YALE NEW HAVEN HEALTH / Application for Medical Staff Guests

PART I

NAME	
DATE(S) REQUESTED	
Relevant YALE NEW HAVEN HEALTH Hospital *(check as applicable)*	☐ Bridgeport ☐ Greenwich ☐ Lawrence + Memorial ☐ Westerly ☐ Yale New Haven
Please specify type of privileges and/or procedures requested	
Please specify patient name/s *(if applicable)*	

PART II

ALL CURRENT HOSPITAL APPOINTMENTS *(please indicate primary hospital)*	
SPECIALTY	
MEDICAL LICENSE(s) *(List all states and license numbers)*	
NPI NUMBER	
SOCIAL SECURITY NUMBER	
BIRTHPLACE	
MALPRACTICE INSURANCE CARRIER	
MALPRACTICE COVERAGE AMOUNT	
MALPRACTICE INSURANCE CONTACT INFORMATION	
MEDICAL SCHOOL *(Institution Name and Address)*	
DEGREE RECEIVED	
DATE OF GRADUATION	
INTERNSHIP *(Institution Name and Address)*	
TYPE	
DATES OF ATTENDANCE *(Include Month and Year)*	
RESIDENCY *(Institution Name and Address)*	
TYPE	
DATES OF ATTENDANCE *(Include Month and Year)*	
FELLOWSHIP *(Institution Name and Address)*	
TYPE	
DATES OF ATTENDANCE *(Include Month and Year)*	

Printed Name: _____ **Signature: _____**

Date: _____

PRACTICE HISTORY INFORMATION

If you answer "yes" to any of the following questions, you must supply full details on a separate sheet.

1. **STATE LICENSURE** Regarding your license to practice your profession in any jurisdiction:
   a. Has your application for a professional license ever been denied? ☐ Yes ☐ No
   b. Has your license ever been limited, suspended or revoked? ☐ Yes ☐ No
   c. Has the relevant licensing board ever investigated your professional practice or censured or sanctioned you for matters having to do with professional practice? ☐ Yes ☐ No
   d. Have you ever entered into a consent order, practice agreement, reinstatement order (or equivalent thereof) with any licensing board? ☐ Yes ☐ No
   e. Have you ever been fined or otherwise sanctioned by a state licensing board? ☐ Yes ☐ No
   f. Have you ever voluntarily surrendered your license? ☐ Yes ☐ No
2. Have you ever been, or are you currently, under investigation or involved in any proceeding or other disciplinary matter involving your practice before any state licensing board? ☐ Yes ☐ No

CONTROLLED SUBSTANCE PRESCRIBING

3. Have you ever been denied a state or federal certificate of authority to prescribe controlled substances or is your state or federal certificate of authority to prescribe controlled substances currently under investigation or has your authority to prescribe ever been under investigation? ☐ Yes ☐ No
4. Has your state or federal authority to prescribe controlled substances ever been voluntarily or involuntarily…
   a. limited by the agency? ☐ Yes ☐ No
   b. suspended? ☐ Yes ☐ No
   c. revoked? ☐ Yes ☐ No
   d. surrendered? ☐ Yes ☐ No
   e. denied renewal? ☐ Yes ☐ No

PROFESSIONAL MEMBERSHIPS

5. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action by any medical organization? ☐ Yes ☐ No
6. Have you ever been sanctioned or subject to disciplinary action by a specialty board or has your specialty or sub-specialty certification ever been suspended or revoked? ☐ Yes ☐ No

EDUCATION

7. In medical/professional school, internship, residency, post graduate training or fellowship, were you ever suspended, placed on probation, subject to disciplinary action, formally reprimanded or asked to resign? ☐ Yes ☐ No
8. Did you ever voluntarily resign or withdraw from any of the above programs? ☐ Yes ☐ No

COMPLIANCE

9. Has your eligibility to participate in the Medicare or Medicaid or any commercial insurance program ever been suspended or terminated or have you ever been threatened with exclusion or debarment from Medicare or Medicaid? ☐ Yes ☐ No
10. Have you ever been the subject of an investigation by any federal or state agency, including those agencies responsible for administering and overseeing the Medicare and Medicaid programs, or by any commercial insurance company, related to your professional practice, conduct or billing for health care services? ☐ Yes ☐ No
11. Have you ever been listed by the OIG (Office of Inspector General), GSA (General Services Administration), OFAC or any State (including the Connecticut Department of Social Services) as debarred, excluded or otherwise ineligible for Federal health program participation or otherwise sanctioned by the Federal government, including being listed on the EPLS (Excluded Parties List System)? ☐ Yes ☐ No

12. Have you ever been charged by any local, state or federal authority, official or agency, entered a plea of guilty or no contest or been convicted of any of the following:
    a. crimes or offenses related to the delivery of or billing for health care services under the Medicare or Medicaid program? ☐ Yes ☐ No
    b. crimes or offenses related to the abuse or neglect of patients in connection with the delivery of health care? ☐ Yes ☐ No
    c. crimes or offenses involving fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of health care or involving any act or omission in a program financed in whole or in part by any federal, state or local government? ☐ Yes ☐ No
    d. obstruction of justice? ☐ Yes ☐ No
    e. crimes or offenses related to the manufacture, distribution, prescription or dispensing of any controlled substance? ☐ Yes ☐ No
    f. any other felony or misdemeanor crimes or offenses (excluding only motor vehicle speeding violations and parking tickets)? ☐ Yes ☐ No

HEALTH CARE FACILITY MEMBERSHIP & PRIVILEGES

13. Have you ever been denied privileges or medical staff membership at any hospital or other health care facility? ☐ Yes ☐ No
14. Have you ever been the subject of a professional review action or any disciplinary action at any hospital or health care facility and/or have you ever been a party to a hearing under any set of medical staff bylaws? *Defined as- adverse clinical privilege actions related to professional competence or conduct ☐ Yes ☐ No
15. Have your hospital or other health care facility privileges or medical staff membership ever been voluntarily or involuntarily cancelled, challenged, reduced, surrendered, limited, suspended, not renewed, revoked or withdrawn? ☐ Yes ☐ No
16. Have there been any adverse professional actions or other disciplinary actions ever been made against you related to disruptive behavior or unprofessional conduct? ☐ Yes ☐ No

HEALTH / BEHAVIORAL

17. Are you dependent upon any controlled substance or alcohol? ☐ Yes ☐ No
18. Are you presently using illegal controlled substances (i.e. controlled substances for which you do not have a prescription from your healthcare provider or that you are using contrary to the prescribed dosage) or are you presently dependent on alcohol? ☐ Yes ☐ No
19. With or without reasonable accommodation, do you have any physical, mental or emotional condition or dependency that would compromise your ability to competently and safely exercise the clinical privileges requested? ☐ Yes ☐ No
20. Has formal disciplinary action or professional review action ever been imposed on you? ☐ Yes ☐ No

LIABILITY HISTORY

Please note that minimum insurance limits for the Medical Staff of $1 million per occurrence and $3 million in the aggregate is required (proof of insurance coverage is required).

21. Have you ever been reported to the National Practitioner Data Bank by any individual or organization for any reason? ☐ Yes ☐ No
22. Has any malpractice or professional liability claim been brought against you?
    If yes, please complete the attached "Claim/Suit Report" for each case and describe the case indicating the following:
    a. date and details of the incident(s)
    b. your role in the incident(s)
    c. current status of the claim
    d. if settled, amount paid
    e. if pending, amount being sought
    f. professional liability insurer involved ☐ Yes ☐ No
23. Have you ever been denied professional liability coverage or has your professional liability coverage ever been revoked or not renewed by action of the insurer? ☐ Yes ☐ No

YALE NEW HAVEN HEALTH
IMMUNIZATION TESTING RECORD

NAME: _____ D.O.B.: _____
DEPARTMENT: _____ DATE: _____

DOCUMENTATION OF IMMUNIZATIONS/TITERS		
	DATES of vaccine or titer	**TITER RESULT**
MEASLES VACCINE (dates for both doses) **or**		N/A
MEASLES TITER (if no vaccine)		
RUBELLA VACCINE (dates for both doses) **or**		N/A
RUBELLA TITER (if no vaccine)		
MUMPS VACCINE (dates for both doses) **or**		N/A
MUMPS TITER (if no vaccine)		
VARICELLA VACCINE received (2 doses of Varivax) **or**		N/A
History of physician-diagnosed illness (chicken pox, herpes-zoster)		N/A
VARICELLA TITER (if neither of the above)		
TETANUS-DIPTHERIA-PERTUSSUS VACCINE received (must be since 2005)		N/A
TB SKIN TEST (negative within past 12 months) **or**		N/A
IGRA (negative within past 12 months)		N/A
INFLUENZA VACCINE (annual)		N/A
COVID-19 VACCINE (dates for doses and brand of vaccine) ALSO UPLOAD IMAGE OF VACCINATION CARD OR DOCUMENTATION FROM ELECTRONIC MEDICAL RECORD		N/A

PPD or IGRA Positive

If **PPD/IGRA** positive, did you have a chest x-ray: **YES** ☐ (please include results) **NO** ☐

If **PPD/IGRA** positive, did you receive prophylactic anti-tuberculosis therapy? **YES** ☐ **NO** ☐

HEPATITIS B

Have you received the **Hepatitis B** Vaccine series? **YES** ☐ **NO** ☐

If no, you must complete the Hepatitis B declination and waiver form.

If yes, what was the result of your **Hepatitis B** surface antibody test following the vaccine series?

POSITIVE ☐ **NEGATIVE** ☐

YALE NEW HAVEN HEALTH
MEDICAL STAFF REQUIREMENTS
IMMUNIZATIONS AND TB SURVEILLANCE

Based upon current standards of OSHA/AHA/CDC/Joint Commission and YNHHS policy, applicants to the Medical Staff and Clinical Fellows are required to submit their immunization/test records to Medical Staff Administration along with the application for appointment. For your convenience, a standardized reporting form is enclosed. The following documentation is required:

- **MEASLES** (for those whose DATE OF BIRTH is 1/1/57 or later), statement of history of illness is not acceptable: A statement of date of positive antibody titer
  Or
  Dates of Immunization with MMR vaccine (2 doses subsequent to first birthday)

- **RUBELLA** (for those whose DATE OF BIRTH is 1/1/57 or later), statement of history of illness is not acceptable: A statement of date of positive antibody titer
  Or
  Dates of Immunization with MMR vaccine (2 doses subsequent to first birthday)

- **MUMPS** (for those whose DATE OF BIRTH is 1/1/57 or later), statement of history of illness is not acceptable: A statement of date of positive antibody titer
  Or
  Dates of Immunization with MMR vaccine (2 doses subsequent to first birthday)

- **HEPATITIS B**
  A statement of date of positive hepatitis b surface antibody titer
  Or
  Date of completion of Immunization series
  Or
  Signed attached declination and waiver

- **VARICELLA-ZOSTER VIRUS**
  A statement of history of physician-diagnosed illness (chicken pox, shingles, or herpes-zoster)
  Or
  Dates of Immunization with Varivax (2 doses)
  Or
  Result of antibody titer.

- **TETANUS-DIPHTHERIA-PERTUSSIS**
  Date of immunization with Tdap since 2005

- **TB SKIN TEST**
  A negative 2-step PPD within the most recent 12 months
  Or
  For those with two years of serial PPD testing, a single baseline negative PPD within most recent 12 months
  Or
  A negative Interferon Gamma Release Assay (IGRA) result for TB within past 12 months

Or
For those with a positive PPD or positive IGRA, date of evaluation for Latent TB Infection (LTBI) and a chest radiograph report subsequent to positive PPD or positive IGRA.

Members of the Medical Staff with negative PPD or negative IGRA result will be required to document annual PPD or IGRA testing during the bi-annual re-credentialing process.

- **INFLUENZA**
  Vaccination required annually: evidenced by documentation from OHS, attestation by practitioner of vaccine receipt, or statement of declination for medical or religious reason.

- **COVID-19** statement of history of illness is not acceptable
  The brand and date(s) of vaccine and booster must be included on the immunization form
  And
  An image of vaccination card or documentation from electronic medical record must be provided, which includes the initial two doses of Moderna or Pfizer, or one dose of J&J, **and** a booster dose

Special Considerations for Lawrence and Memorial and Westerly Hospitals:

Medical Staff of Lawrence and Memorial and Westerly Hospitals ***not*** employed by NEMG are strongly recommended to receive influenza vaccine, but may decline the vaccine.

ADDITIONAL REQUIREMENTS

Medical Staff who care for patients in negative pressure isolation rooms are expected to complete fit testing for the N95 respirator on an annual basis. Medical Staff who interpret tests requiring color discernment (e.g. dipstick of urine) should have normal color vision. YNHHS Occupational Medicine and Wellness Services (OMWS) Clinics are available to carry out N95 fit testing and Ishihara color vision screening for Medical Staff members at no charge. OMWS Clinics also are available at no charge to Medical Staff members who require additional vaccine doses or serological testing for vaccine response. Medical Staff members may contact OMWS at the following numbers:

YNHH YSC: 203-688-2462 (1st floor, YNHH YSC East Pavilion)
YNHH SRC: 789-3721 (175 Sherman Avenue, 5th floor)
Bridgeport Hospital 203-384-3613 (226 Mill Hill Ave # 2)
Greenwich Hospital203-863-3400 (Watson Pavilion, 2nd floor)
L&M Hospital 860-442-0711, ext. 2289 (L&M Hospital)
Westerly Hospital 401-348-3783 (Westerly Hospital)

HEPATITIS B VACCINE DECLINATION

(Please sign if you are declining HepB vaccination):

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with
hepatitis B vaccine. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

_____
(Signature)

_____
Please print Full Name

Authorization & Release

By applying for appointment as a Guest I accept and agree to the conditions set forth in this Authorization & Release, (1)regardless of whether such appointment is granted, (2)throughout the term of any appointment granted, (3)even if my appointment is revoked, reduced, restricted, suspended, or otherwise affected as part of one of the YALE NEW HAVEN HEALTH Affiliate's professional review activities, and (4)with respect to any communications with third parties before, during or after the term of my appointment.

I understand and agree that acceptance of this application does not constitute approval and grants me no rights until such time as I receive written notice. I understand that this application will not be processed until all requested information has been received and the application has been deemed complete in accordance with the applicable Medical Staff Bylaws and Policies/Procedures. I understand and agree that it is my responsibility to provide correct and complete information in connection with this application.

OBTAINING INFORMATION FROM ANY THIRD PARTY
I hereby authorize YALE NEW HAVEN HEALTH Affiliated hospitals, as well as their respective representatives, employees, agents and members, as applicable, to contact and gather information from third parties, including, but not limited to, my prior associates and anyone else regarding any and all information bearing on my professional competence, character, health status, ethics, ability to work cooperatively with others, or other qualifications.

INFORMATION SHARING
I hereby authorize YALE NEW HAVEN HEALTH Affiliated hospitals and their authorized employees and representatives to share any and all information bearing on my professional competence, character, health status, ethics, ability to work cooperatively with others, or other qualifications relevant to my application, including but not limited to my primary source verification information, peer review information, Ongoing Professional Practice Evaluation ("OPPE")and Focused Professional Practice Evaluation ("FPPE") application and health information records, including but not limited to demographics, immunization, titer and PPD records and information, obtained during the course of my guest appointment.

I agree that the information about me as described above may be shared at any time with other YALE NEW HAVEN HEALTH Affiliated Hospital for Medical Staff credentialing.

I consent to and authorize YALE NEW HAVEN HEALTH Affiliated hospitals and their representatives, employees and agents to allow the YALE NEW HAVEN HEALTH Medical Staff Administration Department and accrediting agency or body access to file as requested and, further, to permit such organizations, agencies and bodies to review said files to confirm compliance with applicable contracts.

ABIDE BY MEDICAL STAFF BYLAWS
I have read and agree to abide by the relevant YALE NEW HAVEN HEALTH Affiliated hospital Medical Staff Bylaws, Rules & Regulations and relevant policies (which shall include Infection Control, Safety and Standard Precautions, HIPAA Privacy and Security policies, and any other relevant policies governing my clinical specialty or workspace) I understand that if I have not already received copies of such Medical Staff Bylaws, Rules & Regulations, or policies, it is incumbent upon me to contact the relevant entity to request a copy of such documents before signing this Authorization & Release.

MISREPRESENTATIONS AND OMISSIONS
I declare under penalty of law that all statements, answers, and information contained in or submitted in conjunction with this application are true, correct and complete to the best of my knowledge. I understand that the discovery of any falsification, misrepresentation, or omission of any fact(s)by me will be sufficient cause to cease processing of my application. I agree to inform the YALE NEW HAVEN HEALTH Medical Staff Administration Department in writing, with or without request, of any changes in the information provided and the answers to questions on the application as a result of new information or developments subsequent to my signing of the application for the duration of the guest appointment, if granted.

I agree to defend and indemnify YALE NEW HAVEN HEALTH Affiliated Hospitals, and their representatives, employees, agents and Medical Staff members, for any damages that incur as a result of any false or misleading information provided by me or any material omissions made by me in conjunction with my request for an application, or in conjunction with my failure to comply with any provisions of the respective Medical Staff Bylaws, Rules or Regulations, or policies that require me to provide notification about changes to my qualifications that occur during the term of any appointment granted to me.

IMMUNITY

To the fullest extent permitted by law, I hereby release from liability and agree not to sue all representatives, employees, agents and Medical Staff members of any YALE NEW HAVEN HEALTH Affiliates for any action, recommendation, report, statement, communication and/or disclosure that is made, taken or received in the course of my guest appointment activities. I further release from liability and agree not to sue any and all individuals and organizations who communicate or otherwise provide information to YALE NEW HAVEN HEALTH and its representatives, employees, agents and members concerning my professional competence, ethics, character, and other qualifications.

ATTESTATION

I agree that photocopies of this document will be as binding as the original and attest to the fact that the signature below is my own.

Signature and Date