



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

## Reapplication for Hospital Ancillary Privileges

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### A. PERSONAL INFORMATION

Applicant Name :	Date:	Dept.:
Reapplication Date :	Employment Status :	Profession (RN, etc.):

### 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"/> Laryngeal 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

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**

**\*\*Confidential & Privileged Peer Review Data\*\***  
Pursuant to W.Va. Code 30-3C-1 et. Seq.

1340 Hal Greer Boulevard · Huntington, West Virginia 25701 · 304-526-2053

Applicant Name: \_\_\_\_\_



## 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 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 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: \_\_\_\_\_