NORTH HILLS HOSPITAL

REQUEST FOR CONSIDERATION – Adv Practice Professionals

Thank you for your interest in applying for membership to the Medical Staff at North Hills Hospital. The information below and the attached HCA Credentialing Online Provider Authorization for Delegate form is needed, in its entirety, to complete this request. Your application will come from the HCA Credentialing Processing Center (CPC) based in Houston, Texas. Please contact the Medical Staff Office if you have any questions or concerns during this process.

The following are General Qualifications for appointment for North Hills Hospital:

1) The applicant must possess a current, active license in the State of Texas for the practice of medicine, dentistry, podiatry or an Advanced Practice Professional.

2) To have prescribing privileges for controlled substances, the applicant must possess a current Federal Drug Enforcement Administration (DEA) registration and Texas Department of Public Safety with the applicant's in-state address for the State of Texas.

3) An applicant Practitioner must also have successfully completed a training program for which the Practitioner requests clinical privileges and shall be board certified, board qualified as defined by the specialty board for his/her specialty, or comparably qualified as defined by the Medical Executive Committee.

4) The applicant must document his/her current clinical competence, experience and judgment with sufficient adequacy, as determined at the discretion of the Medical Executive Committee and the Board.

5) The applicant shall possess the ability to perform the clinical privileges requested.

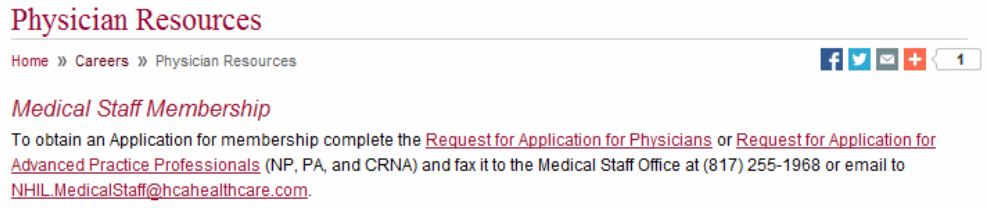
6) The applicant shall maintain professional liability insurance coverage through an insurance carrier authorized as a licensed provider of professional malpractice insurance, for the clinical privileges requested with limits of at least $200,000 for each claim and $600,000 in aggregate.

7) The individual shall not currently be an Ineligible Person and shall not become an Ineligible Person as defined in these bylaws, during the term of an appointment or granting of clinical privileges.

8) No individual shall be eligible for or continue to hold medical staff membership or clinical privileges when the individual has a conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) violence against another, or (v) related to the practice of a health care profession and/or the safety of patients and staff, even if not yet excluded, debarred, or otherwise declared Ineligible.

North Hills Hospital
An Affiliate of HCA

APPLICATION PROCESS
FREQUENTLY ASKED QUESTIONS

QUESTION	ANSWER
How do I obtain an application?	***Go to http://northhillshospital.com/careers/physician-resources.dot***  Download the appropriate pre-application for Physician or Advanced Practice Professional. Fill out the form and attached requested items. Return all to Medical Staff Services.
How long will it take to receive the full application (RFC)?	***24-48 Hours from request*** Once the completed pre-application is received by Medical Staff Services and assured minimum documentation for a full application is received, they will notify the Central Processing Center (CPC) to send a full application. Depending on how the Delegate Authorization form is completed, an application can be via the On-line application (HCO), emailed or sent regular mail. On average this takes approximately 24-48 hours once the request is made by Medical Staff Services.
Once I submit the application (RFC) to the CPC, how long is the process?	***45-60 Days from receipt of complete application (RFC)*** The Central Processing Center (CPC) will determine if a received application is a complete application. They will not begin processing the application without the following forms: 1. Request for Consideration (The Texas Standard Application – all 20 pages) 2. The HCA Addendum to the State Application with a current signature and date. 3. Delineation of Privileges form 4. Authorization, Attestation and Release form with a current signature and date. Upon the determination of completeness, the verification process can begin and will take approximately 45-60 days. A deadline will be set and the CPC will release the file to Medical Staff Services by that date regardless of if the verification process is completed or not.
How can I assist in expediting my application process?	***Assure your application packet (RFC) is complete.*** Other helpful tips include the following: 1. Don't leave anything blank or unanswered on your pre-application, application or addendum. 2. Provide full contact information for all training, affiliations and references including emails, phones and faxes. 3. Submit a case log from the prior 2 years from your primary facility and assure that it meets the criteria on the privilege form. The privilege form provides criteria details. Please review it carefully. 4. Provide written explanations for any adverse responses.
Is my application (RFC) approved when the CPC releases the file to the Medical Staff Office? (Timeline is dependent on completeness of file and responsiveness of applicant to requested documents. If the application is deemed complete it will be reviewed for the next cycle of committees)	***NO***. The application is not approved until it has been audited by Medical Staff Services, reviewed by the appropriate Department Chairman, Credentials Committee, Medical Executive Committee and the Board of Trustees, where the final decision is made. Upon receipt of the application and verifications from the CPC, Medical Staff Services must audit all verifications, complete any verifications not obtained by the CPC, and assure that all facility specific documents are present. Additionally, Medical Staff Services will assure that membership and privilege criteria is met. At any point during this review process you may be asked for additional information. It is important to respond to all requests as soon as possible. Any requests not responded to or information not submitted may deem your application incomplete and withdrawn. You will also be required to schedule an appointment with Medical Staff Services for an in-person orientation and verification of identity, at which point, a photo will be taken for your badge. However, you cannot have your badge until after the Board has made the final approval.

North Hills Hospital
An Affiliate of HCA

APPLICATION PROCESS
FREQUENTLY ASKED QUESTIONS

QUESTION	ANSWER
What will happen if I do not respond timely to requests for clarification or missing information?	***Your application will be in jeopardy of being deemed voluntarily withdrawn.*** The application, verification and privileging process is a time sensitive process. It is important to respond to requests made by Medical Staff Services as soon as possible. When you do not respond or information is missing, the Chairman and Committees reviewing your application may not have enough information to make a decision. If your file continues to be incomplete, your application can be voluntarily withdrawn. The consequence of a withdrawn applications is that you may have to begin the process from the beginning again and because each document in your file has an expiration date there may be items that have to be re-verified, re-signed or re-attested to. This can most importantly cause additional work for you as well as the CPC and Medical Staff Services. Medical Staff Services does not want this to happen so please keep in constant communication with the Coordinator working your file.
How often does the Chairman review Credentials files and how often do the Committees meet?	***Monthly.*** Typically, the Chairman will begin reviewing all completed files in the first week of the month. The Credentials Committee meets the 2nd week of the month (subject to change) The Medical Executive Committee meets the 3rd week of the month (subject to change) The Board of Trustees meets the 4th week of the month (subject to change)
Can temporary privileges be granted if I need to start work sooner than the committee schedule allows?	***Generally, temporary privileges are not granted.*** Temporary privileges are reserved for issues arising from an urgent patient care need and granted rarely. An example where temporary privileges may be considered include but is not limited to: 1. A patient in critical need of a highly specialized physician, where no others are on staff. 2. A shortage of physician staff in a high risk/high volume specialty where daily services are required.
How soon can I begin working in the hospital after my application is approved?	***Activation of system accounts may take a couple of days***. Therefore, if you anticipate being schedule to work on the day of approval or shortly thereafter, please notify Medical Staff Services ahead of time. Medical Staff Services can proactively have your accounts created and access ready to start on the first day if necessary.

If you have any other questions, not addressed here, please do not hesitate to contact Medical Staff Services at (817) 255-1195.

We look forward to assisting you.

Thank you,
Medical Staff Services
North Hills Hospital

Please return to the Medical Staff Office at North Hills Hospital
4401 Booth Calloway Road, North Richland Hills, TX (817) 255-1968 – FAX

Demographic Information:

Name: _____ Primary Office: _____

Home Address: _____ _____

City/State/Zip: _____ Office Ph: _____

Specialty: _____ Office Fx: _____

Home Ph: _____ Cell Ph: _____

SSN: _____ DOB: _____

NPI: _____

Sponsoring Physician (If you need more space, please use separate sheet):

Name: _____ Email: _____

Office Ph: _____ Office Fx: _____

Name: _____ Email: _____

Office Ph: _____ Office Fx: _____

Name: _____ Email: _____

Office Ph: _____ Office Fx: _____

Please tell us which you are applying for by checking the appropriate box below:

☐	Physician Assistant Specialty Area: _____ Are you certified by the NCCPA? ☐ YES ☐ NO
☐	Advanced Nurse Practitioner Specialty Area: _____ Are you certified by the AANP/ANCC/Other certificate? ☐ YES ☐ NO If "Other" please list board: _____
☐	Certified Registered Nurse Anesthetist * Must have current ACLS

Please note for PA's and NP's will need a current ACLS and BLS to obtain and maintain privileges at North Hills Hospital, as well as current certification in your area of specialty. ER PA's and NP's will need to maintain a current ACLS, BLS, and PALS certification.

Please return completed form via fax to the Medical Staff Office at (817) 255-1968 or by email to NHIL.medicalstaff@hcahealthcare.com

Please return to the Medical Staff Office at North Hills Hospital
4401 Booth Calloway Road, North Richland Hills, TX (817) 255-1968 – FAX

Answer the following:

Do you currently hold privileges at other HCA hospitals? ☐ YES ☐ NO

If yes, please list: _____

I request an application for appointment to the Advanced Practice Professional Staff. I understand that the information requested on this application form is sought to enable the hospital and its Medical Staff to make an administrative determination as to whether I am eligible to receive an application. The request for an application form does not constitute an application.

I hereby release from any and all liability, and agree not to sue the hospital and its representatives for their actions in connection with evaluating the information provided on this form and determining whether or not I am eligible to receive an application.

I understand that a determination that I am ineligible to receive an application does not give rise to any hearing rights under the Medical Staff Bylaws, Polices and Procedures.

_____ _____
Signature Date

CHECKLIST OF DOCUMENTS ENCLOSED THAT MUST BE COMPLETED AND RETURNED WITH THIS APPLIATION

- ☐ Application Fee of $200.00 for APP's made out to "North Hills Hospital"
- ☐ HCA Sponsoring Practitioner Agreement
- ☐ PA/NP ONLY – Rules of Conduct and Statement of Compliance
- ☐ Provider Delegate Form
- ☐ MRSA Form
- ☐ NHH Letter of Expectation
- ☐ Documentation of Vaccines/Immunizations as outlined in the NHH Vaccine Policy
- ☐ Code of Conduct Acknowledgement

NORTH HILLS HOSPITAL	POLICY DESCRIPTION: Orientation of Medical Staff Members/Advanced Practice Professional
PAGE: 1 of 2	POLICY NUMBER:

ORIGINAL DATE OF ISSUE: 9/18/2012	REVISION/REVIEWED DATES: 06/13 02/15
FUNCTIONAL AREA/DEPARTMENT: Medical Staff Services	RETIRED:
OWNER & TITLE: Director of Medical Staff Services	
APPROVAL COMMITTEE: Credentials Committee; Medical Executive Committee; Board of Trustees	

SCOPE: All applicants of the medical staff and advanced practice professionals with the exception of telemedicine. Telemedicine includes: Tele-neurology and Tele-radiology that live outside the service area.

PURPOSE: To provide new Medical Staff Members and Advanced Practice Professionals with an orientation and education regarding North Hills Hospital's (NHH) facility, the staff, services provided, and the standards and expectations set forth by the Hospital and the Medical Staff.

POLICY: It is the policy of the Medical Staff of North Hills Hospital that all Medical Staff Members and Advanced Practice Professionals must attend an in-person orientation as part of the credentialing process. The application will not be approved unless the orientation is attended.

PROCESS:

1. No more than 30 days after the practitioner has submitted their application to Parallon Houston Credentialing Processing Center (CPC), they should contact Medical Staff Services at (817) 255-1195 to begin the process of scheduling their orientation. Multiple staff schedules must be coordinated so early scheduling is important.
2. The medical staff orientation may take between 2 and 3 hours and will include at a minimum the following:
    a. Key Bylaws and Rules and Regulations/Medical Staff Policies and Procedures – Standards and Expectations
        i. Core Measure Compliance
    b. Key services
    c. Tour of the service area
    d. Orientation to systems including Computerized Physician Order Entry (CPOE)
        i. If CPOE training is not completed, a badge will not be provided until system training is complete. Confirmation of training completion will be submitted to Medical Staff Services by the Advanced Clinicals Department.
    e. Verification of Identity

3. Prior to the Governing Board meeting, the applicant must arrange for and complete orientation with the Director of Medical Staff Services. The Medical Staff Coordinator will assist in arranging the appointment. Note: Attending orientation does not mean in any way that the application is approved. It is still pending review by the medical staff committees.

4. Failure to attend the orientation will render the application incomplete.. The application will not advance to the governing body for consideration without the orientation being completed, unless previously approved for an extension as noted in paragraph 4.

5. Exceptions or extensions must be approved by the Department Chairman with ratification by the Credentials Committee or Medical Executive Committee and may not be more than 30 days from the

Committee approval date. If Orientation is not complete by the expiration of the extension, then the Request for Consideration (RFC)/Application is voluntarily withdrawn. The practitioner will need to reapply to be re-considered

a. A written request for exception or extension must be provided to the attention of the Department Chairman care of Medical Staff Services prior to the Credentials Committee or Medical Executive Committee for consideration.

6. Orientation materials are also made available via the intranet after approval for future reference.

SPONSORING PRACTITIONER AGREEMENT
To Be Completed at Initial Credentialing or Change in Sponsor

I hereby certify that _____ is under my supervision in the capacity of _____ and that he/she will be under my direction at all times.

I have reviewed the scope of practice for his/her discipline as defined under the regulation of this State, and hereby attest that this individual has the appropriate training, is knowledgeable and skilled to perform the privileges requested. I provide the required supervision and accept responsibility for the patient care services provided by this individual.

I understand that he/she shall have only such authority as is necessary to perform the duties and tasks indicated in his/her approved clinical privileges. Questions of authority shall be referred to me for case-by-case resolution.

To my knowledge, his/her health status is adequate to permit him/her to provide patient care services for which clinical privileges have been requested

I further agree to notify the Entity's Medical Staff Services Office(s) if I no longer require services of the above named.

Signature: _____ Date: _____

(***Original signature is needed, signature stamps cannot be accepted***)

SPONSORING PRACTITIONER EVALUATION

☐ I am unable to evaluate _____as I am a new sponsor.
Please skip Sections I – III, sign and date bottom of professional reference questionnaire.

☐ I am currently a sponsor for _____ at the following entities: _____

_____

☐ I am unable to evaluate _____ at this time due to _____
Please skip Sections I – III, sign and date bottom of professional reference questionnaire.

Based on your personal knowledge, we would appreciate your candid, written appraisal of this provider, particularly anything that warrants caution in granting him/her appointment or particular clinical privileges. Your evaluation should be based on demonstrated performance compared to that reasonably expected of a provider with a similar level of training, experience and background. A copy of his/her delineation of clinical privileges is attached so that you may assess the appropriateness of the privileges for which he/she has requested.

Last Modified: 07/27/2012
Version: 4.1

I. PROFESSIONAL RELATIONSHIP

1. During what time period, in what setting (i.e., office, hospital), and with what frequency (i.e., daily, weekly, infrequently) did you have the opportunity to directly observe his/her practice?

   _____

2. Were you previously, are you now, or are you about to become related to this provider as family or through a professional partnership or financial association? ☐ Yes ☐ No

   If yes, please explain: _____

3. To the best of your knowledge, has the provider's license, clinical privileges, hospital appointment, affiliation with any healthcare organization, or other professional status ever been denied, challenged, investigated, terminated, reduced, not renewed, limited, withdrawn, suspended, revoked, modified, placed on probation, or voluntarily surrendered, or do you have knowledge of any such actions that are pending?
   ☐ Yes ☐ No ☐ No Information

   If yes, please explain: _____

   _____

4. Do you know of any malpractice action instituted or in process against the provider?
   ☐ Yes ☐ No ☐ No Information

   If yes, please explain: _____

   _____

II. PROFESSIONAL KNOWLEDGE, SKILLS, AND ATTITUDE

If you do not have adequate knowledge to answer a particular question, please indicate No information (NI)

1. Evaluation of General Competencies:

Patient Care:	**Superior**	**Good**	**Average**	**Marginal**	**Poor**	**NI**
Gathers accurate and essential information about patients	❑	❑	❑	❑	❑	❑
Makes informed diagnostic and therapeutic decisions based on patient information and preferences, scientific evidence, and clinical judgment	❑	❑	❑	❑	❑	❑
Effectively develops and carries out patient management plans, including obtaining appropriate consults when needed	❑	❑	❑	❑	❑	❑
Care is compassionate	❑	❑	❑	❑	❑	❑
Availability and thoroughness in patient care	❑	❑	❑	❑	❑	❑
Medical/Clinical knowledge:	**Superior**	**Good**	**Average**	**Marginal**	**Poor**	**NI**
General medical knowledge	❑	❑	❑	❑	❑	❑
Judgment, technical and clinical skills	❑	❑	❑	❑	❑	❑
Application of knowledge to clinical problem-solving, clinical decision-making, and critical thinking	❑	❑	❑	❑	❑	❑
Practice-based learning and improvement:	**Superior**	**Good**	**Average**	**Marginal**	**Poor**	**NI**
Analyzes and evaluates practice experiences and implements strategies to continually improve the quality of patient care	❑	❑	❑	❑	❑	❑
Develops and maintains a willingness to learn from errors and use errors to improve the systems or processes of care	❑	❑	❑	❑	❑	❑
Interpersonal and communication skills:	**Superior**	**Good**	**Average**	**Marginal**	**Poor**	**NI**
Ability to communicate verbally with patients	❑	❑	❑	❑	❑	❑
Rapport with patients	❑	❑	❑	❑	❑	❑
Use of effective listening, nonverbal questioning, and narrative skills	❑	❑	❑	❑	❑	❑
Ability to work/cooperate with physicians, nursing staff, advanced practice professionals, hospital administration, and support staff	❑	❑	❑	❑	❑	❑
Interacts with consultants in respectful, appropriate manner	❑	❑	❑	❑	❑	❑
Maintains comprehensive, timely, and legible medical records	❑	❑	❑	❑	❑	❑

Professionalism:	Superior	Good	Average	Marginal	Poor	NI
Demonstrates behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to cultural diversity.	❑	❑	❑	❑	❑	❑
Adherence to Medical Staff Bylaws, Rules & Regulations, Policies and Procedures	❑	❑	❑	❑	❑	❑
Systems-based Practice:	**Superior**	**Good**	**Average**	**Marginal**	**Poor**	**NI**
Actively participates in Medical Staff affairs	❑	❑	❑	❑	❑	❑
Applies evidence-based, cost-conscious strategies to prevention, diagnosis, and disease management	❑	❑	❑	❑	❑	❑
Appropriately uses resources (necessary for admissions, procedures, LOS, tests, etc.)	❑	❑	❑	❑	❑	❑

2a. I provide the required supervision and accept responsibility for the patient care services provided by this individual. My recommendation concerning the specific clinical privileges/services requested is:

☐ Recommend for all requested ☐ Do not recommend certain privileges/service

☐ Limit certain privileges/services ☐ Do not recommend for any privileges/services

2b. Please explain any reservations or concerns regarding any specific privileges/services requested by the provider:

_____

_____

3. Have you ever observed or been informed of any problems which the provider has or had that have or could potentially affect his/her ability to exercise all or any of the privileges requested or to perform the duties of appointment? ☐ Yes ☐ No ☐ No information

If yes, please explain: _____

_____

III. SUMMARY: My recommendation concerning this provider's request for consideration is:

☐ Recommend ☐ Recommend with reservation ☐ Do not recommend

Additional comments, information, or recommendations: _____

_____

_____

Signature: _____ Date_____
(***Original signature is needed, signature stamps cannot be accepted***)

North Hills Hospital
An Affiliate of HCA

INVOICE

$300.00 – Medical Staff Application Fee
$200.00 – Adv Practice Prof Staff Application Fee

Please send payment to:
North Hills Hospital
Medical Staff Services
4401 Booth Calloway Rd.
North Richland Hills, TX 76180

PLEASE SEND BACK WITH YOUR PAYMENT

Provider Name: _____

North Hills Hospital Application Fee

Please check (✓) which payment you are submitting:

☐ **$300.00 – Medical Staff Application Fee**

☐ **$200.00 – APP Staff Application Fee**

Please make checks payable to "North Hills Hospital"

HCA Credentialing Online - Provider's Authorization for Delegate

Step 1

The contact information listed below has been pre-populated based on your information in our credentialing system. If changes are needed, please indicate below.

Provider Name: .

Provider Phone: .

Provider Email (required): _____

NOTE: Provider email must be unique to the provider; it cannot be the same address as a delegate.

Step 2

☐ I do not want to select any delegates at this time. I will personally provide re-credentialing information.
_____ *initial and skip to Step 3*

☐ I understand that one delegate for all entities is preferred; however, I have different people handle my credentialing at different entities. The delegate listed below is my primary delegate for HCA access.

☐ The delegate listed below is my delegate for all entities.

☐ I hereby authorize:

Delegate

name:
email:
phone: ( ) - ext.

(hereinafter, individually referred to as "Delegate") to access the HCA Credentialing Online web portal to enter data and submit documents for the HCA Requests for Considerations (RFC) and HCA Reappointment Requests for Information (RRFCs) requests on my behalf. I understand that I will need to review the data and documents and attest to their accuracy before I submit them to HCA via the HCA Credentialing Online web portal.

I acknowledge that I have voluntarily provided the above information, and I have carefully read and understand this Authorization. I understand and agree that a facsimile or photocopy of this Authorization shall be as effective as the original.

_____ PROVIDER SIGNATURE

_____ NAME

_____ SOCIAL SECURITY NUMBER or NPI

_____ DATE (MM/DD/YYYY)

Step 3

Please complete, sign and date. The form may be returned via:

1. Scanned and e-mailed to email below
2. Faxed to the attention of the Intake Team at the fax below or
3. U.S. mail to the address below

North Hills Hospital
An Affiliate of HCA

MRSA Nasal Swab Order– Physician/Practitioner Attestation

Signatures within this document represent review and acceptance that the MRSA nasal screening protocol will be implemented for the patient populations defined below.

- Patients admitted or transferred into a critical care unit anywhere in the hospital (all adult critical care units, excludes telemetry)
- Patients admitted/transferred from Nursing home, Long Term Care Facility, Other Healthcare Facility (rehab and assisted living facility), Other Hospital, Jail/Prison, or Homeless Shelter
- Patients undergoing total hip, total knee, open spine, CABG procedures and implant devices.
- Chronic Dialysis Patients
- Patients with a history of MRSA (defined as a positive nasal swab within the last 365 days) may be placed directly into isolation without a nasal screen

Physician's will be notified of positive screenings during daytime hours (between 7a.m. and 8p.m.).

_____ _____

Physician Printed Name and dictation number Date

_____

Physician Signature

North Hills Hospital Medical Staff
Communicable Disease Screening and Immunization Record
CHECKLIST FORM

In accordance with medical staff requirements, completion of the Communicable Disease Screening and Immunization Record is required.
Please sign and date this form and attach documentation for each section with the noted guidelines below

TUBERCULOSIS SCREENING	FREQUENCY
• North Hills Hospital is considered a low TB risk facility; therefore documentation for TB at North Hills Hospital will include a TB test (or chest Xray if TST positive) followed by an annual screening form thereafter. However, if you've had a TB test this year we can accept either the test results or the enclosed annual screening form	ANNUAL TB Screening form is attached.
INFLUENZA IMMUNIZATION	
Please attach proof of your current influenza immunization within the last year (or most recent flu season) (Flu Season is between November 1st – March 31st)	ANNUAL
HEPATITIS B VACCINATION PROGRAM Based on risk	
ATTACH PROOF OF HEPATITIS B SEROLOGIC TESTING. If your serologic testing is positive, no further documentation is needed; If your serologic testing is negative, please provide the following: • Obtain a 2nd Hepatitis Vaccine series, recheck titer and submit documentation OR • Complete the Hepatitis B Declination form.	ONCE IN LIFETIME
REQUIRED VACCINATIONS - ATTACH PROOF OF THE FOLLOWING ACCORDING TO DOCUMENTATION REQUIRED:	
VARICELLA: ATTACH WRITTEN DOCUMENTATION OF: • Vaccination With 2 Doses Of Varicella Vaccine; OR • Laboratory Evidence Of Immunity Or Laboratory Confirmation Of Disease; OR • Diagnosis Or Verification Of A History Of Varicella Disease By A Healthcare Provider Who Diagnosed The Disease; OR • Diagnosis Or Verification Of A History Of Herpes Zoster By A Healthcare Provider Who Diagnosed The Disease	ONCE IN LIFETIME FOR ALL
RUBEOLA: ATTACH WRITTEN DOCUMENTATION OF: • Vaccination With 2 Doses Of Live Measles Or MMR Vaccine Administered At Least 28 Days Apart; OR • Laboratory Evidence Of Immunity; OR • Laboratory Confirmation Of Disease; OR • Birth Before 1957 Is Not Required To Provide Documentation	
MUMPS: ATTACH - SAME AS RUBEOLA	
RUBELLA: ATTACH WRITTEN DOCUMENTATION OF: • Vaccination With 1 Dose Of Live Rubella Or MMR Vaccine; OR • Laboratory Evidence Of Immunity; OR • Laboratory Confirmation Of Rubella Infection Or Disease; OR • Birth Before 1957(Except Women Of Childbearing Potential Who Could Become Pregnant, Although Pregnancy In This Age Group Would Be Exceedingly Rare).	
Meningococcal: Attach written documentation of 2 doses of MCV4 vaccine series followed by booster every 5 years for microbiology staff working with these microbes- Laboratory Members Only.	LABORATORY ONLY EVERY 5 YEARS
TDAP: ATTACH PROOF OF ONE CURRENT ADULT BOOSTER OF TDAP FOLLOWED BY TD BOOSTER EVERY TEN YEARS	EVERY 10 YEARS

I attest that the documentation and information I submitted is true.

Signature/Date:_____

Print Name: _____

COLLABORATIVE PRACTICE AGREEMENT FOR PHYSICIAN ASSISTANTS AND ADVANCED REGISTERED NURSE PRACTITIONERS

PRACTITIONER NAME:_____

TABLE OF CONTENTS AND INSTRUCTIONS

I. PURPOSE

THE PURPOSE OF THIS DOCUMENT IS TO:

1. Describe the scope of practice for Advanced Practice Professionals (APP) when initiating management and care for patients of their sponsoring physician working in the Hospital Facility of North Hills Hospital, North Richland Hills, Texas.
2. Serve as written authorization for the APP to initiate medical aspects of patient care, including written physician and nursing orders, and the carrying out or signing of prescription drug orders as determined by the *Delegation of Prescriptive Authority Protocol for Physician Assistants/Advanced Registered Nurse Practitioners included herein*.

SITE WHERE PROTOCOLS WILL BE USED:

The PA/ARNP will provide care under this Protocol to patients at the following location:

Type of Facility: HOSPITAL
Name of facility: NORTH HILLS HOSPITAL
Address: 4401 BOOTH CALLOWAY ROAD, N RICHLAND HILLS, TX 76182

This location represents a Facility Based practice site as that term is defined in Texas Occupations Code, Chapter 157 (Authority of Physician to Delegate Certain Medical Acts) and Texas Administrative Code rules.

II. GENERAL INFORMATION AND CRITERIA

A. APP - The APP must meet all qualifications for hire and continued employment, including:

1. Current criteria for that APP category (ARNP, PA or CRNA) *(Check your appropriate designation)*

___PHYSICIAN ASSISTANTS

a. Graduate of a physician assistant training program accredited by the Accreditation Review Commission on Education for the Physician Assistants Inc
b. Licensed (includes temporary) by the Texas Medical Board;
c. Maintain Certification by the National Commission on Certification of Physician Assistants, Inc.
d. Registered on the sponsoring physicians license as a supervised Physician Assistant
e. Documentation of experience via case log from most recent primary facility from most recent 2 years.
f. BLS/ACLS/PALS/ATLS As required by the Department

___ADVANCED REGISTERED PRACTICE NURSES

a. Current Texas license as a Registered Nurse;
b. Current registration as an advanced practice nurse by Texas State Board of Nurse Examiners;
c. Successful completion of certified nurse practitioner program in requested specialty area;
d. Board certification by AANP, ANCC, or appropriate nursing board in designated area of practice.
    a. For Psychiatric- Mental Health Nurse Practitioner-ANCC certified as Family Psychiatric & Mental Health Nurse Practitioner
e. Registered on the sponsoring physicians license as an Advanced Practice Nurse Delegate
f. Documentation of experience via case log from most recent primary facility from most recent 2 years.
g. BLS/ACLS/PALS/ATLS As required by the Department

2. Credentialing approval and practice privileges as authorization from the Board of Trustees at North Hills Hospital.
3. For Prescriptive Authority Request if applicable: Current documentation with the Department of Public Safety for the State of Texas to prescribe medications and current DEA authorization number for limited prescription of controlled substances as required and delineated in the section 4 "*Delegation of Prescriptive Authority Protocol for Physician Assistants/Advanced Registered Nurse Practitioners*".

PRACTITIONER NAME:_____

B. Physicians - The following must be maintained and up to date with Medical Staff Services in order to delegate medical aspects of care under this guideline (Failure to maintain current documentation with Medical Staff Services will result in suspension of both the sponsoring physician's and Advanced Practice Professional's privileges until renewals are documented and verified per Parallon's policy):

1. Maintain current license
2. Maintain current DEA and DPS
3. Maintain specialty certifications if required
4. Maintain current Malpractice coverage
5. Maintain Privileges to practice at North Hills Hospital

C. Type of Setting Where Guideline Will Be Used

1. The APP is authorized to provide medical aspects of care under this guideline to patients in the following settings within North Hills Hospital:

1. Patient floors; North Hills Hospital; and *(Please select the areas where you will provide services)*

- ☐ Inpatient telemetry units,
- ☐ Inpatient non-telemetry units
- ☐ Critical care units,
- ☐ Senior Clinic
- ☐ Surgical Unit, Operating Room, PACU
- ☐ Geriatric Behavior Unit,
- ☐ Emergency Department

III. RULES

1. APP will wear the appropriate identification badge displaying their designated credentials.
2. APP may not render general medical services nor do any task to any patient unless said patient has been informed that the APP is not a physician. Service will be rendered by the APP only after the patient has consented. The patient has the right at any time to decline evaluation by the APP and will subsequently be seen by a physician
3. APP should introduce them self to the patient at the time of care, but when not solicited is not obligated to differentiate their credentials. If asked, the APP will appropriately identify his or hers credentials; PA-C, NP, CRNA appropriately
4. APPs will not work when the sponsoring physician is not available.
5. APP will not re-delegate any tasks assigned him/her by the sponsoring physician/surgeon
6. If for any reason, the APP discontinues working for the supervising physician, the supervising physician shall inform the North Hills Hospital Medical Staff Office of such termination within seventy-two (72) hours from the effective date thereof. Failure to notify such termination may jeopardize future approvals by the Board of such supervising physician.
   a. Upon termination of employment of the MLP, their specific services may be immediately suspended without notice to them.

IV. PHYSICIAN-APP RELATIONSHIP

Physician Responsibilities

The sponsoring physician will perform the following functions in relationship with the APP:

1. **Supervision** - The delegating physician(s) will provide continuous supervision (constant physical presence of the physician is not required) of the PA/ARNP regarding aspects of care under this Protocol and in accordance with state law including, but not limited to, the Texas Medical Practice Act and Texas Medical Board (TMB) rules. The delegating physician(s) shall comply with all other physician requirements related to delegation of prescriptive authority.
2. **Quality Assurance with Prescriptive Authority**. The Supervising Physician at the facility will review the delegated PA/ARNP's controlled substance orders and prescriptions biannually for two years. For all current providers the two year period will start from the date this Protocol is signed. For all new providers, the review will occur for the first two years of their employment.
   a. The purpose of the controlled substance review will be to analyze the PA/ARNP appropriateness related to dosing and medication selection to identify and act on issues that need to be addressed.
3. **Ongoing Professional Practice Evaluation** - The Supervising Physician will document the biannual review of each PA/ARNP and the documentation will be a part of the facility's Focused and Ongoing Professional Practice Evaluation process.
4. **Consultation**
   a. The physician(s) will be available for collaboration and supervision
   b. It is understood that the APP will have ongoing dialogue with the sponsoring physician. The APP will discuss with the sponsoring physician every patient seen and will bring to his or her attention problems that do not respond within the expected period of time to treatments initiated by the APP, and chronic problems that become unstable.
   c. The APP will notify the sponsoring physician immediately when acute health problems of a complex nature require the physician's immediate attention.
5. **Standard of Patient Care** - The physician will collaborate with the APP to maintain the standard of patient care through concurrent supervision of the APP and patient and through continuous review of APP medical records.

PRACTITIONER NAME:_____

v. SCOPE OF PRACTICE AND MEDICAL FUNCTIONS AUTHORIZED and PRIVILEGES REQUESTED

Applicable Patient Populations and Health Conditions

The APP will be supervised by a Sponsoring Physician in the care of patients. The care provided by the APP under this guideline shall be in connection with providing medical management to adult patients including emergent, urgent, sub-acute, non-acute, and complex care in collaboration with the Sponsoring Physician.

Privileges and Functions:

1. **CORE:** The APP is authorized to perform the medical functions identified below. The list below is not an exhaustive description of the APP's practice but rather is illustrative of the types of medical functions the APP will perform. These medical functions shall be in addition to any function the APP is authorized to perform under his or her professional license and hospital privileges. *All orders, progress notes, observations, consultations must be countersigned by the Sponsoring physician as soon as possible*.

- ☐ History & Physical Examination. Gather and document historical and physical information that may serve as the basis for the history and physical, by order of the physician and to be countersigned as soon as possible.
- ☐ Patient Assessment. Perform and document initial impression, assessment and recommended treatment, which will be reviewed and countersigned by the sponsoring physician by dictation or writing as soon as possible. The physician's documentation will include any changes to the plan and/or patient assessment.
- ☐ Medical Diagnosis. Make diagnoses and prescribe treatments and therapies in the routine management of the sponsoring physician's patient population.
- ☐ Laboratory and Diagnostic Tests. Order, obtain, and review/interpret diagnostic studies including hematologic studies, blood chemistries, cardiac enzymes, microbiologic studies, culture and sensitivities, infectious disease profiles, immunodiagnostic studies, cytologic studies, urine analysis, thyroid function studies, lipid panels, coagulation profiles, liver function tests, iron studies, therapeutic drug monitoring, nutritional studies, radiographic examinations (i.e., chest radiograph, abdominal radiograph, computed tomography, magnetic resonance imaging), ultrasound, electrocardiogram, echocardiogram.
- ☐ Patient Safety and Monitoring. Restraints may only be ordered by a physician; APP's may monitor restraints according to hospital department guidelines/standards.
- ☐ Consultation. Gather information for consultant physician. Order and refer patients to other appropriate health care providers for the purpose of management or consultation as deemed necessary by the sponsoring physician. These providers include but are not limited to occupational therapy, physical therapy, respiratory therapy, cardiac rehabilitation therapy, speech therapy, case management/social services, home health, rehabilitation/long-term care facilities, outpatient specialty/follow-up clinics, and hospice agencies. The APP may also refer patients to appropriate consulting physicians in collaboration with the sponsoring physician. These consultants include oncologists, hematologists, cardiologists, cardiothoracic surgeons, gastroenterologists, infectious disease specialists, pulmonologists, psychiatrists, critical care and other types of specialties.
- ☐ Dictate Discharge Summary. Dictate discharge summary to be reviewed and countersigned by the sponsoring physician.
- ☐ Patient Education. Perform patient and family education
- ☐ Review Charts. Review Charts, check lab and x-ray results to discuss with sponsoring physician.
- ☐ Rounding. Make initial rounds for a sponsoring physician as delegated by the physician. Sponsoring physician will provide follow-up rounding for the patient daily. May not round in lieu of physician.
- ☐ Verbal and Telephone Orders. Verbal or telephone orders from the APP and/or sponsoring physician may be accepted and transcribed in the medical record. Such orders will be personally validated and countersigned by the supervising physician as soon as possible.
- ☐ Initial Orders. May initiate or change orders with physician oversight. The sponsoring physician will review and countersigned orders as soon as possible.
- ☐ Prescribe Medications. Complete Section 4 below for Prescriptive Authority as applicable to criteria.
- ☐ Treatment and Therapies. Complete Section 2 below based of your training and experience per criteria.

PRACTITIONER NAME:_____

2. **TREATMENTS AND THERAPIES (SPECIAL):** The APP may perform treatments and therapies in the management of the sponsoring physician's patients as determined by the scope of clinical privileges granted to the sponsoring physician.

Special Skills: *Criteria:*

I. **Supervision:** The APP does not act independently and is at all times under the supervision of a sponsoring physician; therefore the APP may only perform and/or assist the sponsoring physician in performing procedures for which the sponsoring physician has privileges and is providing on-site supervision. If the sponsoring physician does not have a specific privilege, including any specific privileges listed on this form, the PA/APRN shall not perform that privilege:

II. **The APP may perform procedures for which competency has been established through training, certification, licensing and experience**.

These skills include: (*Check those that apply to your scope of practice for which you can demonstrate competency and have your current or prior sponsoring physician complete the attestation below*)

- ☐ Wound repair
- ☐ Suture/staple removal
- ☐ Basic wound management including debridement
- ☐ Cleaning, and sterile dressing changes
- ☐ Local anesthetic infiltration
- ☐ Insertion of invasive lines
- ☐ Removal of central venous catheters
- ☐ Phlebotomy
- ☐ Bipap monitoring
- ☐ Bedside glucose monitoring
- ☐ Bedside monitoring devices & alarms
- ☐ Writing prescriptions per prescriptive authority under section
- ☐ Abscess incision and drainage
- ☐ Foley placement; splinting and casting
- ☐ Ingrown toenail removal
- ☐ Prescribe durable medical equipment such as walkers or canes when appropriate.

ADDITIONAL SPECIAL PRIVILEGES WITH SEPARATE CRITERIA

- ☐ Lumbar Puncture (**Additional Criteria: Documentation of Training and experience via a case log from the prior 2 years.**)
- ☐ Central Venous Catheter Insertion (**Must be applied for using a separate privilege request form**)

SPONSORING PRACTITIONER ATTESTATION TO COMPETENCY OF SPECIAL SKILLS ABOVE:

I hereby certify that this APP is or has been under my supervision FROM _____ TO _____ (ENTER DATES REPRESENTING TIMEFRAME WHEN SUPERVISED) at _____(ENTER NAME OF FACILITY OR PRACTICE WHERE SUPERVISED) where I have witnessed to his or her experience in the above skills and based on my direct observations, I attest to their competency in performing each skill requested.

LIST ANY EXCEPTIONS:_____

_____

OTHER COMMENTS:_____

_____

Signature: _____ Date: _____

_____

(PRINT SPONSOR NAME)

PRACTITIONER NAME:_____

3. PRACTICE SPECIFIC PRIVILEGES – You may only request privileges within the area of practice for your sponsor. *(If you do not work in the Emergency Department or the Operating Room, skip to section 4.)*

☐ **Emergency Department APP Core -** under the supervision of the Attending Emergency Physician include performing medical screening exams, recognizing/evaluating situations that require the immediate attention of the Attending Emergency Physician and institute, when appropriate, treatment procedures essential for emergent stabilization of the patient. Privileges include performing and/or assisting with appropriate evaluation, management, and disposition for urgent and emergent conditions presenting to the emergency department; instructing and counseling patients regarding matters pertaining to their physical and mental health, social habits, and understanding of management of their illness; and initiating orders and treatment plans under the authority of sponsoring physicians. Core privileges include performing usual and standard diagnostic and therapeutic procedures under the supervision of the attending emergency physician, which reflect normal Emergency Department care. The following procedures are included in the Emergency Medicine APP Core. *Please check those you are requesting*.

- ☐ **Endotracheal Intubation**
- ☐ **External Cardiac Massage**
- ☐ **Defibrillation**
- ☐ **Cardioversion**
- ☐ Discharge of lower acuity patients as defined in the Emergency Department "Policy on the Care and Treatment of Low Acuity Patients Presenting to North Hills Hospital"

CRITERIA: Level I and II Trauma – ATLS required within 9 months of applying for privileges for all APP's working in the Emergency Department.

Emergency Medicine Special Privileges – *Please check those procedures you can demonstrate training and current competency for:*

☐ **Chest Tubes** (Only as assistant to the Emergency Medicine Physician; Cannot be performed independent of the physician)
Initial Criteria: Provide evidence of training and experience
Reappointment: Documentation of current competency

☐ **Lumbar Puncture (Required privilege for Emergency Practitioners)**
Initial Criteria: Provide evidence of training AND experience if available. Proctoring under the supervision of the Emergency Physician is required for the first 5 cases
Reappointment: Documentation of current competency

☐ **Central Lines** (must complete Aim for Zero criteria) done subclavian, femoral and jugular. This privilege will be considered on a case by case basis.
Initial Criteria: Provide evidence of training AND experience; Proctoring under the supervision of the Emergency Physician to be determined on a case by case basis dependent upon the level of training and experience.
Reappointment: Documentation of current competency

☐ **Ultrasound**
Initial Criteria: Provide evidence ultrasound was part of training program OR provide documented evidence of successful completion of a related training course; the first 5 cases will be proctored.
Reappointment: Documentation of current competency, and recommendation from the Sponsoring Physician and/or Department Chairman.

- ☐ Abdominal Aorta Evaluation
- ☐ Biliary Evaluation
- ☐ Emergency Cardiac Evaluation
- ☐ OB/Gyn (Endovaginal and Transabdominal) Evaluation
- ☐ Renal Evaluation
- ☐ Vascular/DVT Evaluation
- ☐ Ultrasound Guided Procedures
- ☐ Trauma (FAST) Evaluation

PRACTITIONER NAME:_____

☐ **Surgical/Operating Room APP Core –** Sponsoring physician must be present in the room at all times. When in the Operating Room, any APPs whose specific services include assisting in surgery will be responsible to the supervising Physician Surgeon, the Circulating Room Nurse, and the Director/Assistant Director of the OR in the same manner as technicians and assistants under employ by North Hills Hospital.

- ☐ Assist surgeon with procedure.
- ☐ Prep patient for procedure (shaving, positioning & draping); surgeons are required to mark surgical sites prior to surgery and in accordance with hospital policy
- ☐ Pass instrumentation
- ☐ Suction/sponge surgical field
- ☐ Retraction
- ☐ Clamp, suture, apply cautery
- ☐ Apply/remove drains, packing, dressings & bandages
- ☐ Wound closure in hospital setting, subcutaneous or skin only; BODY CAVITY CLOSURE EXCLUDED; must verify experience in skin closure with current competency in the procedure required. Sponsoring physician must be present in the surgery area. ***SPONSOR USE ATTESTATION BELOW TO CONFIRM.***
- ☐ Application & removal of cast (Orthopedic PAs only)
- ☐ Sever tissue
- ☐ Remove sutures/staples
- ☐ The specific service of First or second assistant consistent with those authorized for nurse first or second assistants.

Surgical Special Procedures – *Please check those procedures you can demonstrate training and current competency and have your sponsor complete the attestation below.*

Criteria for Surgical Special Procedures:
Documentation of twenty (20) cases wherein the Physician Assistant has satisfactorily harvested the saphenous vein; or

a) If no training or experience in performance of vein harvesting, Physician Assistant may be trained under the direct supervision of the surgeon; and
b) After each case has been performed, the Physician Assistant must submit a Special Procedure Skill Assessment form completed and signed by the surgeon who directly supervised the procedure. Documentation of twenty (20) supervised procedures required.

- ☐ Isolating, incising, and removal of the saphenous vein to be utilized for coronary artery bypass grafting, or other vascular surgeries
- ☐ Maintaining hemostasis of the leg incision through use of vascular clips, Bovie and suture with subsequent closure of leg incision
- ☐ Providing specific services as second assist associated with cardiothoracic, pulmonary and vascular surgeries

REQUIRED IF SPECIAL SURGICAL PROCEDURES ARE REQUESTED:

SPONSORING PRACTITIONER ATTESTATION TO COMPETENCY OF SPECIAL PROCEDURES IF REQUESTED ABOVE:

I hereby certify that this APP is or has been under my supervision FROM _____ TO _____
(ENTER DATES REPRESENTING TIMEFRAME WHEN SUPERVISED) at _____
(ENTER NAME OF FACILITY OR PRACTICE WHERE SUPERVISED) where I have witnessed to his or her experience in the above surgical special procedures and based on my direct observations,

- ☐ ***Harvesting the saphenous vein***: I attest to their competency in performing each skill requested and I attest to his/her performance of at least 20 of these procedures under my direction/supervision.
- ☐ ***Wound Closures***: I attest to their competency in performing wound closures in a hospital settings, (Body cavity closure excluded)

LIST ANY EXCEPTIONS:_____

_____

OTHER COMMENTS:_____

Signature: _____ Date: _____

(PRINT SPONSOR NAME)_____

PRACTITIONER NAME:_____

☐ **Psychiatric-Mental Health Nurse Practitioner (PMHNP) APP Core** - practice in a variety of settings as an interdependent member of the health care team, collaborating with other health professionals to provide mental health care services across the lifespan. In addition to general functions performed by the Advanced Practice Nurse, the PMHNP may provide these specific functions via remote presence or in person

- Diagnose and treat common acute psychiatric problems, illness, and crises
- Psychopharmacologic management in collaboration with psychiatrist
- Provide individual, group, and family psychotherapy
- Care for and counsel clients with common identified chronic psychiatric conditions
- Coordinate and integrate multidisciplinary services for clients with complex psychiatric problems
- Monitor common health care problems and refer for specialized medical treatment as needed
- Provide comprehensive family psychiatric-mental health education
- Work with clients and their families in anticipation of developmental milestones, life cycle events
- Perform or recommend age-appropriate screening procedures
- Promote wellness oriented self-care
- Advocate for family psychiatric-mental health clients and their family
- Tele-Psychiatry patient management: Patient consultations using telecommunications to provide medical data which may include audio, still or live images, between a patient and health professional for use in rendering assessment/diagnosis and treatment plan; medication management at the direction of the sponsoring physician.

PRACTITIONER NAME:_____

4. DELEGATION OF PRESCRIPTIVE AUTHORITY PROTOCOL FOR PHYSICIAN ASSISTANTS / ADVANCED REGISTERED NURSE PRACTITIONERS

☐ *NA - I am not requesting Prescriptive Authority Privileges (Skip to Acknowledgement Section page 9)*

PURPOSE - The purpose of this Delegation of Prescriptive Authority Protocol for Physician Assistants/Advanced Registered Nurse Practitioners is to serve as a written description of the scope of practice of the Physician Assistant or Advanced Registered Nurse Practitioner (PA/ARNP) when ordering and/or prescribing dangerous drugs and controlled substances for patients as delegated by the supervising physician(s) as of January 1st, 2015.

DELEGATION OF PRESCRIPTIVE AUTHORITY: The PA/ARNP and Supervising Physician must register with the Texas Medical Board to delegate prescriptive authority for dangerous drugs and controlled substances.

Check each category that is to be delegated to the PA/ARNP

☐ ***Medication Orders*** at Facility: **(Check the box below to designate the level of RX Authority requesting)**
Delegation of Medication orders at Facility:
Once the PA/ARNP is registered with the Texas Medical Board and in accordance with all applicable laws, the PA/ARNP may order medications at the facility as checked below:

- ☐ **Dangerous drugs- Medication orders at Facility**
  Dangerous drugs (defined as all drugs that can only be dispensed with a prescription from a licensed practitioner) may be ordered under this Delegation of Prescriptive Authority Protocol at the Facility.
- ☐ **Controlled Substances, (Must have Schedules III-V- Medication orders at Facility)**
  Controlled Substances, Schedules III-V, may be ordered under the authority of this Delegation Protocol at the Facility.
- ☐ **Controlled Substances, (Must have Schedule II- Medication orders at Facility)**
  Controlled Substances, Schedule II, may be ordered under the authority of this Delegation Protocol at the Facility with the following restrictions:
  - No orders for children under 2 years of age without prior consultation with the physician. Prior consultation must be noted in the chart.
  - Patient is receiving services in the hospital, including extended observation
  - Patient is being admitted to the hospital for an intended period of at least 24 hours

☐ ***Prescriptions*** at discharge from Facility: **(Check the box below to designate the level of RX Authority requesting)**
Once the PA/ARNP is registered with the Texas Medical Board and in accordance with all applicable laws, the PA/ARNP may write prescriptions for patients being discharged from the at the facility as addressed below:

- ☐ **Dangerous drugs** – ***Prescriptions*** **at discharge from Facility**
  Dangerous drugs (defined as all drugs that can only be dispensed with a prescription from a licensed practitioner) may be prescribed under the authority of this Delegation Protocol at discharge from the Facility.
- ☐ **Controlled Substances Schedule III-V** – ***Prescriptions*** at discharge from Facility
  Controlled Substances, Schedule III-V may be prescribed under the authority of this Delegation Protocol at discharge from the Facility with the following restrictions:
  - **PA/ARNP must maintain their own DEA/DPS covering Schedule III, IIIN, IV, and V.**
- ☐ **Controlled Substances Schedule II** – ***Prescriptions*** at discharge from Facility
  Controlled Substances, Schedule II may be prescribed under the authority of this Delegation Protocol at the Facility with the following restrictions:
  - **PA/ARNP must maintain their personal DEA/DPS covering Schedule II.**
  - No prescriptions for children under 2 years of age without prior consultation with the physician. Prior consultation must be noted in the chart.
  - Patient is receiving services in the hospital, including extended observation
  - PA/ARNP may not write prescriptions for Schedule II Controlled Substances that will be filled outside the Hospital

ADDITIONAL RULES PERTAINING TO PRESCRIPTIVE AUTHORITY

A. No limitations or specific instructions or monitoring beyond the ones that would be considered standard for the drug or drug classification (based on definition of protocol in TMB Rule § 193.2(10)). PA/ARNP must meet all other standards and requirements relating to carrying out or signing prescription drug orders by physician assistants and advanced registered nurse practitioners. In addition, PA/ARNP's must comply with all federal, state and local laws and regulations relating to the prescribing of controlled substances, including but not limited to requirements set forth by the Texas Department of Public Safety and the Drug Enforcement Administration.

B. Generic Substitution. The PA/ARNP may authorize a generic substitution.

C. Number of Dosage Units and Refills Permitted. The number of dosage units that PA/ARNP may prescribe shall not exceed a 90-day supply, including refills, except as the supervising physician may otherwise approve.

D. Patient Instruction. PA/ARNP shall provide appropriate follow-up instruction to the patient on use of any medication prescribed including appropriate warnings and monitoring of lab values.

PRACTITIONER NAME:_____

COLLABORATING PARTIES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF ADVANCED PRACTICE PROFESSIONAL

I verify that I have the training and experience and am competent to provide care to patients within my scope of practice as described in this collaborative agreement. I agree to review this document with the physicians listed below and have my practice monitored by the processes set out by North Hills Hospital Professional Practice Evaluation process. By my signature, I agree to be bound by the Medical Staff Bylaws, Rules and Regulations, and all Policies and Procedures of the Medical Staff and understand that non-compliance with any of these may constitute grounds for withdrawal or restriction of privileges.

The following sections of this agreement have been reviewed and completed as applicable to my scope of practice and documentation of my training, experience and competency has been provided as requested:

- ✓ *Purpose*
- ✓ *General Information and Criteria*
- ✓ *Rules*
- ✓ *Physician and APP Relationship*
- ✓ *Scope of Practice - CORE*
- ✓ *Scope of Practice – Treatment and Therapies (SPECIAL); Included is the current or prior sponsor's attestation:*
- ✓ *Practice Specific Privileges for ED and OR*
- ✓ *Delegation of Prescriptive Authority Protocol and Agreement*

_____ _____

Advanced Practice Professional Signature Date

ACKNOWLEDGEMENT OF THE SPONSORING PHYSICIAN

I agree that the above APP is competent to provide care to patients within their scope of practice as described in this document. This agreement has been developed and reviewed in accordance with the policies of North Hills Hospital. The practitioner's care will be monitored in accordance with Hospital Policies, procedures, Rules and Regulations and Medical Staff Bylaws. I also agree to notify the Medical Staff Services Office of any changes in this agreement.

_____ _____

Sponsoring Physician Signature Date

The Medical Director of the Group may sign on behalf of all group members with an attached list of all sponsoring physicians within the group.

REVIEW AND REVISION OF PRACTICE GUIDELINES/PROTOCOL and PRIVILEGES

This collaboration agreement will be reviewed by the Credentials Committee in collaboration with each Medical Staff Department in order to address recommendations for updates and/or revisions any time the need arises in order to reflect current standards of care and/or scope of practice (i.e., legislative changes to scope, development of new treatments/techniques/medications, etc.).

Description of Revision	*Department Review*	*Credentials Committee*	*Medical Executive*	*Governing Board*
Mid-Level Privilege forms, Rules, collaboration Agreement for all APP and Prescriptive Authority Forms combined. Privileges will not include the ability to order restraints.	*CNO 9/8/15* *CMO*	*9/8/15*	*9/16/15*	*9/23/15*
Addition of criteria and scope or Psychiatric-Mental Health Nurse Practitioner	*Chair-* *CNO-10/8/15*	*10/13/15*	*10/20/15*	*10/28/15*