

ST. DAVID'S SOUTH AUSTIN MEDICAL CENTER

REQUEST FOR INCREASED OR NEW CLINICAL PRIVILEGES

PHYSICIAN NAME: _____ **DATE OF REQUEST:** _____

As a Medical Staff member with approved clinical privileges, I am requesting the following increase in privileges or a new clinical privilege as described below:

INFORMATION REGARDING TRAINING AND EXPERIENCE FOR THE ABOVE REQUESTED PRIVILEGE(S):

Check at least one (1) of the following and provide documentation as appropriate:

Residency/Fellowship Program

Name/Location _____ Dates _____

Post Graduate Course

Title of Course _____ Dates _____

Name of institution Providing Course/Location _____ # of CME Hours _____

Did this course include hands-on training? Yes _____ No _____

If so, how many cases were performed? _____ Were these cases proctored? Yes _____ No _____

Experience

Name of Institution/Location _____ Dates _____

Number of Cases Performed _____ (# Supervised) _____ (# Unsupervised)

PROVIDE THE NAME AND CONTACT INFORMATION OF A PEER WHO CAN ATTEST TO YOUR COMPETENCY WITH REGARD TO THE ADDITIONAL PRIVILEGE(S).

Name _____

Address _____ City/State/Zip _____

Phone _____ Fax/email _____

ATTACH an Authorization, Attestation and Release Form

Does your malpractice liability cover the specific privilege that you are requesting? Yes No (Explain)

PLEASE ANSWER THE QUESTIONS BELOW IN RELATION TO YOUR LAST APPOINTMENT OR REAPPOINTMENT. AFFIRMATIVE RESPONSES REQUIRE A FULL EXPLANATION AND DETAILS ATTACHED.

1. Since your last appointment/reappointment have there been any successful or currently pending challenges, or voluntary relinquishment of licensure or registration?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Since your last appointment/reappointment has there been any voluntary or involuntary reduction in privileges, termination of privileges, or membership at any hospital, acute or long term care facility, ambulatory surgery center, or comparable facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Since your last appointment/reappointment has there been any involvement in any liability actions, including any final judgments or settlements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have any medical or psychological condition that could affect your ability to perform the privileges requested?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Physician Signature

Date

St. David's South Austin Medical Center
Robotic Assisted Surgery for Gynecology, Urology,
Cardiothoracic Surgery, and General Surgery
Credentialing Criteria
Robotic-Assisted Surgery Procedures

INITIAL (1ST) TIME REQUEST

1) To initially obtain privileges to perform regular or advanced robotic-assisted surgery (RAS), a physician is required to meet one of the following criteria:

[] **Completion of a Fellowship or Residency training program that included training and experience on a robotic-assisted surgical system (RASS) within the past 3 years:** Applicants who have completed the above are required to provide documentation from their training program director attesting to the applicant's privilege specific experience, competency, case volume, and outcomes;

(OR,)

[] **Vendor certification for an FDA approved robotic-assisted surgical system course within the past 3 years:** Applicants must provide evidence of attendance at a hands-on training practicum in the use of a robotic- assisted surgical system as required by the manufacturer which includes personal time on the system, and evidence of the observation of one (1) case performed by a qualified RASS surgeon;

AND,

The applicant must:

- 1) hold unrestricted privileges to perform all requested robotic-assisted procedures through the standard approach, both open and laparoscopic (when applicable); and,
- 2) arrange specialty specific proctoring of a minimum of the first four (4) cases with outcome data. The first two (2) cases must be proctored by a company trained proctor and the last two by may be by an appropriately privileged physician.

Proctoring outside of SAMC: Advanced cases proctored during fellowship training or at another TJC accredited hospital during the immediate past six (6) months may be included in meeting this requirement.

Proctors Defined: All proctors must be RASS trained and privileged surgeons.

Additional Proctoring: Additional proctoring may be required at the discretion of the Department Chief (see "Proctoring Review & Recommendations" below).

Waiving of Proctoring: If the applicant has performed twelve (12) or more cases (evidenced by case listing & outcome data) in the past twenty-four (24) months some or all proctoring may be waived at the discretion of the Department Chief based on outcome data. Cases performed during fellowship training may be included in meeting this requirement. Other requests for waiver will be considered on a case by case basis at the discretion of the Department Chief and Medical Executive Committee.

Vendor recommended proctors may be exempted from the proctoring by providing case lists showing the completion of a minimum of twelve (12) robotic-assisted surgical cases over the past twelve (12) months. To proctor advanced procedures a minimum of three (3) of these cases must be of the type to be proctored.

Proctoring Review & Recommendations: The Specialty Service Chief will base his/her recommendations on the review of the proctor evaluations and on the unbiased, objective results of care according to the medical staff's focused professional practice evaluation (FPPE) mechanism. This would include but not be limited to the applicant's conformity to outcome standards for: length of stay, blood loss, complications, operating room time, and conversions to laparoscopic or open procedures.

RENEWAL OF PRIVILEGES – Requirements

[] Request for the renewal of existing RASS privileges: For reapplicants to the Medical Staff who wish to maintain RASS privileges, the reapplicant must have performed at least ten (10) RASS cases within the prior twelve (12) months. If these cases were performed outside of the SAMC the applicant must provide documentation of the cases performed including outcomes.

Review & Recommendations of Renewal Requests: The Department Chief will base his/her recommendations for renewal of privileges on the unbiased, objective results of care according to the organization's quality assurance mechanism. This would include but not be limited to the applicant's conformity to outcome standards for: length of stay, blood loss, complications, operating room time, and conversions to laparoscopic or open procedures.

DEPARTMENT APPROVED: 4/8/2010

MEC APPROVED: 4/9/2010

BOARD APPROVED: 4/15/2010

Peer reference for:
Reference provided by:

A. Professional Relationship with Applicant

1. Have you observed or been associated with the applicant's clinical practice within the last five years?

Yes No

If you answered "No", there is no need to complete the remainder of this form. Please fax this form to the number listed at the bottom of this form. Thank you for your prompt response.

2. Approximate time period when you observed or associated with the applicant's practice?

From: _____ To: _____ (give approximate date range)

3. Practice setting where you observe/associate with the applicant? (check all that apply)

Office/ Clinic
 Hospital
 Other _____

4. Average frequency of your observations or associations with the applicant?

Daily/Weekly
 Monthly/Quarterly
 Other _____

5. Your relationship to applicant? (check all that apply)

Instructor
 Practice partner of the applicant
 Referring or consulting physician to the applicant
 In same specialty but not in same practice
 Department/specialty section chairman
 Other _____ (please include any family relationships, business partnerships, or other relationships)

6. Please indicate the type(s) of information you are using to complete your evaluation. (check all that apply)

Chart review
 Direct observation
 Co-managing patients
 Patient comments
 Applicant's reputation
 Other _____ (please describe)

B. Health Status, Capabilities, Disciplinary History, and Liability Actions

7. Please review the applicant's requested clinical privileges, which are included with this evaluation request (if applicable). Based on your observations, is the applicant currently competent to perform the clinical privileges requested?

Yes No* (please comment on separate page) N/A (clinical privileges not requested)

8. Do you have any concerns related to the applicant's ability to perform clinical privileges (if requested) or the responsibilities of medical staff membership, including any physical or psychological/emotional illnesses or impairment?

No Yes* (please comment on separate page)

9. Do you know of any disciplinary actions or investigations involving the applicant's license, or other credentials, medical staff membership or clinical privileges, including any currently pending?

No Yes* (please comment on separate page)

10. Do you know of any professional liability actions involving this applicant, including any that are currently pending?

No Yes* (please comment on separate page)

Peer reference for:
Reference provided by:

C. Applicant's Knowledge, Skills, Competencies

EVALUATION OF CURRENT PERFORMANCE			ASSESSMENT				
SA – Strongly Agree	A – Agree	D – Disagree <i>(Please comment on a separate page)</i>	SA	A	D	SD	NI
SD – Strongly disagree <i>(Please comment on a separate page)</i>			NI – No information				
11. Patient Care Technical/Clinical Skills – Applicant provides patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life. The applicant has demonstrated this performance in the following areas of practice:							
• Patient assessments and ongoing evaluation							
• Diagnostic and therapeutic decisions							
• Medical/clinical management and care planning/coordination							
• Performing surgical and invasive procedures in accordance with scope of privileges							
• Managing complex medical or surgical conditions in accordance with scope of privileges							
12. Medical/Clinical Knowledge, Clinical Judgment & Practice Based Learning – Applicant demonstrates knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others. The applicant has demonstrated this performance in the following areas of practice:							
• Applying current scientific knowledge							
• Using practice guidelines to adhere to evidence-based clinical care							
• Practicing cost-effective healthcare							
• Providing care that is medically necessary and appropriate							
13. Interpersonal & Communication Skills – Applicant demonstrates interpersonal and communication skills that enable him/her to maintain patient safety, continuity of care and a professional relationship with patients, families, and other members of the healthcare team. The applicant has demonstrated this performance in the following areas of practice:							
• Educating patients and their families including providing adequate information for consent							
• Effectively using information technology in patient care							
• Verbal communication, including hand-offs, receiving critical information, conducting time-outs							
• Providing timely, complete and legible written documentation							
• Working effectively as a member or leader of an interdisciplinary healthcare team							
14. Professionalism – Applicant demonstrates a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward patients, his/her profession, and society. The applicant has demonstrated this performance in the following areas of practice:							
• Showing respect, compassion, integrity and responsiveness to patients, colleagues, and staff							
• Protecting confidentiality of patient information							
• Demonstrating sensitivity to the culture, age, gender, religion, ethnic background, sexual preference, disabilities of others							

D. Summary

15. Please provide your overall recommendation regarding the applicant:

- Recommend without reservations
- Recommend with the following reservations
- Do not recommend

16. Please provide any other comments regarding this applicant:

17. _____

I would prefer to discuss by phone - Your phone number if you prefer a call: _____

Signature: _____ Date: _____

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

Thank you for your time and your candid evaluation.

HCA REQUEST FOR CONSIDERATION (RFC)

Complete all sections that are applicable to you

Authorization, Attestation and Release

I understand and agree, as part of the credentialing application process for participation, membership and/or clinical privileges, (hereinafter, referred to as "Participation" at or with any HSS Systems, LLC affiliated entity (hereinafter, individually referred to as "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and another criteria used by the Entity for determining initial and ongoing eligibility for participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained related to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract acceptance of my application by the Entity will not result in my employment by the Entity.

For Hospital Credentialing: I consent to appear for an interview with representatives of the medical staff, hospital administration, or governing body, if required or requested. As a medical staff member, I pledge to provide continuous care for my patients and I agree that I will be bound by the medical staff bylaws, rules and regulations and policies.

Authorization of Investigation Concerning Application for Participation: I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organizations, or credentialing processing centers (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation: I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Third-Party Sources to Release Information Concerning Medical Professional Liability Insurance/Claims History: I authorize any past or current insurance carriers to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional liability coverage; including dates of coverage, amounts of coverage and any limitations in coverage. I specifically authorize my current and past professional liability carrier(s) to release to the Entity and/or its Agent(s) information relating to reports of any medical professional liability claims activity against me on record that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Ongoing Professional Performance Evaluations, Focused Professional Performance Evaluations and Disciplinary Information: I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release the results of Ongoing Professional Performance Evaluations and Focused Professional Performance Evaluations and any Disciplinary Information, as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release the results of Ongoing Professional Performance Evaluations and Focused Professional Performance Evaluations and any Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning: (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

HCA REQUEST FOR CONSIDERATION (RFC)
Complete all sections that are applicable to you

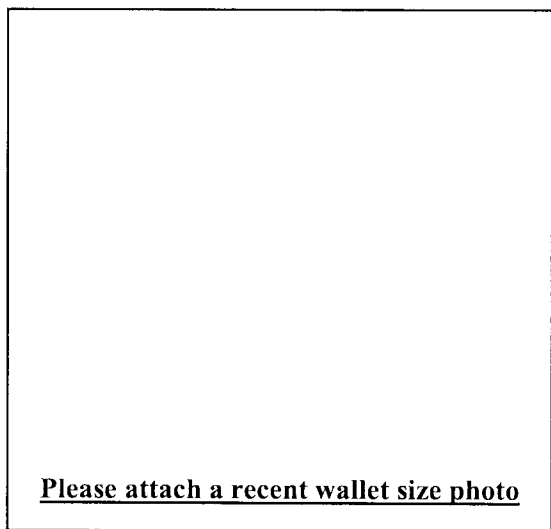
Release from Liability: I extend absolute immunity to, and release from any and all liability any Entity, its Agent(s), and any other third party for their acts performed in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. If I violate this provision, I will pay for all the Released Parties attorney fees, court costs and expenses. The release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third-party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that the documented privileges being requested are accurate and I have the competencies necessary to perform those privileges, and that I will notify the Entity and/or its Agent(s) within one (1) business day of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s).

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

NAME (Please print or type)

DRIVER'S LICENSE # and STATE



LAST 4 DIGITS OF SSN

NPI#

SIGNATURE

DATE (MM/DD/YYYY)

IF INSURED BY HCI, PLEASE COMPLETE THE FOLLOWING:

Facility name while insured by HCI:

Dates of Coverage by HCI:

St. David's South Austin Medical Center
Proctoring Evaluation Form

Please note:

*All consents, H&Ps, etc. must be completed according to policy, prior to procedure.
Form to be turned in to Medical Staff Office upon completion.*

Section I: To be completed by physician being proctored:

Physician Name, printed: _____
Name of Procedure: _____
Indications for procedure: _____
Date of Procedure: _____
Medical Record Number: _____
Consent Complete? YES NO

Section II: To be completed by proctor:

Assessment of Procedural Skills: Excellent Good Fair Poor

Additional Comments: _____

Assessment of Clinical Judgment: Excellent Good Fair Poor

Additional Comments: _____

Are there appropriate indications for procedure? Yes No (*please explain*): _____

Were there any complications? Yes No (*please explain*): _____

Recommendation for continued proctoring? Yes No (*please explain*): _____

Additional Comments / Recommendations, if any: _____

Completed by: _____ (*proctor printed name*)

Signature of Proctor

Date

Section III To be completed by Medical Staff Office:

Date Received in M SO: _____

Proctored case # _____ of _____ required

Notes: _____