Dear Physician:

Thank you for your interest in applying to John C. Lincoln Health Network. Enclosed you will find copies of the list of minimum qualification requirements for the facility you are applying. The medical staff bylaws and rules and regulations are available online for your review at www.jcl.com/credentialing. Also enclosed are the following for you to complete and return:

- Application
- Invoice for non-refundable application fee
- Release and immunity statement
- Privilege delineation form **(print from website)**
- Attestation Statement (required by Medicare)
- Forward the enclosed Clinical Activity Summary to your primary Facility
- CME log (**plus copies of supporting documentation**) ◆
- Covering practitioner statement
- Emergency room call requirements
- NPI form
- Photo request form **(required & must meet criteria)**
- TB Test Written Results or Chest X-ray results **(within 24 mo)**
- Background Check authorization and request forms
- Signature card for Medical Records
- Parking permit application **(required)**
- Automatic faxing of transcribed documents agreement (**optional)**

You are also requested to provide **current** copies of the following:

- Curriculum vitae
- Arizona license (wallet size card)
- DEA certificate
- Malpractice insurance face sheet ($1million minimum with approved carrier)
- A letter of intent describing your practice plans and your plans to use and support John C. Lincoln Health Network.
- Fellowship logs (if fellowship was completed within last two years)
- Board certification certificate(s**) OR** letter of eligibility/qualification from the Board
- Local office address **OR** confirmation from practice you are joining.

PLEASE BE ADVISED THAT DATES AND SIGNATURES ARE ONLY VALID FOR NINETY (90) DAYS.

If you have any questions, please feel free to contact the Network Credentialing office at 623-434-6104. Again, thank you for your interest in John C. Lincoln Network hospitals and we look forward to working with you.

enclosures

JOHN C. LINCOLN HEALTH NETWORK

INVOICE APPLICATION FEE

Please make check payable to:

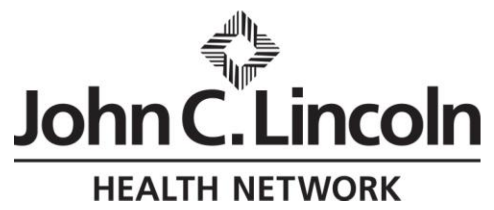
John C. Lincoln Hospital

NORTH MOUNTAIN HOSPITAL ONLY	DEER VALLEY HOSPTIAL ONLY
$360.00	**$400.00**

BOTH NORTH MOUNTAIN & DEER VALLEY HOSPITALS
$560.00

NETWORK PEDIATRICS
$400.00

NOTE: The application fee must accompany the application. If payment is not received, your application will not be processed. This application fee is non-refundable unless qualifications for membership are not met. If you are applying for both North Mountain and Deer Valley **at the time of initial appointment**, you will only pay one application fee. If you have any questions, please call (623) 434-6104.



** FIRST NOTICE **

IDENTITY VERIFICATION/ID BADGE

John C Lincoln Health Network is requiring all new applicants requesting privileges to provide positive identity verification.

Prior to an applicant's first day of practice in the Hospital, each applicant shall present to the **Medical Staff Services office (at either campus) to verify his/her identity and present a legible government issued ID card (current driver's license; military card or passport) or a federal/state government ID with a current photo.**

In addition, JCL has instituted a policy requiring all practitioners with approved privileges to be issued photo ID badges which are to be worn when on either campus for security and patient safety purposes. You can have your photo taken for your ID badge at the same time you come in to do your identity verification.

Please be advised that in accordance with Medical Staff Bylaws Article (6) six, failure to verify identity within 90 days of notification or prior to practicing in the Hospital (which ever comes first) will result in the automatic termination of your privileges.

If you have any questions, please call either Medical Staff Services Department:

John C. Lincoln North Mountain
250 East Dunlap Avenue
Phoenix, AZ 85020
(602) 870-6317

John C. Lincoln Deer Valley
19829 North 27th Avenue
Phoenix, AZ 85027
(623) 879-5409

JOHN C. LINCOLN NORTH MOUNTAIN HOSPITAL

MINIMUM QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP

General Requirements:
Graduation from an approved medical, osteopathic, dental or podiatric schools; or certification by the Education Council for Foreign Medical Graduates; or Fifth Pathway Certification and successful completion of the Foreign Medical Graduate Examination in Medical Sciences.

Board Certification or eligible for certification by a board approved by the American Board of Medical Specialties or the Advisory Board for Osteopathic Specialists as may be required by the appropriate department.

All applicants who initially apply to staff after June 1, 2006 must become board certified within the time frame specified by the board or within 5 years from residency if no time limit is defined. Where the board requires a period of practice prior to submitting an application for certification, the applicant will be deemed "Admissible" during the time period if the director of his/her training program certifies that he/she has met all training requirements necessary to become board certified by the appropriate board. Failure to become board certified within this time period will result in loss of membership and privileges without the procedural rights afforded by the Fair Hearing Plan.

Licensure:
Current license to practice medicine and/or surgery in the state of Arizona.

Office of Inspector General: In accordance with the Network Compliance Program for Business Practices, any provider on the Office of Inspector General's Exclusion List will be ineligible for appointment to the Medical Staff.

Malpractice Insurance:
Professional liability insurance coverage in the amount of $1,000,000 minimum, with a carrier licensed to transact business in the State of Arizona, and satisfactory to the Board of Directors.

Continuing Medical Education:
Shall participate in appropriate programs in continuing medical education totaling a number of hours equal to or exceeding that required by the State Licensing Boards.

Local Office Address:
Medical Staff Bylaws require a local office address within Maricopa County. A letter of intent from the practice you are joining will be acceptable.

The Medical Staff is divided into the following clinical departments:

- Medicine (includes Family Practice, Emergency Medicine, & Radiology)
- Surgery
- OB/GYN
- Pediatrics

*reference general requirements for Medicine, OB/GYN, & Pediatrics

Additional Requirements:

Family Practice: Applicants who completed Medical School prior 1990 shall be considered only if they are Board Certified by the American Board of Family Practice, American Osteopathic Board of Family Practice; or the College of Family Physicians of Canada, or have completed one of the following:

- 3 years of graduate training acceptable to and approved by the American Academy of Family Physicians or the American College of Family Practitioners in Osteopathic Medicine and Surgery; or
- 2 years of graduate training acceptable to and approved by the American Academy of Family Physicians or the American College of Family Practitioners in Osteopathic Medicine and Surgery, followed by two years of family or general practice; or
- 1 year of graduate training acceptable to and approved by the American Academy of Family Physicians or the American College of Family Practitioners in Osteopathic Medicine and Surgery, followed by three years of family or general practice.

Applicants who completed Medical School after 1990 must be certified, eligible, or within the examination system of the American Board of Family Practice, American Osteopathic Board of Family Practice, or the College of Family Physicians of Canada prior to granting privileges.

Surgery: Must be either board certified or board eligible by a board approved by the American Board of Medical Specialties, American Osteopathic Association, Royal College of Surgeons (Canada), American Board of Oral Surgery, or American Board of Podiatric Surgery. Note: Medical Podiatry Privileges - must have graduated from a college of Podiatric Medicine accredited by the Council on Podiatric Education. Dentists must be a graduate of a dental school approved by the Commission of Dental Accreditation.

JOHN C. LINCOLN DEER VALLEY HOSPITAL

MINIMUM QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP

General Requirements:
Graduation from an approved osteopathic or allopathic medical school or dental or podiatric schools; or certification by the Education Council for Foreign Medical Graduates; or Fifth Pathway Certification and successful completion of the Foreign Medical Graduate Examination in Medical Sciences.

Board Certified or Board admissible for examination by the Board of Medical Specialists or the American Osteopathic Association or by a board determined by the clinical department to be equivalent.

All applicants who initially apply to staff after June 1, 2006 must become board certified within the time frame specified by the board or within 5 years from residency if no time limit is defined. Where the board requires a period of practice prior to submitting an application for certification, the applicant will be deemed "Admissible" during the time period if the director of his/her training program certifies that he/she has met all training requirements necessary to become board certified by the appropriate board. Failure to become board certified within this time period will result in loss of membership and privileges without the procedural rights afforded by the Fair Hearing Plan

Exceptions may be granted for an applicant, whose privileges are limited to surgical assisting only, or when the applicant applying for membership possesses qualifications and experience deemed equivalent by the clinical department, Medical Executive Committee and the Board of Directors.

Licensure:
Current license to practice medicine and/or surgery in the state of Arizona.

Office of Inspector General: In accordance with the Network Compliance Program for Business Practices, any provider on the Office of Inspector General's Exclusion List will be ineligible for appointment to the Medical Staff**.**

Malpractice Insurance:
Professional liability insurance coverage in the amount of $1m/$3m minimum, with a carrier licensed to transact business in the State of Arizona, and satisfactory to the Board of Directors.

Continuing Medical Education:
Shall participate in appropriate programs in continuing medical education totaling a number of hours equal to or exceeding that required by the State Licensing Boards.

The Medical Staff is divided into the following clinical departments:
- Medicine (includes Family Practice)
- OB/GYN
- Pediatrics
- Surgery (includes Anesthesia and Pathology)
- Emergency Medicine
- Radiology

Reference the General Requirements for Medicine, OB/GYN, Pediatrics, and Surgery.

Additional Requirements:

Emergency Medicine: Must have completed a minimum of one (1) year post-doctoral training in a hospital in the United States; be either board certified or board eligible in Medicine; be ACLS and ATLS certified or have equivalent training.

Family Practice: Applicants who completed Medical School prior to 1998 shall be considered only if they have completed an approved Family Practice residency and/or internship program or six years active inpatient experience.
Applicants who completed Medical School after 1998 must be board certified, board eligible or within the examination system of the American Osteopathic Board of Family Practice, American Board of Family Practice, or the College of Family Physicians of Canada prior to granting privileges. Physicians on staff at John C. Lincoln Health Network at the time of adoption of this requirement (March 24, 1998)are exempt.

North Mtn Credentials Verification Office
Date Reviewed:_____________________________
Reviewed by: ______________________________
Basic Req. met: ☐ Yes ☐ No

APPLICATION FOR MEMBERSHIP

(__) North Mountain (__) Deer Valley

Name: ____ Degree:______ DOB:_____ Place of Birth:____________
(Last) (First) (Middle)

List other names used: ____ Citizenship: _____________

Specialty: ____ Social Sec #:______________________

Sex: ☐F ☐M Foreign Language(s) ____ ☐ Speak ☐ Write

Home Address____
(street addess) (City) (State) (Zip)

Home Phone: _______________________________ Name of Spouse:_________________________

I. Current/Future Practice Information

Name of **Current** practice group or professional corporation:____

Dates of Affiliation *(or anticipated start date*): From:__________ To:___________ Office Manager:________________

Address:_____________________________________City:_________________State:_______Zip_________

Phone Number: _______________________Fax Number:____________________ Email:____________________

Cell Phone Number: ____________________________ Pager Number:_________________________

Name(s) of Associate(s):____

Name(s) of **other** covering practitioners*:____

(***Must** be members of JCL-NM or DV Medical Staff with privileges in your specialty)

==

☐ Not leaving current practice

Name of **Future** practice group or professional corporation:____

Dates of Affiliation *(or anticipated start date*): From:__________ To:___________ Office Manager:________________

Address:_____________________________________City:_________________State:_______Zip_________

Phone Number:_______________________Fax Number: ____________________ Email:____________________

Cell Phone Number:____________________________ Pager Number:_________________________

Name(s) of Associate(s):____

Name(s) of **other** covering practitioners*:____

(***Must** be members of JCL-NM or DV Medical Staff with privileges in your specialty)

Do you sponsor or employ any Allied Health Practitioners? ☐Y ☐N If Yes, list names:________________________

____

*II. Practice History - list all positions held for the past 10 years, LEAVE NO TIME GAP UNACCOUNTED FOR. (*Indicates Required Information)*

1. Name of practice group or professional corporation:____

   Dates of Affiliation: From:_____________ To:______________ Contact Person: ___________________________

   Address:______________________________________City:________________State:_____Zip_________

   *Phone Number: _____________________________ *Fax Number: _______________________________

   *Reason for leaving: ____

2. Name of practice group or professional corporation:____

   Dates of Affiliation: From:_____________ To:______________ Contact Person: ___________________________

   Address:______________________________________City:________________State:_____Zip_________

   *Phone Number: _____________________________ *Fax Number: _______________________________

   *Reason for leaving: ____

3. Name of practice group or professional corporation:____

   Dates of Affiliation: From:_____________ To:______________ Contact Person: ___________________________

   Address:______________________________________City:________________State:_____Zip_________

   *Phone Number: _____________________________ *Fax Number: _______________________________

   *Reason for leaving: ____

4. Name of practice group or professional corporation:____

   Dates of Affiliation: From:_____________ To:______________ Contact Person:___________________________

   Address:______________________________________City:________________State:_____Zip_________

   *Phone Number: _____________________________ *Fax Number: _______________________________

   *Reason for leaving: ____

5. Name of practice group or professional corporation:____

   Dates of Affiliation: From:_____________ To:______________ Contact Person:___________________________

   Address:______________________________________City:________________State:_____Zip_________

   *Phone Number: _____________________________ *Fax Number: _______________________________

   *Reason for leaving: ____

(*If additional space is needed, attach separate sheet)***

III. Medical Education (attach copies of degrees/certificates. If additional space is needed, attach separate sheet)

Medical School:____

Address: ___________________________________City:_____________ State:_______ Zip _____

Dates attended from:____________ to:______________ Degree Earned:__________

Internship:____

Address: ___________________________________City:_____________ State:_______ Zip _____

Dates attended from:____________ to:_______________ Specialty:_________________________

Program Director: ______________________________________P# _____________F# _____________

Residency:____ Specialty:__________________________

Address: ___________________________________City:_____________ State:_______ Zip _____

Dates attended from:____________ to:_______________

Program Director: ______________________________________P# _____________F# _____________

Residency:____ Specialty:__________________________

Address: ___________________________________City:_____________ State:_______ Zip _____

Dates attended from:____________ to:_______________

Program Director: ______________________________________P# _____________F# _____________

Fellowship:____ Specialty:__________________________

Address: ___________________________________City:_____________ State:_______ Zip _____

Dates attended from:____________ to:_______________

Program Director: ______________________________________P# _____________F# _____________

IV. Educational Commission for Foreign Medical Graduates (attach copy of certificate)

☐ **Does not apply**

ECFMG Certification # ___________________________Date issued: _______________________

**(*If additional space is needed, attach separate sheet)*

V. Military/Public Health Service *(please attach copy of DD214/Statement of U.S. Public Health)*

In the previous 15 years have you served or are you currently serving ☐ Y ☐ N

☐ U.S. Military ☐ Reserves ☐ Public Health Service

If yes, which Branch: ____________________

From: ________ To: ________ Type of discharge: ____________________

****provide copy of DD214****

VI. Employed Faculty Position *(please list all positions held during previous 15 years)*

Institution Name:____________________ Department: ____________________

Position Held: ____________________ Contact Info: P# __________ F# __________

Address: ____________________ City: ____________State: ______ Zip:________

From: __________ To: __________ Reason for leaving: ____________________

Institution Name:____________________ Department: ____________________

Position Held: ____________________ Contact Info: P# __________ F# __________

Address: ____________________ City: ____________State: ______ Zip:________

From: __________ To: __________ Reason for leaving: ____________________

VII. Hospital Affiliations

1. **Primary Hospital/Facility utilized in the past 2 years**: ____________________

2. Please list all hospitals and surgicenters at which you are or were a member of the medical staff during the previous 10 years, or to which you are in the process of applying for medical staff membership. *Attach an additional sheet if necessary*.

Hospital Name/City	Staff Category	Inclusive Dates	(C) Current (A) Applying (P) Past

(*If additional space is needed, attach separate sheet)***

3. Have you ever voluntarily/involuntarily withdrawn/terminated your medical staff application/ membership or voluntarily/involuntarily experienced a limitation, reduction, or loss/denial of clinical privileges at another hospital/healthcare facility? No___ Yes___*
   * *IF YES, PLEASE EXPLAIN*:____

4. Are you currently, or have you ever been subject to disciplinary or corrective action, such as admonition, censure, reprimand, probation, nonprovisional supervision, suspension, termination, revocation, or reduction of privileges by any medical staff and/or healthcare organization? No___ Yes___*
   **IF YES, PLEASE EXPLAIN:*____

VIII. Licensure (attach copies of current licenses)

1. List all state licenses applied for or issued *(if license not issued, please state reason)*:

State	License #	Date Issued	Expiration Date

2. Has any license entitling you to practice your profession in any jurisdiction ever been investigated, denied, suspended, placed under stipulation, limited, revoked or been voluntarily/ involuntarily relinquished or has a letter of censure or concern been issued to you? No___ Yes___*
   **IF YES, PLEASE EXPLAIN:*____

3. Has your narcotics (DEA) license ever been refused, suspended, limited, revoked, or voluntarily/involuntarily relinquished, or is it currently being challenged or investigated? No___ Yes___*
   * *IF YES, PLEASE EXPLAIN:*____

4. Are you presently being investigated by any licensing agency? No___ Yes___*
   * *IF YES, PLEASE EXPLAIN:*____

IX. DEA REGISTRATION

DEA Number: ______________________________ Expiration Date:_________ ☐ DEA Pending ☐ I do not have a DEA

X. Board Certification Status

Please provide information regarding your Board Certification status. (ie: copy of Board Certification or letter from Board showing *that you have applied for and been accepted to become an active candidate for certifications.)*

____
Board Name (Year Certified) (Year Recertified) (Expiration) (Qualified Until)

____
Board Name (Year Certified) (Year Recertified) (Expiration) (Qualified Until)

***All applicants who initially apply to staff after June 1, 2006 must become board certified within the time frame specified by the board or within 5 years from residency if no time limit is defined. Where the board requires a period of practice prior to submitting an application for certification, the applicant will be deemed "Admissible" during the time period if the director of his/her training program certifies that he/she has met all training requirements necessary to become board certified by the appropriate board. Failure to become board certified within this time period will result in loss of membership and privileges without the procedural rights afforded by the Fair Hearing Plan.**

XI. Health Status

1. Have you ever been hospitalized for any medical, surgical and/or psychological reasons? No____ Yes____*
   *IF YES, PLEASE EXPLAIN:*____

2. Are you presently, or have you ever been dependent on or treated for alcohol or drugs? No____ Yes____*
   *IF YES, PLEASE EXPLAIN:*____

3. Are you able to perform all the services and essential functions of a practitioner with the privileges you are requesting, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients? Yes____ No____*
   *IF NO, PLEASE EXPLAIN:*____

4. Are you currently taking medication or under any other therapy that is reasonably likely to affect your ability to perform professional or medical staff duties? No____ Yes____*
   *IF YES, PLEASE EXPLAIN:*____

XII. Other Pertinent Information

1. Have you ever been charged with a crime involving alcohol or controlled substances? No____ Yes____*
   *IF YES, PLEASE EXPLAIN:*____

   Have any felony and/or misdemeanor criminal charges ever been brought against you? No____ Yes____*
   *IF YES, PLEASE EXPLAIN:*____

3. Have you ever been suspended, sanctioned, investigated or otherwise restricted from participating in any private, federal, or state health insurance program (e.g., Medicare, Blue Cross)? No____ Yes____*
   *IF YES, PLEASE EXPLAIN:*____

XIII. Professional Liability Insurance (attach copy of current certificate)

Please list CURRENT professional liability insurance information and list ALL policies under which you've been covered for the previous 10 years.

Name of Policyholder:______________________________ Policy #:______________________

Name of Insurance Carrier:____

Mailing Address:____
City State Zip

Phone Number:__________________________ Fax Number:__________________________

Dates of coverage: From:____________ To: ______________ Retro Date: ______________

(*If additional space is needed, attach separate sheet)***

PRIOR CARRIERS:

Name of Policyholder:_____________________________________ Policy #:____________________________

Name of Insurance Carrier:____

Mailing Address:____
City State Zip

Phone Number:________________________________ Fax Number:_________________________________

Dates of coverage: From:_______________ To: __________________

Name of Policyholder:_____________________________________ Policy #:____________________________

Name of Insurance Carrier:____

Mailing Address:____
City State Zip

Phone Number:________________________________ Fax Number:_________________________________

Dates of coverage: From:_______________ To: __________________

Name of Policyholder:_____________________________________ Policy #:____________________________

Name of Insurance Carrier:____

Mailing Address:____
City State Zip

Phone Number:________________________________ Fax Number:_________________________________

Dates of coverage: From:_______________ To: __________________

Name of Policyholder:_____________________________________ Policy #:____________________________

Name of Insurance Carrier:____

Mailing Address:____
City State Zip

Phone Number:________________________________ Fax Number:_________________________________

Dates of coverage: From:_______________ To: __________________

1. Have there ever been, or are there currently pending, any malpractice claims, suits, settlements, judgments, arbitration proceedings or complaints involving your professional practice? No____ Yes____*

* **If <u>YES</u>, you must complete the attached "Confidential Information Report" for <u>EACH</u> claim, suit, settlement, or judgment. (*If more than one, please copy the Information Report for each.*)**

**(*If additional space is needed, attach separate sheet)*

2. Does your malpractice coverage exclude you from providing any specific procedures or practicing any portions of your specialty? No____ Yes____*
*IF YES, PLEASE EXPLAIN:*____

3. Has your malpractice insurance been canceled or denied by any carrier? No____ Yes____*
*IF YES, PLEASE EXPLAIN:*____

XIV. TIME GAPS ***(must account for time gaps less than 90 days. Gaps greater than 90days must be accounted for by you and verified in writing by someone other than yourself. You must account for all time gaps that occurred during the previous 15 years.***

☐ **I have no time gaps**

1) From: __________ To: __________

Explanation:

____

____

*Provide name and address of person to contact for verification of time gap greater than 90 days.

Name: ________________________________ *P#: ________________ *F#: ____________________

Address: ________________________________ City: ______________ State: _______ Zip: _________

2) From: __________ To: __________

Explanation:

____

____

*Provide name and address of person to contact for verification of time gap greater than 90 days.

Name: ________________________________ *P#: ________________ *F#: ____________________

Address: ________________________________ City: ______________ State: _______ Zip: _________

3) From: __________ To: __________

Explanation:

____

____

*Provide name and address of person to contact for verification of time gap greater than 90 days.

Name: ________________________________ *P#: ________________ *F#: ____________________

Address: ________________________________ City: ______________ State: _______ Zip: _________

(*If additional space is needed, attach separate sheet)***

XV. PEER REVIEW & COMPETENCY REFERENCES

In support of my application for privileges at John C. Lincoln Hospital-North Mountain and/or John C. Lincoln Hospital-Deer Valley, I submit the following names of **four** peer references (no relatives, or current/pending employers or associates) who can attest to my current competency. ***It is advisable, when possible, to include recommendations from a practitioner in your specialty. The peer reference must address your training or experience, clinical competence, and ability to perform the privileges requested.***

Name: ______________________________ Specialty: ____________________

Address: ______________________________ City: ________________ State: ____ Zip Code:_________

*Phone: ________________________ *Fax: _____________________

Name: ______________________________ Specialty: ____________________

Address: ______________________________ City: ________________ State: ____ Zip Code:_________

*Phone: ________________________ *Fax: _____________________

Name: ______________________________ Specialty: ____________________

Address: ______________________________ City: ________________ State: ____ Zip Code:_________

*Phone: ________________________ *Fax: _____________________

Name: ______________________________ Specialty: ____________________

Address: ______________________________ City: ________________ State: ____ Zip Code:_________

*Phone: ________________________ *Fax: _____________________

****Indicates required information***

(*If additional space is needed, attach separate sheet)***

12/08

CONFIDENTIAL INFORMATION REPORT
(Pursuant to A.R.S. 36-445.01)

If you answered "yes" to question 1 under Section IX, you must furnish the following information regarding each lawsuit or complaint. Attach copies of all documentation relating to each case. You may choose to have your attorney complete this form, but it is your responsibility to provide additional documentation.

Mo/Yr of Incident ____________ Where Incident Occurred ____________ Name of Plaintiff(s) ____________

Nature of Incident:____

____

____

____

Outcome of Incident:

Dropped_____ Dismissed_____ Pending_____ Settled_____ Amount $__________

Verdict: for You_____ For Plaintiff_____ Amount $_______

Recommendation by Legal Panel:

For You_____ For Plaintiff_____ Not Presented to Panel_____

Represented by legal counsel for this claim/malpractice lawsuit? Yes _____ No ______

Name of Insurance Company that provided coverage for this claim:

Insurance Company:____

Address & Telephone Number____

____

____ ____________________
Physician Signature Date

____
Name (please print)

(*If additional space is needed, attach separate sheet)***

JOHN C. LINCOLN HEALTH NETWORK HOSPITALS

RELEASE AND IMMUNITY STATEMENT

In making application to the Medical Staff(s) of one or more of the John C. Lincoln Health Network Hospitals, I state that the foregoing information is complete and accurate to the best of my knowledge and belief. I fully understand that any significant misstatements in or omissions from this application constitute cause for denial of appointment or reappointment and/or cause for summary dismissal from the Medical Staff(s).

In making this application for Appointment or Reappointment to the Medical Staff(s) of these Hospitals, I acknowledge that I have received the Bylaws, Rules and Regulations of the Medical Staff(s) of these Hospital; and that I shall abide by the principles of medical ethics of the American Medical Association and/or the American Osteopathic Associations and the Rules and Regulations of the Hospital(s). I agree to be bound by the terms thereof if I am appointed.

By applying for Appointment or Reappointment to the Medical Staff(s), I hereby authorize the John C. Lincoln Health Network Hospitals and their Medical Staff(s) and representatives to consult with representatives and members of the 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, health status and ethical qualifications. I hereby further authorize and consent to the inspection or duplication by - and - in the release to the Hospitals, their Medical Staffs and their representatives 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 moral and ethical qualifications for staff membership.

I hereby release from liability all representatives of the John C. Lincoln Health Network Hospitals and their Medical Staffs for their acts performed in connection with evaluating my application and my credentials and qualifications. I hereby release from any liability any and all individuals and organizations who provide information to the John C. Lincoln Health Network Hospitals or their Medical Staffs 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 hereby further authorize and consent to the release of information by the John C. Lincoln Health Network Hospitals, or their Medical Staffs to other hospitals, medical associations or third party payors with established credentialing mechanisms upon request regarding any information the Hospitals or their Medical Staffs may have concerning me. I hereby release from liability and hereby grant and extend absolute immunity to the John C. Lincoln Health Network Hospitals and their Medical Staffs and all of their representatives for so doing.

I pledge to provide continuous care for my patients at the John C. Lincoln Health Network Hospitals, to delegate the responsibility for the care of my patients only to qualified practitioners and only to members of the respective Medical Staffs of the John C. Lincoln Health Network Hospitals. I hereby agree that, if requested, I shall appear for interviews before the appropriate committee(s) of the Medical Staffs.

I understand and agree that information involving my membership, clinical privileges, competence, character, health status and ethical qualifications, including privileged and confidential peer review information, will be shared by and between the John C. Lincoln Health Network Hospitals during the appointment and reappointment process and at any time thereafter including immediately upon the imposition of a summary suspension of my medical staff privileges at one or both Hospitals.

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

In addition, I agree to notify the Chief Executive Officer, in writing, within sixty (60) days of my receipt of notice of any lawsuit or claim concerning my professional care or treatment of a patient, or of any circumstances arising subsequent to the date of this application which would change any of the responses I have provided herein.

The authorizations, comments and releases granted herein shall continue in full force and effect and shall survive not only the application process for appointment and reappointment to the Medical Staff(s) of the Hospitals, but also the denial, duration and termination of my appointment to such Medical Staff(s)

Dated this________day of __________________, 20______

____
Print Name

____
Signature

CLINICAL ACTIVITY SUMMARY

TO BE COMPLETED BY APPLICANT

APPLICANT RELEASE AND CONSENT

In consideration for the investigation and processing of my application for Medical Staff privileges, I, ___________________________, authorize John C. Lincoln Hospital-North Mountain and/or John C. Lincoln Hospital-Deer Valley and any of their agents or employees to request information necessary to evaluate and act upon this application and consent to the release of such requested information by any person and entity to John C. Lincoln Health Network.

I release, acquit and forever discharge John C. Lincoln Health Network, their agents and employees, and any and all other persons and entities involved in or requested to participate in the application, evaluation and credentialing process for any and all liability of any kind or nature whatsoever, including but not limited to, liability for invasion of privacy, libel, slander, defamation, tortuous interference with contractual relations, breech of contract, or negligence that may arise out of these activities;

I acknowledge that John C. Lincoln Health Network has established a system review of professional practices for the improvement of patient care and the provision of high quality and effective patient care. Accordingly, I consent to the disclosure between John C. Lincoln Health Network of all professional review information, including, but not limited to, information relating to credentialing, privileging, quality review, utilization review or any other professional review actions and acknowledge that such disclosures are confidential pursuant to law.

Practitioner's Primary Hospital/Facility:____
(For the past 2 years)

Signature:____ **Date:**___________________________

TO BE COMPLETED BY MEDICAL RECORDS / MEDICAL STAFF DIRECTOR

INFORMATION REQUIRED FROM MEDICAL RECORDS DIRECTOR OR MEDICAL STAFF DIRECTOR AT THE HOSPITAL, FACILITY, OR SURGICENTER WHERE APPLICANT'S PRIMARY PRACTICE IS LOCATED**. *PLEASE RETURN COMPLETED EVALUATION FORM ASAP***

Re: ___________________________________
Physician's Name

The above named physician has applied for appointment to the Medical Staff of John C. Lincoln Health Network. In order for his/her application to be considered, please provide the following information regarding his/her clinical activity at your hospital during the past two years. If a physician report reflecting the number and type of patients treated by this physician is available, the report will suffice in lieu of the information requested on this form **with the exception of questions number 6 and 7**.

CLINICAL ACTIVITY SUMMARY (within the past two [2] years)

1. **Number of patients attended:** _________
2. **Number of surgeries:** _________
3. **Number of consults:** _________
4. **Number of patients in the Critical Care Unit:** _________
5. **Number of mortalities:** _________
6. **Has the applicant been suspended for medical records violations within the last (12) months: Yes______ No______**
7. **If so, how many times:** _________

I have provided this information for use in the credentialing process at a John C. Lincoln Health Network Hospital. To the best of my knowledge, this information accurately reflects the clinical work of this physician at this facility.

The applicant's authorization and release from liability is noted above. **Please fax your response to 623-434-6106**. Thank you.

____ ___________________________

Signature of Medical Records Director Date

JOHN C. LINCOLN HEALTH NETWORK HOSPITALS
NORTH MOUNTAIN - DEER VALLEY

CONTINUING EDUCATION LOG

PHYSICIAN ____

Please list below or attach a complete listing of all Continuing Education Programs (CME) you attended during the past two (2) years. You may use the reverse side if necessary. NOTE: These programs should be directly related to your specialty.

DATE	COURSE	# OF HOURS

TOTAL NUMBER OF HOURS: _______________

JOHN C. LINCOLN HEALTH NETWORK HOSPITALS
NORTH MOUNTAIN - DEER VALLEY
Phoenix, Arizona

PHYSICIAN ATTESTATION STATEMENT

I hereby acknowledge receipt from John C. Lincoln Health Network Hospitals of the following physician attestation statement required by the Health Care Financing Administration. (49 Fed. Reg. 34728, August 31, 1984).

NOTICE TO PHYSICIANS:

Medicare and TRICARE payments to hospitals are based in part on each patient's principal and secondary diagnosis and the major procedures performed on the patient, as attested to by the virtue of his or her signature on 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.

____
Name (please print)

____
Signature

____
Date

JOHN C. LINCOLN HEALTH NETWORK HOSPITALS
Phoenix, Arizona

COVERING PRACTITIONER STATEMENT

Name of covering practitioner:	Coverage provided at: (circle appropriate facility)	
________________________________	North Mtn	Deer Valley
________________________________	North Mtn	Deer Valley
________________________________	North Mtn	Deer Valley

As part of my application for appointment through John C. Lincoln Health Network Hospitals, I hereby submit the above-named as my covering practitioner(s).

I also understand that it is my responsibility to provide coverage for my patients and I accept this responsibility.

As required, this practitioner(s) is on staff at the facility indicated with privileges similar to those I am requesting.

I have contacted the above-name practitioner(s) and he/she agrees to provide this coverage.

____
Name (please print)

____ ___________
Signature Date

TO: Applicant

FROM: Timothy Kuberski, MD
Chairman, Infection Control Committee

SUBJECT: **TB SKIN TEST**

The Arizona Department of Health Services (DHS) requires each medical staff and allied health member to provide evidence of freedom from infectious pulmonary tuberculosis at least once every 24 months or more often as required by the hospital's infection control committee. This evidence of freedom from infectious pulmonary tuberculosis can be established by a current report of a TB skin test.

If a medical staff or allied health member signs this attestation and cannot produce this evidence upon request, DHS has indicated that it will report the practitioner to AMB/OBEX or the appropriate licensing board.

If you need a TB skin test done, we can assist you at JCLNMH through:

	Direct Dial #	Hosp. Ext.
Employee Health Services	602-870-6332	x1477
Betty Rogers, Infection Control Practitioner	602-870-6060	x1320

The test is available between 7:30 a.m. and 4:00 p.m., Monday through Friday. Please bring this form with you if you plan to receive the TB skin test at JCLNMH.

***IF** you have a history of a positive TB skin test, please contact the Medical Staff office and we will provide you with a health questionnaire.**

Person receiving skin test must sign below:

I attest that I was evaluated for infectious pulmonary tuberculosis and am providing a report of a negative TB skin test dated: ______________________________

______________________________ ______________________

Signature **Date**

JOHN C. LINCOLN HEALTH NETWORK
Phoenix, Arizona

EMERGENCY ROOM CALL REQUIREMENTS

As an applicant for Medical Staff privileges at the John C. Lincoln Health Network Hospitals, please be advised of the departmental requirements for mandatory emergency room call for each facility as follows:

NORTH MOUNTAIN		DEER VALLEY	
MANDATORY	**VOLUNTARY**	**MANDATORY**	**VOLUNTARY**
Cardiothoracic Surgery[1]	Cardiology	Anesthesia[1]	Cardiology
Pediatrics[2]	General Surgery	Pediatrics[2]	GYN
Urology[3]	Neurosurgery	General Surgery[3]	Medicine - Admitting
	OB/GYN		Medicine - Referring
	Orthopedic Surgery		
	Plastic Surgery		
	Vascular Surgery		

North Mountain	Deer Valley
1-mandatory after admission of 5 patients per calendar year	**1**- mandatory for all Anesthesiologists; exception is cardiac surgery and pain management.
2- mandatory for all pediatricians. This is a network department and call covers both Deer Valley and North Mountain; exception for Pediatricians age 55 or older and/or having 20 years or more service..	**2**- mandatory for all pediatricians. This is a network department and call covers both Deer Valley and North Mountain; exception for Pediatricians age 55 or older and/or having 20 years or more service
3- exemption for Urologists age 60 or medical staff member for 20 years	**3**- mandatory for all General Surgeons

Your participation (voluntary or mandatory) will assist the Hospitals in serving our community with appropriate and needed physician coverage for “no doctor” patients presenting in the emergency departments. Associated with call, and as stated within the Medical Staff Rules and Regulations, **“a physician serving on the Emergency Department call rotation must accept any patient who has been referred from the Emergency Department for one visit or until the patient can be safely and legally discharged to the care of another source regardless of the patient’s financial status.”**

PLEASE CHECK ONE AND SIGN BELOW

(as applicable to your specialty per above chart)

CHECK HERE	*NORTH MOUNTAIN*	*CHECK HERE*	*DEER VALLEY*
	I am aware of the **mandatory** emergency call requirements for my specialty as listed above, and I agree to abide by these departmental requirements.		I am aware of the **mandatory** emergency call requirements for my specialty as listed above, and I agree to abide by these departmental requirements.
	Please add my name to the list of physicians participating in the **voluntary** emergency call rotation for my specialty as listed above. I agree to provide appropriate follow-up care as required by the Medical Staff Rules and Regulations		Please add my name to the list of physicians participating in the **voluntary** emergency call rotation for my specialty as listed above. I agree to provide appropriate follow-up care as required by the Medical Staff Rules and Regulations
	Emergency room call is **not applicable** to my specialty		Emergency room call is **not applicable** to my specialty

Printed Name ________________________________

Signature ____________________________________

Specialty _______________________ Date ________

Printed Name _______________________________________

Signature ____

Specialty _____________________ Date __________

POLICIES AND PROCEDURES

SECTION: QUALITY MANAGEMENT

Topic: On-Call Physician Coverage

Reviewed: New (5/00), 4/03,7/04

Last Revision: 7/04

Approval: ______________________ Date: 8/04

1.0 Purpose

1.1 To identify physicians as being “on-call” for a specific rotation to provide treatment necessary to stabilize individuals with emergency medical conditions.

2.0 Policy

2.1 Physicians who have been approved for Staff membership may request emergency department call rotation, except in those specialties where emergency call is mandatory, by contacting Medical Staff Services.

2.2 Each Medical Staff Clinical Department is responsible for establishing its own Emergency Department call requirements.

2.3 Call rotation is from 7 a.m. to 7 a.m. for each day of call at North Mountain, and 8 a.m. to 8 a.m. at Deer Valley. A schedule of call rotation is available in the Emergency Department and in the Medical Staff Services Department at each facility.

2.4 An on-call physician is called only after the patient indicates that he/she does not have a private physician. In the event the patient’s physician is not on staff and the patient needs to be admitted, the Emergency Department will contact the on-call physician after receiving the patient’s approval.

2.5 An on-call physician is responsible for accepting any patient who has been referred from the Emergency Department for one office visit or until the patient can be safely and legally discharged to the care of another source, regardless of the patient’s financial status.

2.6 An on-call physician must be available and accessible by telephone during time on-call and must respond to all calls. The on-call physician must respond in person, if requested to do so by the Emergency Department physician or, in the case of obstetrics, by the Obstetrical RN.

2.7 An on-call physician who refuses to come in and see a patient, necessitating a transfer of the patient to another facility, shall be reported to the appropriate regulatory authority. Pursuant to State Statute, documentation of the refusal must be recorded in the patient record.

2.8 Any physician who experiences a conflict and is unable to take call when assigned, is responsible for finding qualified alternate physician coverage with a physician on the medical staff of the Hospital, for a specific rotation, and for notifying the Medical Staff Services Department of a change in coverage. At North Mountain the Medical Staff Services Department is responsible for communicating a change in call coverage to the Emergency Department and/or Birthing Center. At Deer Valley, the Nursing Supervisor is informed of the change and makes the correction to the schedule in the Emergency Department.

2.9 Failure of the on-call physician to accept his/her on-call responsibility shall be investigated by the applicable Department Chairman and/or the Chief of Staff or their designee. When appropriate, steps shall be taken and a plan or corrective action initiated.

2.10 At North Mountain, on-call services include, General Medicine, (Family Practice and General Internal Medicine); Cardiology; Cardiothoracic Surgery; General Surgery; Hand Surgery; Neurosurgery; Obstetrics-Gynecology; Ophthalmology; Orthopedics; Pediatrics; Plastic Surgery; Trauma Surgery; Urology; Vascular Surgery; Trauma Anesthesia; and OB Anesthesia (North Mountain Birthing Center only).

2.11 At Deer Valley, on-call services include Primary**; Cardiology; ENT; Gynecology; Osteopathic Manipulation & Methods; Ophthalmology; Orthopedics; Pediatrics; Plastic Surgery; and General Surgery.

*** Primary includes all Family Practitioners and Medicine subspecialists with the exception of PM&R, Dermatology, and Psychiatry/Psychology.*

3.0 Procedure

3.1 The Medical Staff Services Department is responsible for the development and distribution of the clinical department's Emergency Department call schedules. Each schedule is prepared on a daily, weekly, bi-weekly, or monthly rotation.

3.2 The Medical Staff Services Department is responsible for mailing each of the on-call schedules, with current policy statement, to each physician at the beginning of each scheduled rotation.

3.3 On-call physicians are responsible for making their own arrangements for coverage with a qualified, credentialed member of the Hospital's Medical Staff in the event he/she is unavailable during the designated assigned rotation.

3.3.1 If a change becomes necessary, the on-call physician is responsible for contacting the Medical Staff Services Department regarding the arrangement for coverage.

3.3.2 The Medical Staff Services Department is responsible for notifying the Emergency Department and any other department, which may need to be aware of a change in a schedule.

3.4 Inappropriate or delayed telephone responses, or failing to appear within a reasonable time, when requested by an Emergency Department physician, shall be documented and referred to the Medical Staff Services Department. The Medical Staff Services Department will be responsible for following up on the report and its findings will be referred to the clinical department chairman and/or the Chief of Staff.

3.5 A record of physicians on-call will be kept for a minimum of five years.

POLICIES AND PROCEDURES

SECTION: COMPLIANCE

Topic: Reporting & Investigating Allegations of Suspected Improper Activities

Reviewed: New (9/06)

Last Revision:

Approval: Date: 11/06

1.0 Purpose

1.1 The Network is subject to numerous local, state and federal laws pertaining to all aspects of its operation. All employees are required to understand and abide by those laws which are applicable to them in the performance of their jobs. Additionally, all employees are required to comply with laws which prohibit health care fraud, abuse and waste. Examples of prohibited activities include, but are not limited to:

1.1.1 Intentionally or knowingly making false or fraudulent claims for payment or approval.

1.1.2 Claiming reimbursement for services that have not been rendered.

1.1.3 Filing duplicate claims.

1.1.4 “Up-coding” to more complex diagnoses or procedures than were actually performed.

1.1.5 Including inappropriate or inaccurate costs on Network cost reports.

1.1.6 Falsely indicating that a particular health care professional attended a procedure or that services were otherwise rendered in a manner they were not.

1.1.7 Billing for services or items that are not medically necessary.

1.1.8 Failing to provide medically necessary services or items.

1.1.9 Offering or receiving remuneration (such as a kickback, bribe or rebate) as an inducement to make a referral for the furnishing (or arranging for the furnishing) of any item or services.

1.1.10 Submitting false information for the purpose of gaining or retaining the right to participate in a plan or obtain reimbursement for services.

1.1.11 Billing excessive charges.

1.2 To set forth the Network's policy for detecting and preventing waste, fraud, and abuse.

1.3 To provide information regarding the provisions of the federal False Claims Act, the administrative remedies that could be imposed for false claims and statements, the state laws regarding penalties for false claims and statements, and the protection from reprisal, retribution, or retaliation that is available for anyone reporting suspected fraudulent activities in good faith. A description of the federal False Claims Act and its associated administrative remedies is included in the attached Exhibit.

1.4 To be in compliance with the provisions of Section 6032 of the Deficit Reduction Act of 2006 regarding the prevention of waste, fraud, and abuse.

1.5 To be in compliance with state laws regarding fraudulent activities, including the following:

1.5.1 Criminal Medicaid Fraud Penalties/Felonies 13-2310; 13-2311

1.5.1.1 **13-2310:** Any person who, pursuant to a scheme to defraud, knowingly obtains any benefit by fraudulent purposes is guilty of a class 2 felony.

1.5.1.2 **13-2311**: Any person who, pursuant to a scheme to defraud, falsifies or covers up material fact or uses any false documents are guilty of a class 5 felony.

1.5.2 Reporting Medicaid Fraud (Whistle blower protection) 23-1501; 38-531

1.5.2.1 **23-1501:** The disclosure by an employee that he/she has information that his/her employer or an employee of the employer, has violated, is violating or will violate the law, to his/her supervisor or another management representative of the employer who has the authority to investigate information provided.

Employee protection from retaliatory discharge following disclosure of information regarding a violation or a potential violation of the law.

1.5.2.2 **38-531:** Definition of terms, to include employee, former employee, personnel actions, etc.

1.5.3 Recipient Issues (Fraud) 36-2905.04; 39-161;13-2310

1.5.3.1 **136-2905.04:** A person shall not provide false or fraudulent information to the state.

1.5.3.2 **13-2310:** A person who, pursuant to a scheme to defraud, knowingly obtains any benefit by means of fraudulent promises is guilty of a class 2 felony.
Scheme to defraud serves to deprive a person of intangible right of honest services.

2.0 Policy:

2.1 The Network does not tolerate fraud, waste, abuse or unethical behavior in conducting business and delivering services to patients and families.

2.2 Network employees, contractors, and agents who prepare or submit claims should be alert so as to prohibit inaccuracies and other errors on claims.

2.3 The Network is committed to compliance with all federal and state laws and regulations. We expect that all employees shall act in a manner which upholds the law and are accountable for ethical behavior in their job performance.

2.4 Any employee of the Network who has knowledge of facts concerning the organization's activities that he or she believe may violate the law has an obligation, promptly after learning such facts, to report the matter to his or her immediate supervisor; to the Director of Compliance or to the JCL Compliance Hotline at (602) 870-6060, ext 5888.

2.5 Violations or suspected violations may be submitted on a confidential basis by the complainant or may be submitted anonymously. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation. Every effort will be made to protect the complainant's identity.

2.6 Employees are encouraged to put their names to allegations because appropriate follow-up questions and investigation may not be possible unless the source of information is identified. Concerns expressed anonymously will be investigated, but consideration will be given to: (a) the seriousness of the issue raised; (b) the credibility of the concern; and (c) the likelihood of confirming the allegation from attributable sources.

2.7 There will be no retribution or discipline for anyone who reports a violation or suspected violation in good faith.

2.7.1 Anyone filing a complaint must have reasonable grounds for believing the information disclosed indicates misconduct, dishonesty, unethical behavior, fraud or fraudulent behavior. Allegations which prove not to be substantiated and which prove to have been made maliciously or knowingly to be false will be viewed as a serious offense and worthy of disciplinary action.

2.8 An employee who retaliates against someone who has reported a violation or suspected violation in good faith is subject to discipline up to an including termination of employment.

2.9 This policy applies to all John C. Lincoln employees, contractors, and agents.

Exhibit 1

False Claims Act and Associated Provisions Description

The False Claims Act (the FCA) is a provision of federal law dating to the Civil War. The law was designed to prevent the submission of false or fraudulent claims to the US Government. In general, the FCA prevents the following activities:

- Knowingly presenting a false or fraudulent claim for payment by the federal government.
- Knowingly using a false record or statement to get a claim paid by the federal government.
- Conspiring with others to get a false or fraudulent claim paid by the federal government.
- Knowingly using a false record or statement to conceal, avoid, or decrease a payment due to the federal government.

Violation of the FCA can result in penalties of up to three times the amount of the federal government may have been defrauded, including civil penalties of $5,000 to $11,000 for each false claim.

The FCA also contains a *qui tam* provision that in some situations permits a private individual to sue those who defrauded the government and receive a percentage of any resulting recovery from the defendant.

John C. Lincoln Health Network
Phoenix, Arizona

EMTALA UPDATE: ON-CALL PHYSICIANS

Many physicians are not aware that in addition to the regulations EMTALA imposes on emergency departments and emergency physicians, it also has significant ramifications for physicians who are on-call for emergency departments. The Emergency Medical Treatment and Active Labor Act (EMTALA), also know as the "Patient Anti-dumping Law," went into effect in 1986 as part of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA). EMTALA places the responsibility on hospitals and physicians to ensure the availability of emergency care for all that need it regardless of their citizenship or ability to pay. Basically, hospitals that have a Medicare provider number cannot turn away anyone who presents on hospital property for the purpose of seeking unscheduled medical care. As part of this obligation to provide emergency care, a hospital that offers a service to the public, must make this service available to the emergency department through on-call coverage.

Hospitals are required to provide an appropriate medical screening examination sufficient to determine the presence of an emergency medical condition and the treatment necessary to stabilize that condition. EMTALA defines an emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain, women in active labor, psychiatric conditions, and or substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual in serious jeopardy; serious impairment to bodily functions(s); or serious dysfunction of any bodily organ or part. It is the **physician actually caring for the patient**, who determines whether an emergency medical condition exists. In the event of a disagreement between the treating/examining physician and an off-site physician, the medical judgment of the treating/examining physician will take precedence over the off-site physician. If such a condition exists, the hospital is further required to provide stabilizing treatment and/or an appropriate transfer.

Final resolution of the emergency medical condition is not required for the patient to be considered "stable for transfer" or "stable for discharge". A patient is considered "stable for discharge" when the treating physician determines, within reasonable clinical confidence, that the patient has reached a point where the care could be performed as an outpatient or later as an inpatient. This would include diagnostic work-up and/or treatment, provided the patient is given a plan for appropriate follow-up care with the discharge instructions. To follow-up plan of care may obligate on-call physicians to accept patients referred as an extension of an emergency room visit, regardless of the patient's insurance coverage or ability to pay.

EMTALA requires hospitals to maintain a list of physicians who are on-call to provide treatment necessary to stabilize an individual with an emergency medical condition. Medical staff bylaws and/or policies and procedures must define the responsibility of on-call physicians to respond, examine and treat patients. Physicians are not required to be on-call at all times, but hospitals must identify contingency plans which are to be followed when a particular specialty is not available or the on-call physician can not respond due to a situation beyond his or her control.

- **EMTALA Investigations of On-Call Physicians Frequently Arise From**:
  - An on-call physician refusing to see a patient deemed to have an emergency medical condition;
  - Delayed arrival of the on-call physician; and/or
  - An on-call physician ordering a transfer without seeing the patient.

- **Penalties for On-call Physicians Found in Violation of EMTALA include**:
  - Up to $50,000 fine per violation (not per patient) paid to the federal government;

- Loss of Medicare participation for gross, flagrant, or repeated violations; and
- Violations are also reported to other federal agencies such as the Internal Revenue Service.

RISK MANAGEMENT RECOMMENDATIONS:

1. Take on-call responsibilities seriously**: If you will be out of town or otherwise unable to fulfill your on-call responsibilities, arrange for another physician with similar credentials and privileges to cover your call and notify the hospital of the change. Additionally, educate office staff to be especially sensitive if a patient calls or presents in the office stating an emergency department referred them and develop protocols or guidelines for how these patients will be accommodated.**

2. **Respond to the emergency department in a timely manner.** Unless you cannot respond due to situations beyond your control or due to your involvement in the care of another patient, you must be available to the emergency department when you are on-call.

3. **Clearly document your assessment and plan of treatment.** Do not rely on the emergency physician or hospital staff to document your participation in patient care. Also document telephone calls relating to the care of emergency department patients. Your documentation will provide credible evidence that you appropriately participated in the patient's care.

4. **Never discriminate against a patient with an emergency medical condition.** The only acceptable reason that patients with an emergency medical condition should be treated differently is because of the needs presented by their medical condition. Whether a patient received the appropriate care with regards to EMTALA will be determined retrospectively and without regard to the clinical outcome of the patient.

If you have any questions regarding EMTALA, please contact the Medical Staff Office at (602) 870-6317 or (623) 879-5412.

M E M O R A N D U M

TO: New Applicants

FROM: Medical Staff Services

RE: **NPI Number**

Effective May 23, 2007, CMS will only accept your National Provider Identifier **(NPI)** number for electronic transactions for healthcare. All practitioners must have an NPI number. All claims submitted by the hospital must have the practitioners NPI number on it.

You can apply for your NPI number beginning May 23, 2005 by submitting an online application.
(https://nppes.cms.hhs.gov)

Please provide your NPI number below. ***PLEASE NOTE:*** this is not your Social Security Number or your Tax ID Number.

________________________ ______________________________________

NPI Number ***PLEASE PRINT NAME***

The John C. Lincoln Health Network is requiring all applicants to provide a current wallet-size photograph for our Medical Staff data base. **This photograph MUST be black & white or colored but needs to be a *GLOSSY* finish.** Please do not send copies of photos, as we cannot scan these into our data base. Please feel free to call either Medical Staff Services Office if you have any questions. Deer Valley 623-879-5409/ North Mountain 602-331-5712.

Please attach wallet-size photo here

NAME ___________________________

SIGNATURE CARD

In order to assist the Medical Records staff with the verification of providers' signatures/initials during the review of patient records, you are requested to sign and return the attached card.

Please call 602-870-1809 if you have any questions. Thank you for your cooperation.

John C. Lincoln North Mountain Hospital	John C. Lincoln Deer Valley Hospital
__________________________ Name	__________________________ Name
_____________________________ Physician Signature	_____________________________ Physician Signature
_______________ Date	_______________ Date

APPLICATION FOR PHYSICIAN PARKING PERMIT

Physician Name: ____

If you are interested in obtaining a permit for the areas reserved for physician parking, please provide the following information:

Primary Vehicle:

____
Year Make Model Color

License Plate Number: ______________________________ State: ________________

Second Vehicle, if additional parking permit is needed:

____
Year Make Model Color

License Plate Number: ______________________________ State: ________________

____

For Office Use Only:

Permit Number Issued: __________ (green sticker)	Permit Number Issued: ______________ (green sticker)
DV NM BOTH	**DV NM BOTH**

AGREEMENT TO PARTICIPATE

AUTOMATIC FAXING OF TRANSCRIBED DOCUMENTS

I have reviewed the attached guidelines for the Automatic Faxing of Transcribed Documents and agree to participate in this program.

I understand that I may withdraw from this program at anytime by notifying the Medical Records Department.

I realize that in order to achieve the greatest benefit from this program the following recommendations should be in place:

1. A plain paper facsimile machine;
2. A dedicated fax line;
3. The facsimile machine remains on at all times; and,
4. The complete name of all physicians to receive copies must be dictated.

____
Printed Name

____ Date ______________________________
Signature

____
FAX NUMBER

***I wish to utilize the auto fax program at the following facility(s):**

_____ John C. Lincoln Deer Valley Hospital

_____ John C. Lincoln North Mountain Hospital

AUTOMATIC FAXING OF TRANSCRIBED DOCUMENTS

GUIDELINES

1. This is a voluntary program open to any member of the Medical Staff of John C. Lincoln Health Network.

2. The facsimile machine in your office should be a "plain paper" machine to allow for a permanent copy. Thermal or silver-paper fax machines produce copies that deteriorate thus requiring the physician's office personnel to make a copy of the fax which would be counter productive.

3. The facsimile machine should always be turned on and a dedicated telephone line is highly recommended. We are transcribing 24 hours per day seven days a week and the autofax option will dial the number only three times.

4. The machine should be located in a secure, non-public area where access is controlled and limited to the physician's office personnel in order to maintain confidentiality.

5. The physician or office staff should notify Medical Staff Services of any changes to the facsimile machine(s) telephone number.

6. The dictating physician must state the full name of all physician(s) that are to receive copies. Spelling of the last name(s) will also better facilitate copies being distributed properly.

7. If the transmission fails for any reason, the physician will receive a copy via the courier service.