

REQUEST FOR REAPPOINTMENT TO THE MEDICAL STAFF

I hereby request reappointment to the medical staff of:

(Hospital/Health Center) (Town/City) (State)

I request that my clinical privileges be:

- Renewed as presently granted.
- Increased as designated in a memorandum attached hereto.
- Reduced as designated in a memorandum attached hereto.

CONTINUING PROFESSIONAL EDUCATION

Describe topics, sources, and dates of all continuing education you have completed in the past year.

Current CPR, ACLS, ATLS, PALS Training Status

1. Certified in basic life support? _____
Certification expires: _____.
2. Certified in advanced cardiac life support? _____
Certification expires: _____.
3. Certified in advanced trauma life support? _____
Certification expires: _____.
4. Certified in pediatric advanced life support? _____
Certification expires: _____.

LIABILITY CLAIMS AND ADVERSE ACTION

If your answer to any of the following is "yes," please provide full details on an attached separate sheet if this information has not previously been submitted to this medical staff.

1. Have there been any previously successful or any currently pending challenges to any of your licenses or registrations (State or district, Drug Enforcement Administration) or the voluntary relinquishment of licenses or registrations?
YES: _____ NO: _____
2. Has your medical staff membership at another hospital been voluntarily or involuntarily terminated? Have your clinical privileges at another hospital been voluntarily or involuntarily limited, reduced, or lost?
YES: _____ NO: _____
3. Are you currently or have you been involved in any professional liability actions?
YES: _____ NO: _____

Signature

Date

After review of the applicant's performance, in accordance with the medical staff bylaws and as summarized in the IHS Work Sheet for Reappointment to the Medical Staff, I do ___ do not ___ recommend reappointment to the _____ medical staff.

I do ___ do not ___ recommend renewal of clinical privileges as requested above.

Clinical Director

Date

Comments:

I do ___ do not ___ recommend renewal of clinical privileges as requested above.

Service Unit Director

Date

Comments:

Reappointment and privileges are ___ are not ___ approved.

Chair of the Governing Body

Date

TO BE COMPLETED BY CLINICAL DIRECTOR OR DESIGNEE
WORKSHEET FOR REAPPOINTMENT TO THE MEDICAL STAFF OF:

(Hospital/Health Center)

(Town/City)

(State)

Name of Applicant: _____

Note: Any "no" answer on items 1-14 and any "yes" answers on items 15-23 need to be explained fully on attached page(s).

| Description | Yes | No |
|---|--------------------------|--------------------------|
| 1. Is this applicant physically, mentally, and emotionally capable of performing the services required of a member of the medical staff and requested privileges? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has this applicant consistently complied with the medical staff bylaws, rules, and regulations of this facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has this applicant provided verification of current licensure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have favorable reports been received on this applicant's professional competence, clinical judgment, and personal character? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are the privileges being sought the same as those currently granted? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does this applicant relate and work well with other patient care staff? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Is this applicant readily available and responsive when needed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does this applicant regularly attend medical staff meetings? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has this applicant shown willingness to serve on, or chair, appropriate committees when asked to do so? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. When appointed to a committee, has this applicant served in the capacity to which appointed and attended meetings with appropriate regularity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has this applicant willingly participated in the quality assurance program and functions of this IHS facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has this applicant been cooperative in observance of medical staff and hospital procedural rules? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has this applicant been cooperative in compliance with established medical records requirements? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Has this applicant consistently completed medical records within prescribed time limits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have any adverse actions been initiated or any judgments rendered against this applicant or against the Federal Government on the basis of this applicant's patient care practices? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Has this applicant required counseling due to non-conformance with standards in his/her clinical practice or medical staff related activities? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Has any disciplinary action been taken against this applicant? | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> |

| Description | Yes | No |
|---|--------------------------|--------------------------|
| 18. Has this applicant exercised any clinical privileges which had not been granted? | | |
| 19. Has there been any reduction or revocation of clinical privileges for this applicant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Has there been any change in the physical, mental, or emotional health or condition in this applicant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Has this applicant shown evidence of any alcohol or drug abuse or dependency? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Has this applicant had any treatment for alcohol or drug abuse or dependency? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Did the National Practitioner Data Bank query reveal any adverse information? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Relative to the review functions listed, how does this applicant's performance as a member of the patient care staff compare to the staff as a whole in numbers of problems attributed to his/her patient care practices? | <input type="checkbox"/> | <input type="checkbox"/> |

| | Fewer Than Average | More Than Average | Average | Does not Apply |
|---------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Monitoring functions | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Surgical case review | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Pharmacy/therapeutics review | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Medical records review | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Blood usage review | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Antibiotic usage review | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Morbidity/mortality review | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Emergency care review | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Infection control | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Utilization review | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Incidence reports | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l. QA committee reports | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Quantify and comment on any "more than average" ratings.

25. Information presented to the Medical Staff Executive Committee? Yes: ___ No: ___ Date: _____

26. Comments of Medical Staff Executive Committee:

27. Recommendation of the Medical Staff Executive Committee:

- a. ____ Continue membership with privileges as requested, including requested modifications, if any.
- b. ____ Continue membership with same privileges as previously granted. Changes requested by applicant denied.
- c. ____ Continue membership with privileges modified as recommended by the Medical Staff Executive Committee. (Attach these recommendations.)
- d. ____ Discontinue membership.

CERTIFICATION

I certify that the information provided herein is true and correct to the best of my knowledge.

Clinical Director

Date

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

Public reporting burden for this collection of information is estimated to average 60 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: Reports Clearance Officer, Indian Health Service, 801 Thompson Avenue, TMP Suite 450, Rockville, MD 20852, ATTN: PRA (0917-0009). Please *do not send* this form to this address.
