6. a b c d
7. a b c d
8. a b c d
9. a b c d
10. a b c d
11. a b c d
12. a b c d
13. a b c d
14. a b c d
15. a b c d
16. a b c d
17. a b
18. a b
19. a b
20. a b
21. a b
22. a b
23. a b
24. a b
25. a b
26. a b
27. a b
28. a b

Applicant: _____

University Hospital & Clinics
Lafayette General Health

Delineation of Sedation Privileges for Residents/Fellows

Pediatric Sedation Criteria:

- Minimal- privileges are delineated within the clinical duties of each residency and fellowship program and who fulfill the below requirements for the administration of sedation by non-anesthesia providers. Each medical staff department chair is responsible for delineating the level of competency for each resident/fellow enrolled in their program.
    - PALS/ACLS Certification
    - Completion of Sedation/Analgesia module and satisfactory completion of Sedation/Analgesia module test
- Moderate and Deep- privileges are NOT a clinical duty allowed to any resident and/or fellow

Adult Sedation Criteria:

- Minimal- privileges are delineated within the clinical duties of each residency and fellowship program and who fulfill the below requirements for the administration of sedation by non-anesthesia providers. Each medical staff department chair is responsible for delineating the level of competency for each resident/fellow enrolled in their program.
    - PALS/ACLS Certification
    - Completion of Sedation/Analgesia module and satisfactory completion of Sedation/Analgesia module test
- Moderate- privileges are delineated within the clinical duties of each residency and fellowship program and who fulfill the below requirements for the administration of sedation by non-anesthesia providers. Each medical staff department chair is responsible for delineating the level of competency for each resident/fellow enrolled in their program. Moderate sedation privileges requires ACLS certification.
    - PALS/ACLS Certification
    - Completion of Sedation/Analgesia module and satisfactory completion of Sedation/Analgesia module test
- Deep- deep sedation may ONLY be administered under the direct supervision of UHC Staff physicians with deep sedation privileges in ICU, GI Lab, and ED for House Officers ≥ 3 and who fulfill the below requirements for the administration of sedation by non-anesthesia providers.
    - PALS/ACLS Certification
    - Completion of Sedation/Analgesia module and satisfactory completion of Sedation/Analgesia module test

Current Certification(s) (to be completed by resident/fellow):

☐ BLS Expiration date: _____
☐ ACLS Expiration date: _____
☐ PALS Expiration date: _____
☐ NRP Expiration date: _____

Criteria Met: (to be completed by Credentials Coordinators or Anesthesia)		
PALS	ACLS	Module & Test Passed
☐	☐	☐

I have read and understand the UHC Procedural Sedation/Analgesia policy.

Physician Signature: _____

Applicant: _____

EMR Needs Assessment

The purpose of this form is to identify which electronic medical records to which you will need access and training. We will use this information after credentialing is complete to contact you for a personalized training session. Please fill in the following information:

First name:_____ Middle name:_____ Last name:_____

DOB: _____ Last 4 digits of SS#: _____

NPI #:_____ LA State License #:_____ DEA #:_____

Specialty:_____ Credentials (MD, DO, NP, etc):_____

Address:_____

Email & Phone number: _____

Please indicate the following locations you intend to see patients and your role at these facilities:

University Hospital & Clinics
Lafayette General Health

I intend to see patients:
_____in the inpatient setting
_____in the clinics
_____as an emergency room provider
_____operating in the OR
_____performing procedures (GI, cath lab, etc)
_____Other, please clarify _____

Lafayette General Medical Center

I intend to see patients:
_____ in the inpatient setting
_____in the clinics
_____as an emergency room provider
_____operating in the OR
_____performing procedures (GI, cath lab, etc)
_____Other, please clarify _____

Lafayette General Surgical Hospital

I intend to see patients:
_____operating in the OR
_____performing procedures (GI, cath lab, etc)
_____Other, please clarify _____

St. Martin Hospital
Lafayette General Health

I intend to see patients:
_____in the inpatient setting
_____as an emergency room provider
_____Other, please clarify _____

Start date (or tentative start date): _____

Have you ever had any previous Cerner training or experience at other sites? ◯ Yes / ◯ No

Office Use Only: Once this form has been filled out, please send a copy to Pat Goeghagan (pageoghagan@lgmc.com) and Dianna Perkins (dperkins@lgmc.com) in the IS department.