Dear Doctor:

Enclosed is an application for appointment/reappointment to the medical staff of Suffolk Surgery Center. In order to consider your application, the following documents must be available for review:

1. Completed application, including requested privileges;
2. Copy of current N.Y.S. license;
3. Copy of current N.Y.S. registration;
4. Copies of Degrees/Diplomas;
5. Copy of current Drug Enforcement Administration Certificate (DEA);
6. Copy of CPR card;
7. Copy of current malpractice insurance certificate (face sheet) indicating limitation, effective and expiration date;
8. Copy of Board Certification, if applicable;
9. A letter from your Physician attesting to your physical and mental health, including results of required TB test, proof of immunity to Rubella, and proof of immunity to Measles, if born on or after January 1, 1957;
10. UPIN Number;
11. Two (2) professional references addressed to me;
12. Hospital affiliation and evidence of credentialling; and
13. Proof of citizenship, i.e. Driver's license and social security card or passport/alien registration card.
14. Copy of your current C.V.

Enclosed for your information are copies of the Medical Staff By-Laws and Rules and Regulations of the Center; please review, sign, date, and return the Acceptance Statement. This information should be forwarded to me within thirty (30) days in order to expedite the review.
Please call me at (631) 205-9090, should you have any questions regarding the appointment/reappointment process.

Sincerely,

Charles Walters
Administrator, Suffolk Surgery Center

Credentialing Application

Suffolk Surgery Center, LLC
1500 William Floyd
Shirley, NY 11967

Instructions:
1. Information must be typed or printed.
2. All questions must be answered and signed where necessary.
3. If more space is needed, please attach additional sheets and reference the question being answered.
4. Please return the following with your application:
   - ☐ Privileges requested.
   - ☐ Copy of current NYS license.
   - ☐ Copy of current DEA registration.
   - ☐ Copy of front sheet of liability insurance.
   - ☐ Copy of Board Certification.
   - ☐ Copies of Diplomas.
   - ☐ Copy of Hepatitis B Vaccination or Waiver and proof of immunity to rubella and measles.
   - ☐ Copy of most recent PPD test.
   - ☐ A letter from your Physician attesting to your physical and mental health.
   - ☐ UPIN #
   - ☐ NPI #

Identifying Information

Last Name	First Name	Middle Initial	SSN

Professional Group Name and Address

City	State	Zip

Tel. #	Fax #	Email

UPIN #	NPI #

Home Address	Tel. #

City	State	Zip

Tel. #

Date of Birth	Place of Birth	Citizenship

Physician providing coverage	Tel. #	Fax #	Email

Credentialing Application

Suffolk Surgery Center, LLC
1500 William Floyd
Shirley, NY 11967

Medical Licensure/Certification

NYS License Number | Expires

DEA Number | Expires

Other State Medical License # | State | Expires

Premedical Education

College/University | Degrees/Honors

Address | Date of Graduation

Medical Education

Medical School | Degrees/Honors

Address | Date of Graduation

Foreign Medical Graduate Exam in Medical Sciences, if applicabl;e | Date

Other Professional Education

College/University | Degrees/Honors

Address | Date of Graduation

Internship

Hospital | Dates Attended

Address | Full Name of Program Director

Type | Kind (Medical, Surgical, etc.)

Credentialing Application
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Residency(ies)

1.____
Hospital | Dates Attended

____
Address

____
Description | Full Name of Program Director

2.____
Hospital | Dates Attended

____
Address

____
Description | Full Name of Program Director

Training, Fellowships, Preceptorships, Postgraduate Education

List in chronological order. Give complete school or hospital name and address, including zip codes; beginning and ending dates; and the name of the immediate superior.

1.____
School or Hospital | Address

____
Dates | Superior

2.____
School or Hospital | Address

____
Dates | Superior

3.____
School or Hospital | Address

____
Dates | Superior

Hospital and University Affiliations

List all present and past affiliations in chronological order. Indicate “Staff Status” as: Active/Courtesy, etc. or Academic Title..

1.____
Name of Institution | Address

____
Dates Affiliated | Staff Status

____
Department | Dept. Chief/Chairman (full name)

Credentialing Application

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1500 William Floyd
Shirley, NY 11967

2. ____
Name of Institution | Address

____
Dates Affiliated | Staff Status

____
Department | Dept. Chief/Chairman (full name)

3. ____
Name of Institution | Address

____
Dates Affiliated | Staff Status

____
Department | Dept. Chief/Chairman (full name)

4. ____
Name of Institution | Address

____
Dates Affiliated | Staff Status

____
Department | Dept. Chief/Chairman (full name)

Previous Medical Practice

____
Type | Location (full address/group name) | Dates Practicing

____
Type | Location (full address/group name) | Dates Practicing

____
Type | Location (full address/group name) | Dates Practicing

Certification

____
Certified by American Board of (Specialty) | Certification # | Expires

____
Sub-specialty Board Status (Name of Board) | Certification # | Expires

____
If not certified, give present status | Date | Date of Exam

Credentialing Application

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Professional Societies, Awarded Fellowships (ACS, ACP, etc.)

List all memberships past, present or pending in professional societies. Please include date of membership. Please give complete names and addresses, including ZIP codes in all instances. Attach additional sheet if necessary.

____

____

____

____

____

Professional Peer References

List three professional references familiar with the applicant's qualifications during the three years immediately preceding this application. One professional reference must be from the Chief of the department or service where the applicant last furnished professional services.

1. ____
Name Professional Relationship

____
Address City State Zip

2. ____
Name Professional Relationship

____
Address City State Zip

3. ____
Name Professional Relationship

____
Address City State Zip

Professional Liability

____
Insurance Carrier Amount of Coverage

____
Policy # Agent Expiration Date

Have any professional liability law suits been filed against you during the past ten years (including those closed)? □ Yes □ No
Are there any now still pending? □ Yes □ No
Has any judgment or settlement ever been made against you in any professional liability cases? □ Yes □ No
Have you ever been denied professional insurance, or has your policy ever been cancelled? □ Yes □ No
If yes to any of the above, please explain on separate sheet

Credentialing Application

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Professional Sanctions

Question		
Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked?	□ Yes	□ No
Have you ever been refused membership on a hospital medical staff?	□ Yes	□ No
Has your request for any specific clinical privileges ever been denied or granted with stated limitations?	□ Yes	□ No
Have your privileges at any hospital ever been suspended, diminished, revoked or not renewed?	□ Yes	□ No
Has your narcotics registration ever been suspended or revoked?	□ Yes	□ No
Have you ever been denied membership or renewal thereof or been subject to disciplinary action (other than discipline for failure to complete medical records) in any medical organization or health insurance plan?	□ Yes	□ No
Have you ever received a criminal conviction other than minor traffic violations?	□ Yes	□ No
Have you been sanctioned by either the Medicare or Medicaid program?	□ Yes	□ No

If yes to any of the above, please explain on separate sheet.

Health Status

Have you had an illness or physical disability that impairs, or could impair your ability Practice your medical specialty? □ Yes □ No

If yes, please explain on separate sheet.

Credentialing Application

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1500 William Floyd
Shirley, NY 11967

By applying for clinical privileges, I hereby signify my willingness to supply information and/or appear for an interview in regard to my application, authorize the facility, its Medical Staff and their representatives to consult with the chief executive officers and members of the medical staffs of other hospitals, the New York State Medical Society and health facilities with which I have been associated and with others who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the release of information from my present and past malpractice insurance carrier(s) and to inspection of by the facility and its Medical Staff of all records and documents, including medical records, at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested, as well as my ethical qualifications for staff membership.

I hereby release from liability all representatives of the facility, and its medical staff, for their acts performed in good faith, and without malice in connection with evaluating my application, credentials and qualifications, and I hereby release from any liability all individuals and organizations who provide information to the facility or its medical 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 further authorize the facility to communicate to other facilities and to other persons or organizations with a legitimate interest therein any information concerning my professional competence, character and ethics that the facility may have to acquire, and where such communication is made in good faith and without malice, I consent thereto and agree to hold the facility and its authorized representatives free of liability therefore.

I understand and agree that I, as an applicant for Medical Staff membership or privileges, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

By accepting appointment and/or reappointment to the medical staff at Tarrytown Surgery Facility, I hereby acknowledge and represent that I have read and am familiar with the bylaws, rules and regulations of the facility, 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. I agree to conduct my professional activities in the facility and elsewhere in accordance with the highest ethical traditions.

In addition, I agree to notify the facility of any circumstances 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 in or omissions from this application shall constitute cause for denial or 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 photostatic copy of the requests, authorizations, and release to this application to serve as the original.

____ ______________________________

Signature Title Date

____

Please PRINT or TYPE Name

Suffolk Surgery Center

MALPRACTICE CLAIMS FORM

1. Name of Practitioner:______________________________

2. Name of Claimant:______________________________

3. Insurance Company providing coverage:______________________________

4. Please indicate the status of this claim by one of the following:

   Case Pending ____________
   Case Resolved: verdict on your behalf ____________
   Case Resolved: verdict on patient's behalf ____________
   Case Resolved: settlement ____________
   Case Resolved: abandoned by patient ____________
   Other, specify:______________________________
   ____

5. For pending claim, describe all activity on this claim within the last 12 months (e.g., testified at an EBT, verdict on appeal):
____
____
____
____
____
____
____
____
____
____
____

6. Were you ever served with a summons on this claim?
   No [ ] Yes [ ]

   If YES:
   A. When were you served with the summons?______________________________
   B. Summons was issued in what court (e.g., Supreme Court _County, Federal Eastern or Southern District Court, Small Claims Court)____________
   ____
   ____

MALPRACTICE CLAIMS FORM

7. Date of occurrence giving rise to this claim:____________________

8. Location of treatment of patient (please check one):

_______ Doctor's office
_______ Clinic
_______ Hospital or Nursing Home
_______ Other (specify)____________________

9. Nature of alleged incident:____________________

I, ____________________, declare that all the information contained on this malpractice claims form is true and correct.

____________________ ____________________
Signature Title Date

Suffolk Surgery Center

SIGNATURE FORM

Practitioner's Name ______________________________________
(Please Print)

Practitioner's Titl e ______________________________________

Practitioner's Initials ____________

Practitioner's Signature ______________________________________

Suffolk Surgery Center
1500 William Floyd Parkway, Shirley, NY 11967
(631) 205-9090 Fax (631) 205-9257

Quality Assurance Files

Policy:

Each member of the medical staff of Suffolk Surgery Center will have a quality assurance file. The members of the medical staff include: Physicians and Physician Assistants.

This file will be identified by a code number, to ensure confidentiality of the practitioner and will be maintained by the Administrator, as directed by the Medical Director.

This file will contain evaluations and Quality Assurance/Risk Management findings and will be utilized during the review required by the reappointment process.

Suffolk Surgery Center
1500 William Floyd Parkway, Shirley, NY 11967
(631) 205-9090 Fax (631) 205-9257

PRACTITIONER REFERRAL FORM

POLICY:

A practitioner referral form is utilized whenever a Quality Assurance/Risk Management issue is identified. This form will be reviewed by the Medical Director when the issue occurs and during the reappointment process. This form may be initiated by:

1. The Medical Director
2. The Administrator
3. The OR Supervisor

For the following reasons:

1. Negative health care outcomes
2. Patient complaints and grievances
3. Medical record deficiencies
4. Other, which must be specified

Procedure:

1. The initiating party completes the top section of the form through "reason for referral" section and forwards it to the Medical Director for completion.
2. The Medical Director reviews the information and notes the actions taken, identifies the type of deficiency, and follows through with the notification of the practitioner.
3. All forms are then placed in the practitioner's quality assurance file.

4. The Medical Director follows the directions on the form as to copies being sent to the Quality Assurance/Risk Management Committee and the responsible practitioner.

5. The forms, maintained in each practitioner's quality assurance file, are to be reviewed by the medical director at the time of reappointment of each practitioner.

Suffolk Surgery Center
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(631) 205-9090 Fax (631) 205-9257

PRACTITIONER REFERRAL FORM

Date Referred: ______________________________

REASON OF REFERRAL:
_____Patient Care Outcome
_____Patient Complaint or Grievance
_____Medical Record Audit
_____Other

REFERRED BY:
_____Medical Director
_____Administrator
_____OR Supervisor

PRACTITIONER: ______________________________
PATIENT MEDICAL RECORD #: ______________________________
REASON FOR REFERRAL: ______________________________

MEDICAL DIRECTOR REVIEW: ______________________________

ACTIONS: ______________________________

DEFICIENCY:
_____Minor - No impact on care, but fails to meet documentation rules and regulations.
_____Major - Impacts on patient care.
_____Serious - Fails to meet professionally recognized standards.
_____Critical - Threat to patient life and safety; or produces permanent major disability or untoward death.

PRACTITIONER NOTIFIED:______ No _____ Yes By Whom: ______________________

Practitioner Signature:______________________ Date:______________________

_____Original placed in Practitioner's file. Date: ______________________
_____Copy sent to QA/RM Committee. Date: ______________________
_____Copy sent to responsible Practitioner. Date: ______________________

______________________________ ______________________
Signature of Reviewer/QA/RM Committee Date

HIV/MEDICAL RECORD CONFIDENTIALITY

Policy:

All employees will read and sign the HIV/medical record confidentiality statement during orientation and annually thereafter, after receiving appropriate in-services to ensure an understanding of and to abide by the New York State Public Health Law Article 27f, regarding disclosure of HIV and AIDS related information

Suffolk Surgery Center 1500 William
Floyd Parkway, Shirley, NY 11967
(631) 205-9090 Fax (631) 205-9257

HIV/MEDICAL RECORD CONFIDENTIALITY STATEMENT

I, ______________________________________, have read and fully understand the attached policy regarding HIV confidentiality.

Additionally, I fully understand that medical records are confidential documents which are maintained for the benefit of the patient, the physician, and other members of the health care team. Medical records are the property of the Center and, as such, must be protected from unauthorized disclosure.

The Center has the responsibility of ensuring that only authorized individuals, agencies, and/or institutions are provided access to patient records. The release of patient information by unauthorized individuals and/or organizations will be considered a breach of confidentiality.

Employees of the Center, by signing this statement, agree to treat all records in a confidential manner and will not divulge any information to unauthorized sources. Failure to comply will be cause for disciplinary action, which may include termination of employment.

_________________________________ _________________________________
Employee Signature Date

Suffolk Surgery Center

Confidentiality Agreement

Suffolk Surgery Center maintains confidential medical information on the patients it serves. It is the responsibility of every employee to assure that patients' confidentiality is observed and adhered to at all times.

By affixing your signature below, you agree to maintain and protect confidentiality and will discuss patient issues only when pertinent to providing patient care.

Any other release of information will only be allowed pursuant to the patient's written authorization.

Unauthorized release of patient information as discussed above could be grounds for disciplinary action, including termination.

____
PRINT NAME

____
SIGNATURE

____
DATE

Suffolk Surgery Center

REQUIREMENT FOR PHYSICAL EXAMINATION

In accordance with applicable New York State Department of Health Codes, Rules, and Regulations, each practitioner who seeks Appointment to the Medical Staff is required to have a current physical examination and recorded medical history of sufficient scope to insure that no practitioner shall assume his/her duties unless he/she is free from a health impairment which is of potential risk to a patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter the practitioner's behavior.

In addition, a reassessment of health status shall be required as frequently as necessary, but no less than annually, to insure that each practitioner is free from health impairments which pose potential risks to patients or Center personnel or which may interfere with the performance of duties.

CERTIFICATE OF EXAMINING PHYSICIAN

The examining Physician shall complete the following certification:
I, ______________________________________, am a Physician duly licensed to practice medicine in the State of New York, (License #_______).
On ______________, ________________, I conducted a physical examination of the following patient____

On the basis of such physical examination, I am of the opinion that the patient is free from any health impairments which are of potential risk to a patient or which might interfere with the performance of his/her duties as a member of the Center's Medical Staff, including the habitation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substance which may alter the patient's behavior. In addition, I have performed or have been provided with appropriate documentation which verifies that the patient has received:

*(i) immunization for rubella

*(ii) immunization for rubeola (measles), if born after January 1, 1957

*(iii) ppd (Mantoux) skin test for tuberculosis. I understand that positive findings require appropriate clinical follow-up, consistent with good medical practice, but no repeat skin test.

*Please see attached.

______________________________ ______________________________

Signature of Examining Physician Date

SUFFOLK SURGERY CENTER
CONFIDENTIAL MEDICAL INFORMATION

Name: ____________________ Soc. Sec. #: _________________ Date of Exam: ___ / ___ / ___

Vision: Right 20/___ Left 20/ ____ Height: _______ Weight: ________

Correct to: Right 20/ ___ Left 20/ ____ Blood Pressure: ______ Pulse: ________

Describe fully in the space provided below any abnormalities in the following systems.

System	Normal	Abnormal	Comments
Head, Ears, Nose and Throat			
Eyes (including Opthalmoscope)			
Hearing			
Neck- Thyroid			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Metobolic / Endocrine			
Neuropsychiatric			
Skin			

Laboratory Results:

Complete CBC: ________
Urinalysis: ________
VDRL: ________
( ) Negative ( ) Reactive
____

Hepatitis B Screening Status:
Reactive: ______ Date: ______
Non Reactive:_____ Date: ______
Vaccination: ____ ____
1 2 3

BCG Vaccine: Yes ____ No ____ Date: _______
Tuberculin Test – PPD Date: ______ Results: _______ or Chest X-ray Date: ______ Results: ____
Tetanus & Diphtheria Booster Date: _____

Rubella Titre: Date: _______ Results: ___________ (Note: Required for all applicants - M/F)
Measles: Year ______ Immunization: ___________ Titre Results: ______________
Mumps: Year ______ Immunization: ___________ Titre Results: ______________
Chicken Pox: Year ______ Immunization: ___________ Titre Results: ______________

Based on health history, physical examination / health assessment and on the laboratory tests performed, this person is free from any health impairment that is a potential risk to the patients of Suffolk Surgery Center, or may interfere with the performance of his/her duties.

I HAVE EXAMINED THE ABOVE NAMED INDIVIDUAL AND FOUND HIS/HER HEALTH TO BE ADEQUATE FOR WORK PERFROMED IN THE HEALTHCARE FIELD.

Physician's signature: ______________________ Date: ____ / ____ /____

Physician's Name: ______________________ (Please print)

Address: ____________________________

City and State: _________________ Phone: _________

Physician's stamp

Suffolk Surgery Center

Employee Orientation Checklist

NAME: ____________________ TITLE: ____________

During the orientation period, I have received instruction, explanation, and review of the following subjects. The signature(s) below indicate satisfactory completion of the orientation.

COMPLETED	ITEM
	History and Philosophy of the Center.
	Tour of Center
	Table of Organization
	Job Descriptions
	Personnel Policies
	Dress and Conduct Code Policies; Identification
	Policy and Procedure for Reporting Accidents/Incidents/Complaints
	Center Hours and Assignments
	Emergency/Disaster Preparedness and Fire/Safety
	O.S.H.A. Requirements; Infection Control, Universal Precautions, and TB
	Patient Rights and Complaint Procedure
	Confidentiality, including HIV
	Child Abuse and Victims of Domestic Violence
	Clinical Record Documentation, Forms and Sample Chart
	Quality Assurance/Risk Management Program
	HIPPA

Employee Signature Title Date

Orientator's Signature Title Date