Kaleida Health

Dear Advanced Practice Provider:

Thank you for requesting an application to the Medical/Dental Staff of Kaleida Health. Kaleida Health utilizes the Medical Staff Office to complete the primary source verification process.

Please complete all relevant information fields, including dates, names, complete mailing addresses and telephone/fax numbers. This will ensure that your application is processed in a timely manner.

Please note your references should have recent experience in observing and working with you and should be able to provide adequate information pertaining to your present professional competence and character.

Once your application is received and processed by the Medical Staff Office, you will receive an email from *Courion@kaleidahealth.org*. This email will provide you with your system user name and with important instructions. Please add *Courion@kaleidahealth.org* to your email address book now, so that this important email does not go into you Junk folder.

If your application is deemed incomplete (unanswered questions or omissions, including signatures, on the application or if any of the required documentation is not submitted), the Medical Staff Office will notify you of the outstanding information required from you. Your application will also be deemed incomplete if the need arises for new, additional or clarifying information at any time during the application process.

Accreditation standards require verification of certain data with the primary source. This is accomplished by requesting verification directly from the individual or institution and requiring that their response be returned directly to our office. Information requiring primary source verification includes, but is not limited to, professional school graduation, postgraduate training, professional references, hospital affiliations, malpractice history and professional licenses. In addition, we query the National Practitioner Data Bank and the Office of Inspector General's List of Excluded Individuals as part of consideration of any applicant. For your application to be considered complete, all information must be verified. **Please remember it is ultimately the applicant's responsibility to ensure that all information has been received.**

Upon completion of the primary source verification, your application with all related verification and supporting documentation will be reviewed by your department Chief of Service. The Chief of Service will complete the privileging and decision making portion of the application process. The Medical Staff Office will notify you when your application and request for privileges has been approved. Completion of the application **DOES NOT** guarantee acceptance by Kaleida Health.

If you have additional questions, please contact the Medical Staff Office at 716-859-5501.

Kaleida Health

Please enclose the following:

- ❑ Non-refundable application processing fee of $125. You may submit a check payable to the Kaleida Health Medical Staff or remit payment using a charge card
- ❑ Two recent professional 'quality' color photo, passport size (Driver's license NOT acceptable). We cannot process your application unless these are submitted with your application (photos need to be originals; fax or scanned copies are not accepted)
- ❑ If not U.S. citizen, provide a copy of VISA, H1B/I-94, Perm Resident Card and/or employment authorization, including ECFMG certification
- ❑ Signed copy of your current NYS License Registration Certificate. If you have a limited license, please provide a copy of the license AND a copy of your Affidavit of Agreement with the NYS Dept. of Health
- ❑ Copy of your driver's license
- ❑ Copy of school diploma and/or other post graduate level education for which your degree was obtained
- ❑ Copy of your current Federal DEA Certificate, if applicable
- ❑ Copy of the facesheet of your current malpractice or professional liability insurance - minimum $1M/$3M
- ❑ Copy of your current Curriculum Vitae (CV must contain month, day, year and your personal email address)
- ❑ Copy of the mandatory NYS Infection Control training course certificate
- ❑ Copy of board certification/recertification certificate
- ❑ Copy of all other certifications (CPR, BLS, ACLS, ATLS, NRP, PALS, APLS, etc.)
- ❑ Completed New Practitioners Medical Evaluation form – Pages 8-10 (Note: TB tests are required annually. Applicants aged 70 years or older must undergo and release the results of an IME by an approved neurologist in accordance with MED.19 The Aging Provider Policy as well as any repeat testing recommended by the neurologist.)
- ❑ Completed Chronological List of Activities form – Page 11 (Note: Kaleida Health has a zero day time gap policy)
- ❑ Completed Background Check Authorization form – Page 12
- ❑ Completed Professional Liability Claims Information form, if applicable – Page 13
- ❑ Completed General Indemnification form – for use by non-Kaleida Health employees only – Page 14
- ❑ Completed 4NP/Verification of Practice submitted to the NYS Education Department – nurse practitioners only
- ❑ Completed and signed Collaborating Physician Agreement - Newly appointed nurse practitioners require a collaborating agreement per the Kaleida Health Nurse Practitioner Collaborative Relationship Policy. – Page 15
- ❑ Reviewed and signed Certifications, Authorizations and Waivers of Liability Form – Page 23
- ❑ Read the documents found in the Bylaws and Manuals tab at the following website: http://www.kaleidahealth.org/providers/bylaws_manuals.asp. Print and sign the Documentation Attestation and return with your application
- ❑ Completed and signed Scopes of Practice form(s). Scopes of Practice forms are found at http://www.kaleidahealth.org/providers/advanced-practice-providers-privileges.asp

Note: If requesting conscious/moderate privileges at Kaleida Health, follow the instructions on the Scope of Practice form. This information is also available at http://www.kaleidahealth.org/providers/support/sedation-guidelines-poster.pdf

Kaleida Health

ADVANCED PRACTICE PROVIDER APPLICATION FOR MEDICAL/DENTAL STAFF MEMBERSHIP

If there is any additional information that is not accommodated on this form, please submit on separate paper.

PLEASE TYPE OR PRINT

I. IDENTIFYING INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	DEGREE	GENDER

OTHER LAST NAME UNDER WHICH INFORMATION MAY BE FOUND (Example: Maiden Name)	NPI NUMBER

DATE OF BIRTH	PLACE OF BIRTH	SOCIAL SECURITY NUMBER	CITIZENSHIP

HOME ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE NUMBER	HOME FAX NUMBER

CELL NUMBER	CELL PHONE TYPE	PAGER NUMBER	EMAIL (For business-related communication)
	__ iPhone __ Blackberry __ Android Brand _____ __ Other _____ Name of Carrier _____		PERSONAL EMAIL

PERSONAL EMERGENCY CONTACT	PHONE NUMBER	RELATIONSHIP

II. REQUESTED HOSPITAL AFFILIATION

Hospital Affiliation			
	Buffalo General Medical Center	☐ **Yes**	☐ **No**
	Women & Children's Hospital of Buffalo	☐ **Yes**	☐ **No**
	DeGraff Memorial Hospital	☐ **Yes**	☐ **No**
	Millard Fillmore Suburban Hospital	☐ **Yes**	☐ **No**

PRIMARY PRIVILEGES REQUESTED IN THE DEPARTMENT OF: SUBSPECIALTY AREA, IF ANY:	**SECONDARY** PRIVILEGES REQUESTED IN THE DEPARTMENT OF: SUBSPECIALTY AREA, IF ANY:

WILL YOU BE WORKING AS A HOSPITALIST? ☐ **Yes** ☐ **No**

DO YOU ANTICIPATE WORKING IN A KALEIDA HEALTH CLINIC? ☐ **Yes** ☐ **No**
If yes, please provide the name of the clinic _____

WILL YOU BE EMPLOYED BY KALEIDA HEALTH? ☐ **Yes** ☐ **No**

III. PRACTICE LOCATIONS

PRIMARY PRACTICE LOCATION		**CREDENTIALING LOCATION**	
GROUP PRACTICE LEGAL NAME (IF APPLICABLE)		GROUP PRACTICE LEGAL NAME (IF APPLICABLE)	
STREET ADDRESS (INCLUDING SUITE NO.)		STREET ADDRESS (INCLUDING SUITE NO.)	
CITY, STATE, ZIP CODE		CITY, STATE, ZIP CODE	
TELEPHONE ( )	FAX NUMBER ( )	TELEPHONE ( )	FAX NUMBER ( )
OFFICE MANAGER or CONTACT PERSON		OFFICE MANAGER or CONTACT PERSON	
EMAIL ADDRESS OF OFFICE MANAGER OR CONTACT PERSON		EMAIL ADDRESS OF OFFICE MANAGER OR CONTACT PERSON	
PREFERRED METHOD OF COMMUNICATION		□ Mail Address □ Email Address □ Fax Number	

PLEASE SUBMIT ANY ADDITIONAL PRACTICE LOCATIONS ON A SEPARATE SHEET OF PAPER.

Kaleida Health

IV. HOSPITAL AFFILIATIONS List all present and previous affiliations in chronological order, most recent first. Please designate the one facility which you consider your primary hospital.

HOSPITAL NAME	ADDRESS	PRIMARY	NATURE OF AFFILIATION/ POSITION	SPECIALTY /SUBSPECIALTY	DATES (From – To)

V. LICENSES AND NUMBERS INFORMATION List all professional licenses currently held. Attach a copy of state registrations.

NEW YORK STATE LICENSE (attach signed copy)	LICENSE NUMBER	ISSUED	EXPIRATION
RESTRICTED OR UNRESTRICTED OR LIMITED PERMIT? (If restricted or limited, please explain)			
DO YOU HAVE ANY LICENSES IN OTHER STATES AND/OR COUNTRIES? (If yes, please list)			
STATE/COUNTRY	LICENSE NUMBER	ISSUED	EXPIRATION
RESTRICTED OR UNRESTRICTED OR LIMITED PERMIT? (If restricted or limited, please explain)			
STATE/COUNTRY	LICENSE NUMBER	ISSUED	EXPIRATION
RESTRICTED OR UNRESTRICTED OR LIMITED PERMIT? (If restricted or limited, please explain)			
DEA NUMBER (attach copy)	**DEA EXPIRATION DATE**	**ECFMG # (attach copy)**	

VI. BOARD STATUS List all present and previous boards. Attach copy of board certification.

BOARD NAME	CERTIFIED?	ELIGIBLE?	DATES (FROM – TO)
PRIMARY SPECIALTY			
SECONDARY SPECIALTY			

Kaleida Health

VII. PROFESSIONAL LIABILITY INSURANCE

List current AND all previous insurance carriers from the beginning of your medical practice. If there is additional previous insurance carrier information that does not fit on this form, please submit on separate paper. Please attach a copy of each malpractice insurance facesheet if available.

CURRENT PRIMARY INSURANCE CARRIER (Insurance carrier, not employer)		POLICY NUMBER	
STREET	CITY	STATE	ZIP CODE
CONTACT PERSON	TELEPHONE	COVERAGE LIMITS ($1, $3 million minimum)	DATES (FROM – TO)
ALL PREVIOUS LIABILITY INSURANCE CARRIER(S) (From beginning of your medical pr actice)		POLICY NUMBER	
STREET	CITY	STATE	ZIP CODE
CONTACT PERSON	TELEPHONE	COVERAGE LIMITS	DATES (FROM – TO)
PREVIOUS LIABILITY INSURANCE CARRIER	POLICY NUMBER		
STREET	CITY	STATE	ZIP CODE
CONTACT PERSON	TELEPHONE	COVERAGE LIMITS	DATES (FROM – TO)
PREVIOUS LIABILITY INSURANCE CARRIER	POLICY NUMBER		
STREET	CITY	STATE	ZIP CODE
CONTACT PERSON	TELEPHONE	COVERAGE LIMITS	DATES (FROM – TO)

VIII. MEDICAL/DENTAL REFERENCES

List two (2) professionals from your specialty. Please let your references know that they will received a letter from the Medical Staff Office.

NAME	
ADDRESS	
CITY, STATE, ZIP CODE	
TELEPHONE	
EMAIL	
NAME	
ADDRESS	
CITY, STATE, ZIP CODE	
TELEPHONE	
EMAIL	

Kaleida Health

IX. DIPLOMA AND/OR OTHER GRADUATE LEVEL EDUCATION List school of graduation. If others, list separately. Attach copy of diploma.

DO NOT ENTER 'REFER TO CURRICULUM VITAE'. (PLEASE ATTACH COPIES OF ALL EDUCATIONAL CERTIFICATES IF NOT PREVIOUSLY SUBMITTED.)			
INSTITUTION			
STREET	CITY	STATE	ZIP CODE
CONTACT PERSON		TELEPHONE	
DEGREE		GRADUATION DATE	DATES (FROM – TO)
INSTITUTION			
STREET	CITY	STATE	ZIP CODE
CONTACT PERSON		TELEPHONE	
DEGREE		GRADUATION DATE	DATES (FROM – TO)

X. OTHER TRAINING/CERTIFICATIONS List separately and attach current certification of completion (ACLS, PALS, BLS, CPR, etc.)

NAME OF INSTITUTION	DATE OF GRADUATION	DEGREE
INFECTION CONTROL TRAINING (Attach certification of completion of an approved course within the past 36 months)		

Kaleida Health

CONFIDENTIAL PROFESSIONAL INFORMATION

Please completely fill in the answer blocks for each question. Do not draw circles around your answers or use an arrow or line for selections. Applications that do not follow these instructions will be returned.

1. **Have any of the following been denied, revoked, suspended, sanctioned, reduced, limited, monitored, placed on probation, not renewed, or voluntarily relinquished to avoid possible disciplinary action in any jurisdiction? These questions include, but are not limited to any teaching appointment, fellowship, internship, residency and medical school programs.**

a.	Medical, dental or other professional license	☐ Yes	☐ No
b.	Controlled substance registration (DEA)	☐ Yes	☐ No
c.	Academic appointment	☐ Yes	☐ No
d.	Membership in or affiliation with any healthcare facility staff	☐ Yes	☐ No
e.	Clinical privileges at any healthcare facility	☐ Yes	☐ No
f.	Prerogatives or rights at any healthcare facility	☐ Yes	☐ No
g.	Professional society membership or fellowship	☐ Yes	☐ No
h.	Board certification	☐ Yes	☐ No
i.	Professional liability insurance	☐ Yes	☐ No
j.	Participate in any practice, Federal or State insurance program (eg. Medicare, Medicaid)	☐ Yes	☐ No

2. **To the best of your knowledge:**

a.	Have you ever been charged with professional misconduct or received an administrative warning by any state agency or professional association?	☐ Yes	☐ No
b.	Are you the subject of any current investigation by any state agency or professional body?	☐ Yes	☐ No
c.	Have any misdemeanor or felony charges been brought against you?	☐ Yes	☐ No
d.	Have there ever been any findings or have you ever been found to be in violation of Patient Rights?	☐ Yes	☐ No
e.	Have any judgments or settlements been rendered against you in a professional liability case?	☐ Yes	☐ No
f.	Have you received notice of malpractice actions which are pending?	☐ Yes	☐ No
g.	Do you have any physical or mental disorders which may interfere with the practice of your discipline/specialty including alcohol or drug dependence?	☐ Yes	☐ No

3. **Are you presently using illegal drugs or receiving treatment or counseling for the use of illegal drugs? ☐ Yes ☐ No**

4. **If the answer is YES to any of the above questions, please complete the attached Professional Liability Claims Information form or explain on a separate sheet of paper.**

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO IMMEDIATELY ADVISE KALEIDA HEALTH IN WRITING OF ANY NEW, DIFFERENT OR ADDITIONAL INFORMATION RESPONSIVE TO THE ABOVE QUESTIONS.

Kaleida Health

NEW PRACTITIONERS MEDICAL EVALUATION FORM

Please check your primary affiliation:

___ Kaleida Health
___ Erie County Medical Center
___ Roswell Park Cancer Institute
___ Mercy Hospital of Buffalo
___ Kenmore Mercy
___ Sisters of Charity Hospital
___ Other _____

In keeping with the requirements of the New York State Department of Health, I certify by my signature below that I have performed a medical evaluation on:

Name_____ **Date of Birth**_____/_____/_____
Please Print

Section A: PAST HISTORY

MEDICAL

_____

_____

SURGICAL

_____

_____

FAMILY HISTORY

_____

_____

REVIEW OF SYSTEMS

_____

_____

ALLERGIES

_____

MEDICATIONS

_____

HABITS

_____

Kaleida Health

NEW PRACTITIONERS MEDICAL EVALUATION FORM (CONTINUED)

Name_____ **Date of Birth**_____/_____/_____

Please Print

Section B: IMMUNIZATIONS

Immunity to Rubella: Rubella antibody test date_____/_____/_____ Result_____

If negative, date of immunization_____/_____/_____

Immunity to Measles has been documented as follows: (Please check)

____Rubeola Date of Titer_____/_____/_____ Result _____
____Vaccination with Live Measles Vaccine Date immunized_____/_____/_____
____MMR Date Immunized_____/_____/_____
____Born before or on January 1, 1957 (excluded from requirement)

Tuberculin Skin Test (PPD): Date performed_____/_____/_____

Result (please check) _ Positive/active TB ruled out by chest x-ray
___ Chest x-ray Date_____/_____/_____ Result _____
___ Negative (MUST BE REPEATED ANNUALLY)

IF PPD NOT PERFORMED, PLEASE INDICATE THE REASON BY CHECKING ONE OF THE FOLLOWING AND INCLUDE A COPY OF YOUR CHEST X-RAY REPORT:

___ Adequate treatment of known prior disease,
___Completion of Adequate Preventive Drug Therapy, eg. INH/No clinical signs/symptoms suggestive of active TB

VACCINE HISTORY:

Hepatitis B Date_____/_____/_____
DT Date_____/_____/_____
Pneumonia Date_____/_____/_____
Flu Vaccine Date_____/_____/_____
Other Date_____/_____/_____

Kaleida Health

NEW PRACTITIONERS MEDICAL EVALUATION FORM (CONTINUED)

Name_____ **Date of Birth**_____/_____/_____

Please Print

Section C: PHYSICAL EXAMINATION

BP _____ TEMP_____ PULSE _____ RESP_____WEIGHT _____

EYES _____

ENT _____

NECK _____

LUNGS _____

HEART _____

BREASTS _____

ABDOMEN _____

RECTAL _____

PELVIC _____

EXTREMITIES_____ NEUROLOGIC_____

Please Note: Kaleida Health **does not** allow a practitioner to attest to his/her own health status. If you submit the Catholic Health H & P form, another physician **must** attest to your health status.

I have determined that the above-named practitioner is free from any health impairment which is of potential risk to patients or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

_____ _____/_____/_____

Signature of Examining Practitioner Date

_____

Print or Type Name

Kaleida Health

CHRONOLOGICAL LIST OF ACTIVITIES

PROVIDER'S NAME_____

DATE (month/day/year)		TYPE OF ACTIVITY BEGINNING WITH GRADUATION DATE FROM PROFESSIONAL SCHOOL. INCLUDE NAME AND ADDRESS OF EMPLOYERS.
FROM	TO	

Kaleida Health

Consent Form
CF-051914

Disclosure In relation to your application for employment, or your current employment, your prospective employer or present employer may obtain a consumer report and or an investigative consumer report. Such reports may include information as to your character, general reputation, personal characteristics, and or mode of living. Also, subsequent reports may be requested to update, renew or extend employment. This disclosure is given to you in compliance with the Federal Fair Credit Reporting Act and applicable state law. You have the right to request additional disclosures as to the nature and scope of the investigation from your prospective or present employer. Such request must be made in writing.

The following information is for the sole purpose of conducting an employment background investigation

Current Name First Name	Middle Name	Last Name
Maiden First Name	Middle Name	Maiden Last Name
Alias/Other First Name	Middle Name	Alias/Other Last Name

Date of Birth – Month/Day/Year *

* *The Age Discrimination Act in 1967 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is for consumer report purposes only.*

Social Security Number

Driver's License Number

State of Issue

Current ZIP Code

Daytime Phone Number

Male

Female

⇨ List Current and all Counties and States you have lived in for the past 7 Years

County	State	ZIP Code	From Month	From Year	To Month	To Year

Have you ever been convicted of crime? Yes ☐ No ☐ Misdemeanor ☐ Felony ☐ Any pending criminal charges? Yes ☐ No ☐

If yes, give location of Court: City _____ County _____ State _____

Type of Offense _____ Date of Offense _____ Case Number _____

Explain _____

****** (IF YOU HAVE MORE THAN ONE CONVICTION OR NEED ADDITIONAL SPACE, LIST ALL INFORMATION ON A SEPARATE SHEET OF PAPER) ******

Authorization Release: I certify receipt of this notice and give permission to my prospective employer and or current employer and its agents to verify the information submitted by me and to conduct a background search on me. I understand this search may include social security number verification and address history, criminal history, driving history, a credit report, education history, license/certification verification, past employment information, and/or reference checks. Such verification shall not constitute a violation of my right to privacy in any manner and I hereby release them from all liability whatsoever for actions related to this information. I understand that the sole purpose for obtaining this information is for employment reasons

_____	_____	_____
Print Name of Applicant/Employee	Signature of Applicant	Date

***** For Employer Use Only *****

Company Name _____ Requested By _____
(PRINT NAME CLEARLY)

DMV Driving History ☐ Drug Screen ☐ Date _____

Kaleida Health

PROFESSIONAL LIABILITY CLAIMS INFORMATION FORM

The following information is necessary to complete the credentialing verification process and will be kept confidential. Please PRINT or TYPE answers to the following for any malpractice claims reported to your malpractice insurance carrier, opened, closed, settled or paid. Please complete a separate form for each professional liability claim. Only list one case per sheet. (You may photocopy if additional sheets are needed.)

PROVIDER'S NAME				
NAME OF PATIENT INVOLVED	AGE	MONTH/YEAR OF OCCURRENCE	MONTH/YEAR OF LAWSUIT	INSURANCE CARRIER AT TIME

WHAT IS/WAS YOUR STATUS? ☐ Primary Defendant ☐ Co-Defendant ☐ Other, please explain:	LIST OTHER DEFENDANTS

WHAT WAS THE PATIENT'S OUTCOME?

HOW WERE YOU ALLEGED TO HAVE CAUSED HARM OR INJURY TO THE PATIENT?

PLEASE PROVIDE SPECIFICS IN REFERENCE TO THE ADVERSE EVENT

WHAT IS/WAS YOUR ROLE IN THIS EVENT?

CURRENT STATUS		
☐ Still Pending	Who is handling the defense of the case?	
☐ Trial date set (awaiting trial) – Date _/ _/____		
☐ Dismissed – Date____/___/____		
☐ Defense Verdict – Date____/___/____		
☐ Settled out of court – Date _/___/___	Total Amount of Settlement $	Amount Paid by You $
☐ Judgment – Date _/ _/____	Total Amount of Judgment $	Amount Paid by You $

This Professional Liability Claim Information Form is required on all claims/lawsuits that are reported by your malpractice carrier and/or the National Practitioner Data Bank. Clinical details are required for all suits, regardless of status or settlement amount.

I certify that the information contained in this form is correct and complete to the best of my knowledge.

Signature	Date

GENERAL INDEMNIFICATION AGREEMENT
(To be completed by applicants NOT EMPLOYED by Kaleida Health)

Name of Practitioner (Print) _____ Department _____

I hereby verify that the above-named individual is in my employment and/or under my supervision as described on the attached job description/delineation/scope of practice. I hereby agree to be responsible for all of the duties performed by the above-named person in the performance of responsibilities as an Advanced Practice Provider of KALEIDA HEALTH under my supervision. I also agree to notify you when he/she leaves my/our practice or if his/her capacity changes in any way.

I further agree to defend, indemnify and hold harmless Kaleida Health, its employees, managers and directors, against all actions, suits, claims, losses, liabilities, and demands whatsoever, including costs, expenses, and reasonable attorneys' fees, resulting from or claimed to have resulted from any intentional or negligent acts or omissions of the candidate while employed/supervised by me. The provisions of this paragraph will survive termination of this Agreement.

Collaborating/Supervising Physician's Name (Print) _____ Date _____

Collaborating/Supervising Physician's Signature _____

Mailing address _____

_____

_____

Telephone _____

Fax _____

Area of current practice _____

Area of specialty practice _____

NURSE PRACTITIONER PRACTICE AGREEMENT (Kaleida Health employees only)

This Agreement sets forth the terms of the Collaborative Practice Agreement between_____("NP") whose specialty is_____(specialty as listed on NYS issued certificate) and _____("Collaborating Physician"), whose specialty is_____, at Kaleida Health, a New York not-for-profit corporation with a location at_____(name and address of Kaleida Health site where services will be provided).

INTRODUCTION

_____, RN, NP, meets the qualifications and practice requirements as stated in Article 139 of New York Education Law, holds a certificate as a Nurse Practitioner pursuant to §6910 of New York Education Law and herein meets the requirements of maintaining a collaborative practice agreement with _____, MD, a duly licensed and currently registered physician in good standing under Article 131 of New York State Education Law.

SCOPE OF PRACTICE

The practice of a registered professional nurse as a nurse practitioner may include the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures including prescribing medications for patients whose conditions fall within the authorized scope of practice as identified on their NYS issued certificate. These privileges include the prescribing of all controlled substances under a DEA number. The nurse practitioner, as a registered nurse, may also diagnose and treat human responses to actual or potential health problems through such services as case finding, health counseling, health teaching and provision of care supportive to or restorative of life and wellbeing. This practice will take place at_____(Kaleida Health site noted above).

The following exceptions to the certified scope of practice have been agreed upon by the undersigned parties (list exceptions, if any).

_____

_____

PRACTICE AGREEMENT

NP agrees to perform service in accordance with this Practice Agreement and the Practice Protocols agreed upon between the NP and Collaborating Physician, and approved by Kaleida Health; a copy of such protocols are attached hereto and made part hereof as **Appendix A**. Such protocols shall be filed with the New York State Education Department within ninety (90) days of the date of this Agreement.

RESOLUTION OF DISAGREEMENTS

a. In the event of a disagreement between NP and Collaborating Physician, with respect to the method of treatment or diagnosis of any particular patient that is within the scope of practice of both parties, the following process will be utilized to resolve conflicts:

   If either party questions the protocol, or if the conflict involves an issue not covered by an existing protocol, the Chief Medical Officer of Kaleida Health will arbitrate and will be responsible for a definite

decision. This decision will prevail in every circumstance with the understanding that the Nurse Practitioner will be insulated from any and all liability related to the Chief Medical Officer's exercise of professional judgment.

b. In the event of a disagreement between NP and a non-collaborating physician, the NP shall consult with the Collaborating Physician and the Collaborating Physician's opinion will prevail.

PHYSICIAN CONSULTATION

The Collaborating Physician, or the Collaborating Physician's designee, shall be at all times available to NP for consultation. Such availability will include either on-site or electronic access, including but not limited to, telephone, facsimile, and email.

RECORD REVIEW

A representative sample of patient records shall be reviewed by the Collaborating Physician every three months to determine if NP's practice is congruent with the practice protocols identified in **Appendix A**. Summarized results of this review will be signed by both parties and shall be maintained at the NP's practice site for possible regulatory agency review.

PROVISION FOR ABSENCE OF COLLABORATING PHYSICIAN

In the unexpected event that the Collaborating Physician of record must be absent due to extended illness or leave of absence, the NP shall be notified and an interim acting Collaborating Physician determined. It will then be the responsibility of the NP to notify the State Education Department of the change in practice.

PROVISION FOR UNEXPECTED ABSENCE OF NP

In the event that the NP must be absent due to extended illness or leave of absence, the Collaborating Physician will be notified and will be responsible for making provisions within the practice site to maintain continuity of care for all patients. The NP will be responsible to notify the State Education Department of the change of practice.

REVIEW AND MODIFICATION OF THIS AGREEMENT

This Agreement will be reviewed on an annual basis and may be modified or amended only in writing.

MISCELLANEOUS

This Agreement will be governed by, and construed in accordance with, the laws of the State of New York. The parties agree to submit to the personal and exclusive jurisdiction of the courts located in Erie County, New York. This Agreement contains the entire agreement between the parties with respect to its subject matter, and supersedes any prior agreement or understanding. If any section or portion of this Agreement will be determined to be invalid, such determination will not affect the enforceability or validity of the remainder of this Agreement. Any waiver of a breach of any of the provisions of this Agreement will not be deemed a waiver of any other provision of this Agreement. All headings are included for convenience of reference only and are not of substantive effect.

Having read and understood the full contents of this document, the parties hereto agree to be bound by its terms.

Nurse Practitioner's Name (Print)	Nurse Practitioner's Signature	Date
Collaborating Physician's Name (Print)	Collaborating Physician's Signature	Date

APPENDIX A

The practice protocols, as outlined on the attached listing, serve only as a guide and the nurse practitioner is not bound and shall not be liable for strict adherence to the aforementioned texts since such texts do not address and cannot contemplate every exigent circumstance and every relevant factor. Accordingly, where there is a disagreement between the aforementioned texts and the nurse practitioner's professional judgement, or there is a circumstance or situation not explicitly identified in the aforementioned texts, the nurse practitioner's professional judgement shall prevail.

Kaleida Health

NURSE PRACTITIONER: APPROVED PROTOCOL TEXTS

(Please note: more recently published editions of the same text title are acceptable)

- American Academy of Pediatrics Staff. (2008) *Pediatric primary care: Tools for practice.* Elk Grove Village, IL: American Academy of Pediatrics.
- American Academy of Pediatrics. (2009) *2009 Red book: Report of the committee on infectious diseases* (28th ed.). Elk Grove Village, IL: American Academy of Pediatrics.
- American Psychiatric Association Staff. (2000) *Diagnostic and statistical manual of mental disorders, DSM-IV-TR: Text revision* (4th ed.). Arlington, VA: American Psychiatric Publishing, Inc.
- Barkley, T. W., & Myers, C. M. (2007) *Practice guidelines for acute care nurse practitioners* (2nd ed.). Philadelphia, PA: Saunders [Imprint].
- Boynton, R. W., Dunn, E. S., Stephens, G. R., & Pulcini, J. *(2009) Manual of ambulatory pediatrics* (6th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Burns, C. E., Dunn, A. M., Brady, M. A., Starr, N. B., & Blosser, C. (2008) *Pediatric primary care* (4th ed.). Philadelphia, PA: Saunders [Imprint].
- Camp-Sorrell, D., & Hawkins, R. A. (2006) *Clinical manual for the oncology advanced practice nurse* (2nd ed.). Pittsburgh, PA: Oncology Nursing Society.
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Kaleida Health

CERTIFICATIONS, AUTHORIZATIONS AND WAIVERS OF LIABILITY

I fully understand that any misstatements in or omissions from this application or the supporting documentation submitted herewith constitutes cause for denial of appointment or cause for summary dismissal from the Kaleida Health Medical/Dental Staff to which I am applying. All information submitted by me in connection with this application is true and complete to the best of my knowledge and belief, and no pertinent information has been omitted.

In making this application for appointment to the Medical/Dental Staff of Kaleida Health, I acknowledge that I have received and read the bylaws, rules and regulations of the Medical/Dental Staff, and that I am familiar with the principles and standards of the DNV, the guiding principles for physician-hospital relationships of the New York State Medical Association and the Principles of Ethics of the American Medical Association. I agree to be bound by the terms thereof if I am granted membership or clinical privileges in all matters relating to my appointment to the Kaleida Health Medical/Dental Staff, and I further agree to abide by such hospital and Medical/Dental Staff bylaws, rules, regulations and policies as may be from time to time amended and enacted.

By applying for appointment to the Medical/Dental Staff, I hereby signify my willingness to appear for a personal interview in regard to my application, authorize Kaleida Health, its Medical/Dental Staff and their representatives to consult with administrators and members of the Medical/Dental Staff(s) of other hospitals or institutions with which I may have been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by Kaleida Health, its Medical/Dental Staff and its representatives of all records and documents, including medical records from other hospitals that may be made material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership. I hereby release from liability Kaleida Health, its Medical/Dental Staff and its representatives for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications. I hereby release from any liability, any and all individuals and organizations, including the hospital(s), its/their Medical/Dental Staff and its/their representatives, who provide information to the hospital(s) or its/theirs Medical/Dental Staff in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I understand and agree that I, as an applicant for Medical/Dental Staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any questions or doubts about such qualifications**.** I have been advised of, and hereby acknowledge, my obligation to advise the hospital(s) in writing immediately of any new, different or additional information responsive to any of the questions or items requested in or in connection with this application which, at anytime it comes to my attention or is made known to me.

_____ _____/_____/_____

Signature Date

_____

Print Name