ORIENTATION CHECKLIST

ORIENTATION ITEMS FOR REVIEW	DATE COMPLETED	ORIENTATION BY	EMPLOYEE INITIALS
1. FACILITY OVERVIEW ❑ Organization Mission Statement, Vision Statement and its goals ❑ Organizational Chart ❑ Corporate Compliance Program ❑ Introduction to Facility Personnel ❑ Tour of this facility ❑ Introduction to Work Stations ❑ Equipment Management ❑ Storage, handling and access to supplies			
2. HUMAN RESOURCE POLICIES ❑ Quality Management Plan ❑ Incident reporting (aka Adverse Event) ❑ Staff grievance and complaints policy **FORMS STAFF MEMBER COMPLETES** ❑ Employment Application ❑ Employer References ❑ Job Descriptions ❑ Competency Assessments ❑ Performance Evaluations ❑ Orientation Checklist ❑ Annual In-Service Module ❑ Confidentiality Agt/HIPAA ❑ Conflict of Interest ❑ Employment Verification ❑ Health Status Attestation ❑ Flu, HEP-B, HIV Consents **DOCUMENTS STAFF MEMBER PROVIDES** ❑ Curriculum Vitae/Resume ❑ Valid, unexpired professional licenses and other credentials for inspection & photocopy ❑ Valid, unexpired CPR certificate (ACLS/BLS) ❑ Valid, unexpired US Passport, or government-issued photo ID in conjunction with a Social Security Card, or other acceptable form of photo ID listed on page 9 of Form I-9 ❑ PPD/CXR TB Results; Immun. Record			
3. ENVIRONMENT OF CARE EMERGENCY PREPAREDNESS ❑ Life & Fire Safety ❑ Emergency Evacuation ❑ Actions in Unsafe Situations ❑ Emergency Management Plan			
4. INFECTION PREVENTION AND CONTROL PRACTICES ❑ Universal Precautions ❑ Influenza Vaccination Program ❑ OSHA Bloodborne Pathogens ❑ Sharps Injury Prevention ❑ Hand Hygiene ❑ Personal Protection Equipment (PPE) ❑ Identifying, handling, and disposing of hazardous or infectious materials.			
5. PATIENT CARE ❑ Ethical aspects of patient care. ❑ Patient care services this facility provides. ❑ Patient safety. ❑ Patient confidentiality, privacy, and HIPAA requirements. ❑ Patient rights and responsibilities. ❑ Medication Reconciliation ❑ Advance Directives. ❑ Responsibility to report patient abuse and neglect.			

The above facility policies and procedures have been reviewed with me. I understand it is my responsibility to direct any questions regarding the foregoing to my manager or to Human Resources personnel for further clarification.

Print Employee Name: _____

Employee Signature: _____ Date: _____

Supervisor / HR Signature: _____ Date: _____

Allied Practitioner Application & Credentialing Questionnaire

INSTRUCTIONS: This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application.

1. IDENTIFYING INFORMATION

Full Legal Name:_____ Contact Phone:_____

Full Address:_____

Social Security no.:_____ Date of Birth.:_____ Email Address:_____

2. CREDENTIALS

Allied Profession.:_____ License/Certificate no.:_____ Issued by:_____ Expires:_____

DEA Registration Cert. no.:_____ Expires:_____ Life Support: ___ACLS ___BLS Expires:_____

Medicare no.:_____ Medicaid/Cal no.:_____ UPIN:_____ NPI:_____

Physician for whom you will work under, free of license restrictions that prohibit PA supervision (PAs only):_____

3. SPECIALTIES and BOARD CERTIFICATION

Primary Specialty:_____ Issuing Board:_____ Date Certified:_____ Expires:_____

Secondary Specialty:_____ Issuing Board:_____ Date Certified:_____ Expires:_____

Tertiary Specialty:_____ Issuing Board:_____ Date Certified:_____ Expires:_____

4. EDUCATION

Undergraduate Institution:_____ City & State:_____ Degree:_____ Year Graduated:_____

Graduate Institution:_____ City & State:_____ Degree:_____ Year Graduated:_____

Trade/Vocational School:_____ City & State:_____ Degree:_____ Year Graduated:_____

5. CLINICAL EMPLOYMENT HISTORY

Facility Name:_____ from:_____ to:_____ Position:_____

Address:_____ Reason for Leaving:_____

Office Manager/Credentialing Officer:_____ Office Phone no.:_____

Facility Name:_____ from:_____ to:_____ Position:_____

Address:_____ Reason for Leaving:_____

Office Manager/Credentialing Officer:_____ Office Phone no.:_____

Facility Name:_____ from:_____ to:_____ Position:_____

Address:_____ Reason for Leaving:_____

Office Manager/Credentialing Officer:_____ Office Phone no.:_____

6. PEER REFERENCES

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges. **NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.**

Name of **1st** Reference:_____ Phone No.:_____

Mailing Address:_____ Email Address.:_____

Name of **2nd** Reference:_____ Phone No.:_____

Mailing Address:_____ Email Address.:_____

Name of **3rd** Reference:_____ Phone No.:_____

Mailing Address:_____ Email Address.:_____

7. ATTESTATION QUESTIONS

Professional liability

a) Has any insurer ever denied, cancelled, refused to renew, or imposed restrictions upon your professional liability insurance? ____YES ____NO

b) Has there been any claim activity, filed or settled, with respect to your professional practice during the past 5 years? If "Yes", provide the following information on a separate sheet of paper: (1) how the matter was resolved; (2) the amount that was paid by you or on your behalf and date of settlement; (3) your role in the matter; (4) the patient outcome; and (5) detailed narrative regarding each incident of malpractice (or complete page 4 of application). ____YES ____NO

Privileges

a) Have your clinical privileges ever been voluntarily surrendered, expired, or withdrawn during a quality of care investigation? ____YES ____NO

b) Have your clinical privileges ever been voluntarily or involuntarily denied, restricted, reduced, or terminated? ____YES ____NO

c) Have you ever been the subject of disciplinary action, such as, but not limited to, punitive or disciplinary observation, preceptorship, or sponsorship in any type of healthcare facility? ____YES ____NO

Governmental

a) Has any regulatory or licensing agency ever suspended or revoked your license (whether or not such revocation or suspension was stayed), placed you on probation, issued a public or private reprimand with respect to your practice, or otherwise concluded that you engaged in professional misconduct? ____YES ____NO

b) Are you currently being investigated by or are you on probation with any governmental agency? ____YES ____NO

c) Has any sanction ever been imposed upon you by Medicare ____or recommended by the Medicare PRO ____? ____YES ____NO

d) Have you ever been expelled or suspended from receiving payment under Medicare, _____ Medi-Cal,_____ or TRICARE/CHAMPUS_____? ____YES ____NO

e) Have you ever been convicted of a felony or misdemeanor (including those deferred, set aside, dismissed, expunged, or issued a stay of execution? ____YES ____NO

Other

a) Have you ever been expelled from or disciplined by a medical organization for professional competency reasons? ____YES ____NO

b) Has your contract with an insurer, healthcare service plan, or any similar entity ever been terminated? ____YES ____NO

c) Do you have any health problems that might affect your practice of medicine? ____YES ____NO

d) Do you currently use illegal drugs? ____YES ____NO

e) Are there any reasons you would not be able to perform all the services required by your agreement with and the bylaws of this IDTF with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients? ____YES ____NO

By my signature, I affirm that my answers to the above Attestation Questions and the information provided in this Allied Practitioner Application & Credentialing Questionnaire as well as any addenda thereunder are true, current, correct, and complete to the best of my knowledge and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges granted hereafter and may be reportable to medical boards or other licensing entities as required by law.

Date	Allied Practitioner Signature (sign here)	Print Name	License of Certificate No.

10. Adverse Events Disclosures

Allied Practitioner Name:_____

INSTRUCTIONS: **You must sign and date this form.** Please take a moment to explain in your own words the circumstances surrounding events that have given rise to any malpractice claim or other disciplinary action made against you or your license. Your response will be kept strictly confidential and will be reviewed only by this healthcare facility's credentialing department and a committee of your peers. Photocopy and complete this form including all relevant clinical information for each claim filed or settled in the past five years. If more space is needed, continue information on your letterhead. **If you have no Adverse Events to disclose, write in "N/A" in line no. 1.** Please write legibly.

a) Patient's initials or case I.D: _____ **2.** Date of Incident:_____

b) Your professional role at the time incident occurred:_____

c) Specific allegation:_____

d) Status:

____ Lawsuit/arbitration/claim currently pending

____ Withdrawn/dropped/date:_____

____ Lawsuit/arbitration/judgment

____ Dismissed/date:_____

____ Settlement/date:_____

- Total amount paid:_____
- Amount paid on your behalf:_____

____ Lawsuit is related to a Medical Board accusation/action Date:_____

____ Lawsuit is related to a cancellation of liability insurance Date:_____

e) Condition and diagnosis of patient at time of incident:

_____

_____

_____

f) Dates and clinical description of professional services rendered:

_____

_____

_____

g) Condition of patient subsequent to professional services, (dates of follow-up visits and outcome of incident) if known:

_____

_____

_____

h) Comments (including any additional education or changes to practice):

_____

_____

_____

Date	Allied Practitioner Signature (sign here)	Print Name	License of Certificate No.