



|                        |       |
|------------------------|-------|
| <b>OFFICE USE ONLY</b> |       |
| Date Received :        | _____ |
| ID Number :            | _____ |
| Check Number :         | _____ |

## Application for Hospital Ancillary Privileges

Please attach copies of the documentation required in Section I of the attached criteria.  
(Your application will not be approved if these items are not included.)

### A. PERSONAL INFORMATION

|                               |                      |                  |
|-------------------------------|----------------------|------------------|
| Last Name :                   | First Name :         | Middle Initial : |
| Home Telephone No. :          | Social Security No.: | Date of Birth :  |
| Home Address :                | City :               | State : Zip :    |
| Sponsoring Agency/Physician : | Dept.:               | Telephone :      |
| Address :                     | City :               | State : Zip :    |

### B. PRIVILEGES APPLIED FOR

|   |  |
|---|--|
| <input type="checkbox"/> Arterial Puncture (ABG) (Neonate / Peds / Adult)             | <input type="checkbox"/> Audiologist   |
| <input type="checkbox"/> Autopsy Technician   | <input type="checkbox"/> Chart Review  |
| <input type="checkbox"/> Clinical Instructor (Non-Contractual)                        | <input type="checkbox"/> Emergency Chest Tube Insertion                                  |
| <input type="checkbox"/> Emergency Intubation (EI) (Neonate / Peds / Adult)           | <input type="checkbox"/> Emergency Release of Pleural Air by Needle Aspiration           |
| <input type="checkbox"/> Hospice Nurse  | <input type="checkbox"/> Intraosseous Infusion   |
| <input type="checkbox"/> Larngeal Mask Airway (LMA)                                   | <input type="checkbox"/> LPN Clinic Nurse  |
| <input type="checkbox"/> Massage Therapist  | <input type="checkbox"/> Pain Management Clinician                                       |
| <input type="checkbox"/> Percutaneous Central Venous Catheter by NICU Nurse           | <input type="checkbox"/> Peripherally Inserted Central Catheter (Neonate / Peds / Adult) |
| <input type="checkbox"/> PIC Line (Neonate / Peds / Adult)                            | <input type="checkbox"/> Private Dental Assistant  |
| <input type="checkbox"/> Private Dental Hygienist                                     | <input type="checkbox"/> Private First Assistant ; RN, LPN, Surgical Technologist        |
| <input type="checkbox"/> Private Physician's Clinical Nurse Educator                  | <input type="checkbox"/> Private Scrub Nurse: RN/LPN, Surgical Technician                |
| <input type="checkbox"/> Professional Educator & Employees of Outside Agencies        | <input type="checkbox"/> Prosthetist/Orthotist   |
| <input type="checkbox"/> Research Assistant/Study Coordinator                         | <input type="checkbox"/> Social Workers/Counselors/Rehabilitation Counselors             |
| <input type="checkbox"/> Speech Therapist   | <input type="checkbox"/> Stand-Alone Privileges  |
| <input type="checkbox"/> Umbilical Artery/Vein Catheter Insertion by NICU Nurse (UAC) |  |

\* Refer to Cabell Huntington Hospital Credentialing Committee Criteria

1340 Hal Greer Boulevard · Huntington, West Virginia 25701 · 304-526-2053  
Applicant Name: \_\_\_\_\_

### C. EDUCATION

High School :

|      |          |       |
|------|----------|-------|
| Name | Location | Dates |
|------|----------|-------|

College :

|      |          |       |        |
|------|----------|-------|--------|
| Name | Location | Dates | Degree |
|------|----------|-------|--------|

Other :

|      |          |       |        |
|------|----------|-------|--------|
| Name | Location | Dates | Degree |
|------|----------|-------|--------|

|      |          |       |        |
|------|----------|-------|--------|
| Name | Location | Dates | Degree |
|------|----------|-------|--------|

List any special training :

|      |             |                    |                  |           |
|------|-------------|--------------------|------------------|-----------|
| Type | Institution | Program Completed? | Program Director | Telephone |
|------|-------------|--------------------|------------------|-----------|

|      |             |                    |                  |           |
|------|-------------|--------------------|------------------|-----------|
| Type | Institution | Program Completed? | Program Director | Telephone |
|------|-------------|--------------------|------------------|-----------|

### D. EMPLOYMENT HISTORY

List all hospitals/institutions at which you have been employed – if more space is needed, please attach additional sheet.

|                  |         |           |
|------------------|---------|-----------|
| Institution Name | Address | Telephone |
|------------------|---------|-----------|

|               |                 |            |            |
|---------------|-----------------|------------|------------|
| Position Held | Dates (from/to) | Supervisor | Department |
|---------------|-----------------|------------|------------|

|                  |         |           |
|------------------|---------|-----------|
| Institution Name | Address | Telephone |
|------------------|---------|-----------|

|               |                 |            |            |
|---------------|-----------------|------------|------------|
| Position Held | Dates (from/to) | Supervisor | Department |
|---------------|-----------------|------------|------------|

|                  |         |           |
|------------------|---------|-----------|
| Institution Name | Address | Telephone |
|------------------|---------|-----------|

|               |                 |            |            |
|---------------|-----------------|------------|------------|
| Position Held | Dates (from/to) | Supervisor | Department |
|---------------|-----------------|------------|------------|

**Note to the applicant:** The following sections, Physician/Employer Statement of Need, Evaluation and Statement of Responsibility, to be completed by your supervising physician, agency director, or other applicable supervisory person.



Procedure : \_\_\_\_\_

I hereby certify that I have performed the designated procedure satisfactorily in accordance with established policy and procedures.

| Type / Site | Patient Number | Date  |
|-------------|----------------|-------|
| ____ / ____ | _____          | _____ |
| ____ / ____ | _____          | _____ |
| ____ / ____ | _____          | _____ |

**TYPE : A-Adult   P-Pediatric   N-Neonate   SITE for ABG : R-Radial   B-Brachial   F-Femoral**

Procedure : \_\_\_\_\_

I hereby certify that I have performed the designated procedure satisfactorily in accordance with established policy and procedures.

| Type / Site | Patient Number | Date  |
|-------------|----------------|-------|
| ____ / ____ | _____          | _____ |
| ____ / ____ | _____          | _____ |
| ____ / ____ | _____          | _____ |

**TYPE : A-Adult   P-Pediatric   N-Neonate   SITE for ABG : R-Radial   B-Brachial   F-Femoral**

Procedure : \_\_\_\_\_

I hereby certify that I have performed the designated procedure satisfactorily in accordance with established policy and procedures.

| Type / Site | Patient Number | Date  |
|-------------|----------------|-------|
| ____ / ____ | _____          | _____ |
| ____ / ____ | _____          | _____ |
| ____ / ____ | _____          | _____ |

**TYPE : A-Adult   P-Pediatric   N-Neonate   SITE for ABG : R-Radial   B-Brachial   F-Femoral**

Procedure : \_\_\_\_\_

I hereby certify that I have performed the designated procedure satisfactorily in accordance with established policy and procedures.

| Type / Site | Patient Number | Date  |
|-------------|----------------|-------|
| ____ / ____ | _____          | _____ |
| ____ / ____ | _____          | _____ |
| ____ / ____ | _____          | _____ |

**TYPE : A-Adult   P-Pediatric   N-Neonate   SITE for ABG : R-Radial   B-Brachial   F-Femoral**

ATTESTATIONS:

**PROFESSIONAL INFORMATION :** If your answer to any of the following is yes, please provide a full explanation of the details on the back of this application.

- 1. Has there been denial, revocation, successful challenge, currently pending challenge, involuntary relinquishment of your license/certification in any state/district? \_\_\_ Yes \_\_\_ No
2. Have there been any disciplinary actions/investigations by the licensing/certification board on any state/jurisdiction or against you? \_\_\_ Yes \_\_\_ No
3. Have you ever been convicted or, or entered a please of guilty to any crimes other than minor misdemeanors? \_\_\_ Yes \_\_\_ No

**PROFESSIONAL LIABILITY INSURANCE:** If the answer to any of the questions below is yes, please provide a full explanation of the details on the back of this application.

- 1. \_\_\_ Yes \_\_\_ No Has your present professional liability insurance carrier excluded any specific procedures from your insurance coverage?
2. \_\_\_ Yes \_\_\_ No Have any professional liability suite been filed against you or professional liability claims made against you which are presently pending?
3. \_\_\_ Yes \_\_\_ No Have any professional liability suits been filed against you or professional liability claims made against you in the past?
4. \_\_\_ Yes \_\_\_ No Have any judgments/settlements been made against you or have you entered into settlement of any liability suit/claim?

**CLINICAL PRIVILEGES:** If the answer to any question is yes, please provide a full explanation of the details on the back of this application.

- 1. \_\_\_ Yes \_\_\_ No Has your application for clinical privileges ever been denied at any other hospital or institution?
2. \_\_\_ Yes \_\_\_ No Has your employment ever been involuntarily terminated at any other hospital or institution?
3. \_\_\_ Yes \_\_\_ No Have you ever had an involuntary limitation, reduction or loss of clinical privileges at any other hospital or institution?
4. \_\_\_ Yes \_\_\_ No Have you ever resigned or withdrawn your application for clinical privileges at any other hospital or institution?
5. \_\_\_ Yes \_\_\_ No Are there any proceedings currently in process with regard to your clinical privileges at any other hospital/institution?

**HEALTH STATUS :** Do you have a physical or mental condition which could affect your ability to exercise the clinical privileges requested or require an accommodation in order for you to exercise the privileges at any other hospital/institution?

\_\_\_ Yes \_\_\_ No

If you application fulfills all the criteria of the privilege for which you are applying and you answer yes to the above question, the Credentials Committee may request further information to determine what accommodations are necessary to allow you to practice safely.

In making an application for ancillary privileges at Cabell Huntington Hospital, I state that the foregoing information is complete and accurate to the best of my knowledge and belief. I acknowledge and agree that inaccurate, incomplete or missing answers shall be grounds for denial of my application. If I am approved for privileges at Cabell Huntington Hospital, I agree to abide by the Hospital policies and procedures and, if applicable, the Bylaws, Rules & Regulations of the Medical and Dental Staff.

By applying to Cabell Huntington Hospital for clinical privileges, I hereby :

- Signify my willingness to appear for interviews regarding my application ;
• Authorize representatives of the Hospital to consult with my present and former employer(s), representatives of other hospitals where I have or have had ancillary privileges and with others who may have information bearing on my competence, character and ethical qualifications.
• Consent to inspection by the representatives of the Hospital of all records and documents that may be pertinent to an evaluation of my professional qualifications and competence and health status, if requested, to carry out the clinical privileges I request as well as to an evaluation of my moral and ethical qualifications ;
• Release from liability all representatives of the Hospital and its staff for disclosures made and acts performed in good fait hand without malice in connection with evaluating my credentials ;
• Release from any liability all individuals and organizations who provide data including otherwise privileged or confidential information) to the Hospital in good faith and without malice concerning my competence, qualifications and clinical privileges.

# CHH ADDENDUM - HOSPITAL REQUIRED INFORMATION ALLIED HEALTH PROFESSIONAL

## A. AUTHORIZATION FOR RELEASE OF INFORMATION

In applying for authorization to provide clinical services at Cabell Huntington Hospital, I state that the foregoing information contained in the application and/or the re-application credentialing form is complete and accurate to the best of my knowledge and belief. I acknowledge and agree that inaccurate, incomplete or missing answers shall be grounds for denial of my application. If I am authorized to provide clinical services at Cabell Huntington Hospital, I agree to abide by the Hospital policies and procedures, and, if applicable, the Bylaws, Rules and Regulations of the Medical and Dental Staff.

By applying to Cabell Huntington Hospital for authorization to provide clinical services, I hereby:

- a) signify my willingness to appear for interviews regarding my application, if requested;
- b) authorize representatives of the hospital to consult with my present and former employer(s), representatives of other hospitals where I have or have had clinical privileges, and with others who may have information bearing on my competence, character and ethical qualifications;
- c) consent to inspection by the representatives of the Hospital of all records and documents that may be pertinent to an evaluation of my professional qualifications and competence and health status, if requested, to carry out the clinical privileges I request as well as to an evaluation of my moral and ethical qualifications;
- d) release from liability all representatives of the Hospital and its staff for disclosures made and acts performed in good faith and without malice in connection with evaluating my credentials; and
- e) release from liability all individuals and organizations who provide data (including otherwise privileged or confidential information) to the Hospital in good faith and without malice concerning my competence, qualifications and clinical privileges.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Applicant

## B. PHYSICIAN EMPLOYER/SPONSOR STATEMENT OF RESPONSIBILITY

As the employing/sponsoring physician who will be supervising the applicant named herein, I state that the foregoing information contained in the application and/or the re-application credentialing form provided is complete and accurate to the best of my knowledge and belief, and I hereby accept responsibility for all activities performed at Cabell Huntington Hospital by this individual.

\_\_\_\_\_  
Signature of Employing/Supervising Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Employing/Supervising Physician

\_\_\_\_\_  
Signature of Employer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Employer

**C. RECOMMENDATIONS AND APPROVAL (office use only)**

**RECOMMENDATION OF HOSPITAL CREDENTIALING COMMITTEE:**

- Authorization to Provide Clinical Services Approved as Requested
- Authorization to Provide Clinical Services Approved with Modification \_\_\_\_\_
- Authorization to Provide Clinical Services Not Recommended

**SIGNATURE OF CHAIR** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**RECOMMENDATION OF CREDENTIALS COMMITTEE :**

- Authorization to Provide Clinical Services Approved as Requested
- Authorization to Provide Clinical Services Approved with Modification \_\_\_\_\_
- Authorization to Provide Clinical Services Not Recommended

**SIGNATURE OF CHAIR** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**RECOMMENDATION OF MEDICAL EXECUTIVE COMMITTEE :**

- Authorization to Provide Clinical Services Approved as Requested
- Authorization to Provide Clinical Services Approved with Modification \_\_\_\_\_
- Authorization to Provide Clinical Services Not Recommended

**SIGNATURE OF CHAIR** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**APPROVED AND APPOINTED BY BOARD OF DIRECTORS:**

- Authorization to Provide Clinical Services Approved as Requested
- Authorization to Provide Clinical Services Approved with Modification \_\_\_\_\_
- Authorization to Provide Clinical Services Not Recommended

**SIGNATURE OF CHAIR** \_\_\_\_\_ **Date:** \_\_\_\_\_