GUAM MEMORIAL HOSPITAL AUTHORITY
APPLICATION FOR MEDICAL STAFF APPOINTMENT/PRIVILEGES
(PLEASE TYPE OR PRINT LEGIBLY)

Date:_____

PLACE

PASSPORT PHOTO

HERE

2" x 2"

1. An initial application fee of *$230.00* which is non-refundable MUST accompany this application. The check must be made payable to "Guam Memorial Hospital Authority".

2. Please ATTACH copies of the following documents to this application:

   a. Current Guam Medical License;

   b. Current Guam Controlled Substance License (or signed statement explaining unavailability);

   c. Current Federal Narcotics Registration Certification (DEA);

   d. A letter from the facility of your most recent appointment stating staff status, dates affiliated and standing.

   e. Professional liability insurance policy certificate of coverage from insurance carrier showing your name, the amount of coverage, dates of coverage and address of insurance company (If applicable);

   f. ECFMG and/or Fifth Pathway Certificate (If international medical graduate);

   g. Medical School Diploma

   h. Internship and Residency Certificates;

   i. Evidence of Board Certification and Re-certification (If application);

   j. Current BLS, ACLS, ATLS, PALS certification, as appropriate, if requesting for privileges in specialty areas. BLS required for all practitioners;

   k. A curriculum vitae, if the dates of your academic activities or employment/affiliation are not evident on this application;

   l. Copies of clinical privileges sheet;

   m. CME Certificates within last two (2) years;

   n. Physical/Mental Health Examination (most recent);

   o. Passport size photo.

Revised Dates:
12/91, 4/93, 10/93, 6/94, 11/94, 2/95; 01/99

NAME OF APPLICANT:_____ DATE OF APPLICATION: ___/___/__

If more space is needed for any items, attach additional sheets and make reference to the question bein answered.

PERSONAL IDENTIFICATION DATA

Full Name_____ Degree_____ Sex_____

Other Name Used_____

Date of Birth____/____/____ Birth Place_____ SSN_____

Citizenship_____ If not a citizen of the United States, please indicate the status of your visa at the present time:_____

Group Name:_____

Office Address_____ Telephone_____

City/State/Zip_____

Mailing Address_____ Telephone_____

City/State/Zip_____

Send mail to office: ___Yes ___No; Specify where:_____

Pager #/Beeper #_____ Cellular_____ FAX_____

Home Address_____ Telephone_____

City/State/Zip_____

Marital Status_____ Spouse Name_____

DEPARTMENT AND SPECIALTIES:

[ ] MEDICINE DEPARTMENT: Check one (1) below:

[ ] Internal Medicine	[ ] Dermatology	[ ] Radiology/Nuclear Medicine
[ ] Cardiology	[ ] Psychiatry	[ ] Pathology
[ ] Neurology	[ ] Other:_____	

[ ] SURGERY DEPARTMENT: Check one (1) below:

[ ] Anesthesia	[ ] General Surgery	[ ] Orthopedic
[ ] Ophthalmology	[ ] Plastic Surgery	[ ] Oral Maxillofacial/Dentistry
[ ] Otolaryngology	[ ] Podiatry	[ ] Urology
[ ] Vascular	[ ] Other:_____	

NAME OF APPLICANT:_____ DATE OF APPLICATION: ___/___/__

CONTINUATION OF DEPARTMENT AND SPECIALTIES: Check one (1) below:

[ ] EMERGENCY MEDICINE, [ ] FAMILY/GENERAL PRACTICE, [ ] PEDIATRICS,

[ ] OBSTETRIC/GYNECOLOGY

Do you wish to apply for additional privileges? ____Yes ____No;
If "Yes", check the following that applies: [ ]EMD [ ]ICU [ ]CCU [ ]PICU [ ]NICU
[ ] Other:_____

To which STAFF CATEGORY do you wish to apply?
[ ]Active [ ]Active Associate [ ]Courtesy [ ]Honorary [ ]Locum Tenens [ ]Visiting Consultant

NOTE: All new members are initially appointed to the Provisional Medical Staff for one (1) year.

What other languages do you speak fluently?_____

HMO/PPO Affiliation on Guam:_____

BOARD CERTIFICATION

Names of specialty boards by which you are certified.

Board	Certification Date	Recertification Date	Expiration Date

Name of Board you are eligible for:_____ Date eligibility expires_____

If not certified, have you applied for certification examination? ____Yes ____No; If "No", do you intend to apply for certification examination? ____Yes ____No; If "Yes", when?_____

Have you been accepted to take the certification examination? ____Yes ____No; If yes, what dates are you scheduled to take the certification examination?_____

LICENSURE

_____

Drug Enforcement Administration (DEA) REGISTRATION NUMBER, CLASSES and EXPIRATION DATE

_____

Guam Controlled Substance REGISTRATION NUMBER, CLASSES EXPIRATION DATE

_____

Guam Medical License NUMBER and EXPIRATION DATE

NAME OF APPLICANT:_____ DATE OF APPLICATION: ___/___/___

OTHER STATE MEDICAL LICENSES (Certificates; all past/present)

State	License Number	Expiration Date
State	License Number	Expiration Date
State	License Number	Expiration Date
State	License Number	Expiration Date

PROFESSIONAL LIABILITY INSURANCE DATA

Insurance Carrier_____ Policy Number_____

Expiration Date:_____ Amount (PER OCC)_____ Amount AGG_____

Complete Address_____

Coverage Limits_____ Class #_____

LIST ALL PAST PROFESSIONAL LIABILITY INSURERS BELOW:

Insurance Carrier_____

Beginning Date_____ Ending Date_____ Policy #_____

Complete address_____

Coverage Limits_____ Class #_____

Insurance Carrier_____

Beginning Date_____ Ending Date_____ Policy #_____

Complete address_____

Coverage Limits_____ Class #_____

1. Has your professional liability insurance coverage ever been terminated by action of the insurance company? ____Yes ____No
2. Have you ever been denied professional liability insurance coverage? ____Yes ____No
3. If the answer to questions 1 or 2 is "Yes", state when, why, and by what company_____

NAME OF APPLICANT:_____ DATE OF APPLICATION: ___/___/___

PROFESSIONAL LIABILITY DATA CONTINUATION

4. Has your present professional liability insurance carrier excluded any specific procedures from your coverage? ____Yes ____No

If the answer to question 4 above is "Yes", list the procedures which have been excluded and provide a full explanation on a separate sheet, including the name of the carrier, the date and specific information concerning any limitations.

LEGAL ACTIONS

Have any professional liability suits been filed against you? ____Yes ____No

Have any professional liability suits been filed against you which are presently pending? ____Yes ____No

Have any judgements or settlements been made against you in professional liability cases? ____Yes ____No

Have you any involvement in a professional liability action under circumstances specified in the medical staff bylaws, rules and regulations, and policies? ____Yes ____No

If the answer to any of the questions above is "yes", please provide a full explanation of the details on a separate sheet and attach. The explanation must include the NAME OF THE COURT in which the suit was filed, the CAPTION AND DOCKET NUMBER OF THE CASE , and the NAME AND ADDRESS OF THE ATTORNEY DEFENDING YOU and THE NATURE OF THE SUIT. Indicate if the suit is settled, pending, if any judgement or settlement has been made and all other relevant details.

EDUCATION COMMISSION OF FOREIGN MEDICAL GRADUATES, (if applicable)

Are you a Foreign Medical Graduate (FMG)? ____Yes ____No

ECFMG Number_____ USME Number_____

PROFESSIONAL SCHOOL

Undergraduate School_____ Degree_____

Address_____ Date of Graduation_____/19___
Street City/State Zip

Medical/Dental/Podiatric School_____ Degree_____

Address_____ Date of Graduation_____/19___
Street City/State Zip

IF MORE THAN ONE SCHOOL, PLEASE LIST ON SEPARATE SHEET AND ATTACH.

NAME OF APPLICANT:_____ DATE OF APPLICATION: ___/___/___

CONTINUATION OF PROFESSIONAL SCHOOL

INTERNSHIP

Institution_____ Type_____

Address_____ Date (Month/Year)_____
Street City/State Zip From To

Institution_____ Type_____

Address_____ Date (Month/Year)_____
Street City/State Zip From To

RESIDENCIES

Institution_____ Type_____

Residency Director_____

Address_____ Date (Month/Year)_____
Street City/State Zip From To

Institution_____ Type_____

Residency Director_____

Address_____ Date (Month/Year)_____
Street City/State Zip From To

IF MORE THAN TWO RESIDENCIES WERE BEGUN OR COMPLETED, PLEASE SUPPLY THE SAME INFORMATION ON A SEPARATE SHEET AND ATTACH.

FELLOWSHIP

Institution_____ Type_____

Fellowship Director_____

Address_____ Date (Month/Year)_____
Street City/State Zip From To

IF MORE THAN ONE FELLOWSHIP WAS BEGUN OR COMPLETED, PLEASE SUPPLY THE SAME INFORMATION ON A SEPARATE SHEET AND ATTACH.

NAME OF APPLICANT:______________________________ DATE OF APPLICATION: ___/___/__

HOSPITAL AFFILIATIONS (Do not include internship, residency, fellowship)

List in CHRONOLOGICAL ORDER all former and current hospital affiliations since completion o postgraduate education. This includes all hospitals, corporations, military assignments or government agencies Complete address must be included. If more space is needed, attach additional sheet.

Institution______________________________
Complete Address______________________________
Telephone Number______________________________ FAX Number______________________________
Department______________________________ Staff Status______________________________
Department Chair______________________________
Dates of Affiliation (Month/Year) From______________________________ To______________________________
Reason for Leaving, if no longer affiliated______________________________

Institution______________________________
Complete Address______________________________
Telephone Number______________________________ FAX Number______________________________
Department______________________________ Staff Status______________________________
Department Chair______________________________
Dates of Affiliation (Month/Year) From______________________________ To______________________________
Reason for Leaving, if no longer affiliated______________________________

Institution______________________________
Complete Address______________________________
Telephone Number______________________________ FAX Number______________________________
Department______________________________ Staff Status______________________________
Department Chair______________________________
Dates of Affiliation (Month/Year) From______________________________ To______________________________
Reason for Leaving, if no longer affiliated______________________________

Institution______________________________
Complete Address______________________________
Telephone Number______________________________ FAX Number______________________________
Department______________________________ Staff Status______________________________
Department Chair______________________________
Dates of Affiliation (Month/Year) From______________________________ To______________________________
Reason for Leaving, if no longer affiliated______________________________

Institution______________________________
Complete Address______________________________
Telephone Number______________________________ FAX Number______________________________
Department______________________________ Staff Status______________________________
Department Chair______________________________
Dates of Affiliation (Month/Year) From______________________________ To______________________________
Reason for Leaving, if no longer affiliated______________________________

ATTACH COPIES OF CLINICAL PRIVILEGES SHEETS for all hospitals listed above.

NAME OF APPLICANT:_____ DATE OF APPLICATION: ___/___/_

PROFESSIONAL REFERENCES

List 3 professional references and character references, do not include your residency director, fellowsh director or current partners or associates in practice. The references should be those who have had rece extensive experience in observing and working with you and who can provide adequate information pertainir to your present professional competence and character. Provide current and complete addresses.

Name_____ Specialty_____

Address_____

Phone_____ FAX:_____ Number of years known_____

Name_____ Specialty_____

Address_____

Phone_____ FAX:_____ Number of years known_____

Name_____ Specialty_____

Address_____

Phone_____ FAX:_____ Number of years known_____

HEALTH STATUS

Date of last complete physical/mental health examination_____

Present health status: ____Good ____Fair ____Poor

Have you ever been hospitalized or had any surgery any time during the past five years? ___Yes ___No

Have you ever been denied health, life or disability insurance? ____Yes ____No

Have you any limitations on your health, life, or disability insurance? ____Yes ____No

Have you ever had any problems with alcohol or drug dependency? ____Yes ____No

Are you currently under any limitations, concerning your activities or work load? ____Yes ____No

Are you currently under the care of a practitioner? ____Yes ____No

If you have answered "Yes" to any questions above, please give a full explanation of the details on a separate sheet and attach. Also, provide a copy of your most recent Physical/Mental Health Examination.

NAME OF APPLICANT:_____ DATE OF APPLICATION: ___/___/__

MISCELLANEOUS INFORMATION

Medicare No._____ Medicaid No._____ UPIN No._____

Military Service ___Yes ___No; If yes, provide the following and a copy of your DD Form 214 if possible.

Branch of Service_____ Type of Discharge_____

From_____ To_____ Specialty Training (Specify)_____

CONTACT PERSON IN CASE OF EMERGENCY:

Name_____ Relationship_____

Address_____ City/State/Zip_____

Telephone_____ FAX:_____

OTHER INTERESTS in practice, research, etc._____

NAME TWO (2) PHYSICIAN(S) WHO WILL ATTEND YOUR PATIENTS IN YOUR ABSENCE:(Must be in the appropriate area of clinical practice and privileged by GMHA)

_____

PRACTICE INFORMATION

Please answer each of the following questions in full. If the answer to any question is "YES", please provide full explanation and details on a separate sheet and attach.

1. Have you previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration? ____Yes ____No

2. Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal or state health insurance program? ____Yes ____No

3. Have you ever been the subject of an investigation by any private, federal or state agency concerning your participation in any private, federal or state health insurance program? ____Yes ____No

4. Have you ever been named as a defendant in any criminal proceeding (other than minor traffic violations)? ____Yes ____No

5. Has your employment, medical staff appointment or privileges ever been suspended, diminished, revoked or refused at any hospitals or other health care facility? ____Yes ____No

6. Have you ever voluntarily or involuntarily terminated medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital? ____Yes ____No

NAME OF APPLICANT:_____ DATE OF APPLICATION: ___/___/__

CONTINUATION OF PRACTICE INFORMATION

7. Have you ever been the subject of disciplinary proceedings at any hospital or health care facility? ____Yes ____No

If the answer to any of the questions above is "Yes", please provide a full explanation of the details on a separate sheet and attach.

CONTINUING MEDICAL EDUCATION

To what official recording body (e.g., AMA, CMA) do you report your CME hours?

Please list_____

_____

Please attach copies or list of CMEs taken in the past two years on a separate sheet.

PROFESSIONAL ASSOCIATIONS

Have you ever been denied membership or renewal thereof, or been subject to disciplinary proceedings in any professional organizations? ___Yes ___No If yes, please provide full explanation of the details.

_____

_____

_____

IF NOT ON ISLAND, HOW SOON WILL YOU RELOCATE?_____; and HOW LONG DO YOU INTEND ON STAYING ON GUAM?_____

PRIVILEGES

1. COMPLETE, SIGN and DATE the checklist for privileges requested at Guam Memorial Hospital Authority.

2. The clinical privilege checklist should be completed to reflect your pattern of practice. Privileges will be granted on the basis of training, experience and demonstrated competence. You should, therefore, not request privileges simply because you may encounter a particular condition, but rather your request should reflect your intended practice. Carefully select the privileges for which you apply for; because if you are denied, the denial may be reported to the National Practitioner Data Bank.

IF THIS FORM IS NOT COMPLETED IN ITS ENTIRETY, INCLUDING THE ATTACHMENTS, THIS COULD RESULT IN A DELAY IN YOUR APPOINTMENT AND PRIVILEGES.

Medical Staff Bylaws 5.1-3 states that "Applications remaining incomplete for consideration by the Credentials Committee for six (6) months after issuance and NOT ACTIVELY BEING PURSUED BY THE APPLICANT shall be considered withdrawn without prejudice and must be resubmitted in their entirety."

NAME OF APPLICANT:_____ DATE OF APPLICATION: ___/___/___

APPLICANT'S CONSENT AND RELEASE

I hereby apply for medical staff appointment and/or clinical privileges as requested above. I am willing to make myself available for interview in regard to this application.

As an applicant, I have the burden of producing adequate information for proper evaluation of my application. I also agree to provide the hospital with updated, current information regarding all questions on this application form as such information becomes available and such additional information as may be requested by the hospital or its authorized representatives. Failure to produce this information or additional information will prevent my application from being evaluated and acted upon.

Information given in or attached to this application is accurate and fairly represents the current level of my training, experience, capability and competence to practice the clinical privileges requested. As a condition to making this application, any misrepresentation or misstatement in, or omission from this application, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application resulting in denial of appointment and clinical privileges. In the event that appointment or clinical privileges have been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in immediate termination of such appointment or privileges.

By applying for appointment and clinical privileges, I accept the following conditions during the processing and consideration of my application, regardless of whether or not I am granted appointment or privileges, and for the duration of such appointment as I or reappointment as I may be granted:

a. I extend absolute immunity to, and release from any and all liability, the hospital, its authorized representatives and any third parties, as defined in subsection (c) below, for any acts, communications, reports, records, statements, documents, recommendations or disclosures involving me, performed, made, requested, or received by this hospital and its authorized representatives to, from or by any third party, including otherwise privileged or confidential information, relating, but not limited to the following:

(1) applications for appointment or clinical privileges, including temporary privileges;

(2) periodic reappraisals undertaken for reappointment or increase or decrease in clinical privileges;

(3) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary sanction;

(4) summary suspension;

(5) hearing and appellate reviews;

(6) medical care evaluations;

(7) utilization reviews;

(8) any other hospital, medical staff, department, services or committee activities;

(9) matters or inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and

(10) any other matter that might directly or indirectly have an effect on my competence, on patient care or on the orderly operation of this or any other hospital or health care facility.

NAME OF APPLICANT:_____ DATE OF APPLICATION: ___/___/__

The foregoing shall be privileged to the fullest extent permitted by law. Such privileges shall extent to the hospital and its authorized representatives, and to any third parties.

b. I specifically authorize the hospital and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on my satisfaction of the criteria for initial or continued appointment to the medical staff, as well as to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties relating to such questions. I also specifically authorize said third parties to release said information to the hospital and its authorized representative upon request.

c. The term "hospital and its authorized representatives" means the Guam Memorial Hospital Authority and any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application or conduct in the hospital: the members of the hospital's Board of Trustees and their appointed representatives, the Hospital Administrator or his designees, other hospital employees, consultants to the hospital, the hospital's attorney and his partners, associates or designees, and all appointees to the hospital medical staff. The term "third parties" means all individuals, including appointees to the hospital's medical staff, and appointees to the medical staff of other hospitals or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether hospitals, health care facilities or not, from whom information has been requested by the hospital or its authorized representatives or who have requested such information from the hospital and its authorized representatives.

I acknowledge that (1) medical staff appointment and/or clinical privileges at this hospital are not a right of every licensed professional who makes application for the same; (2) my request will be evaluated in accordance with prescribed procedures defined in the hospital and medical staff bylaws, rules an regulation, (3) all medical staff recommendations relative to my application are subject to the ultimate action of the hospital Board, whose decision shall be final; (4) if appointed, my initial appointment and clinical privileges shall be provisional for the time period determined by the Board; (5) I have the responsibility to keep this application current by informing the hospital and the medical staff, through the Hospital Administrator, of any change in my professional liability insurance coverage, the filing of a lawsuit against me and any change in medical staff status at other hospital; and (6) reappointment and/or continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the hospital, as evidenced by admission, treatment and continuous care and supervision of patients for whom I have responsibility and acceptable performance of all responsibilities related thereto as well as other factors deemed relevant by the hospital. Reappointment and/or continued clinical privileges shall be granted only on formal application, according to hospital and medical staff bylaws, rules and regulations, and upon final approval of the hospital Board.

I have received and had an opportunity to read a copy of the medical staff bylaws including rules and regulations of the medical staff presently in force. I specifically agree to abide by all such bylaws, policies, directives and rules and regulations as are in force during the time I am appointed or reappointed to the medical staff or exercise clinical privileges at the hospital.

If appointed and/or granted clinical privileges, I specifically agree to: (1) refrain from fee splitting or other inducements relating to patient referral, (2) refrain from delegating responsibility for diagnoses or care of hospitalized patients to any other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised; (3) refrain from deceiving patients as to the identity of any practitioner providing treatment or services; (4) seek consultation whenever necessary or required; (5) abide by generally recognized ethical principles applicable to my profession; (6) provide continuous care and supervision as needed to all patients in the hospital for whom I have responsibility; and (7) accept committee assignment and such other duties and responsibilities as shall be assigned to me by the hospital Board and medical staff.

Date:_____ Applicant:_____

GUAM MEMORIAL HOSPITAL AUTHORITY

850 GOV. CARLOS G. CAMACHO ROAD
OKA, TAMUNING, GUAM 96911
TEL: 646-5801; 646-6876; 646-6711 thru 18
TELEX 671-6227, FAX 671-649-0145

AUTHORIZATION TO OBTAIN AND FOR THE RELEASE OF INFORMATION

As an applicant for Allied Health Professional privileges or an applicant for Medical Staff Membership, I understand that I am responsible for providing adequate information for proper evaluation of my competence, character, physical and mental health status, ethics and other qualifications, and of resolving any doubts about such qualifications. I have the responsibility of providing evidence that all statements made and information given on the application are factual and true. Until I have provided all information requested by the Hospital, my application will be deemed incomplete and will not be processed.

I authorize the release of information related to all reported, pending or settled malpractice claims and coverage information from my present/past professional liability insurance agents/carriers. I also consent to the Hospital's query of the National Practitioner Data Bank.

I authorize the Guam Memorial Hospital Authority and its authorized representatives to consult with any third party who may have present and past information bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter reasonably having a bearing on the my meeting satisfactorily the criteria for initial and continued appointment to the staff.

I also authorize the hospital to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such questions. I also authorize said third parties to release said information to the hospital and its authorized representatives upon request.

I authorize the hospital and its authorized representatives to release such information to other hospital, health care facilities and their agents, who solicit such information for the purpose of evaluating the applicant's professional qualifications pursuant to the applicant's request for appointment or clinical privileges.

I understand that it is my responsibility to provide a complete application, including adequate responses from references. An incomplete application will not be processed, and I will be informed in writing.

I further understand that approvals of applications to the Medical Staff of the Hospital will be limited in number so as to be consistent with the stated goals of the Hospital, its manpower needs, and the ability of the Hospital's facilities to accommodate additional Staff Members.

I also agree that there shall be no legal liability on the part of, and no cause of action for damages shall arise against, any individual or organization providing information in good faith to the hospital or its medical staff concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges.

_____	_____
APPLICANT'S SIGNATURE	WITNESS' SIGNATURE
_____	_____
APPLICANT'S PRINTED NAME	WITNESS' PRINTED NAME
_____	_____
Date Signed	Date signed

GUAM MEMORIAL HOSPITAL AUTHORITY

850 GOV. CARLOS G. CAMACHO ROAD
OKA, TAMUNING, GUAM 96911
TEL: 646-5801 thru 5; 646-6710 thru 19
FAX: (671) 649-0145

MEDICAL STAFF PEER REVIEW
CONFIDENTIALITY AGREEMENT

As a member of the Guam Memorial Hospital Authority Medical Staff, I recognize that effective credentialing, peer review and quality improvement cannot be achieved unless the confidentiality of all discussions, deliberations, records and other information generated in connection with these activities is maintained.

I further recognize that such confidentiality is necessary to ensure the candid participation of staff members in these activities which is critically important for the evaluation and improvement of the quality of care rendered in the hospital.

Therefore, I agree to respect and maintain the confidentiality of all discussions, deliberations, records and information related to these activities.

I agree not to disclose voluntarily any information to anyone, except to persons authorized to receive it in the conduct of medical staff affairs or as directed by the Medical Executive Committee or the hospital's Board of Trustees. If I have any questions regarding whether information is confidential, I will consult with the President of the Medical Staff and the Hospital Administrator prior to disclosing it.

I understand that the hospital and its medical staff are entitled to undertake such action as deemed appropriate to ensure that this confidentiality is preserved as defined in PL 22-87 (Section 413, Title 6 Guam Code Annotated) and classified as client-attorney privilege. I further understand and acknowledge that any breach of this agreement, or threatened breach of this agreement, may subject me to legal action to prevent disclosure as well as to corrective action under the medical staff bylaws.

I understand that the Hospital Administration and Hospital Attorney have pledged the support of the Guam Memorial Hospital Authority to fight through legal means any attempt to discover peer review proceedings.

PRINTED NAME:_____

SIGNATURE:_____

Date:_____

BOT Approved: 8/24/94; revised 11/16/94.
forms#2:CONFI-AG

GUAM MEMORIAL HOSPITAL AUTHORITY

850 GOV. CARLOS G. CAMACHO ROAD
OKA, TAMUNING, GUAM 96911
TEL: 646-5801; 646-6876; 646-6711 thru 18
TELEX 671-6227, FAX 671-649-0145

ALTERNATES FOR GMHA ON CALL SCHEDULE

Kindly submit two practitioner alternates who must be in the appropriate area of clinical practice and privileged by GMHA to the Medical Staff Office as soon as possible. This will help in updating the Practitioners Alternate Listing. In addition, please have practitioner alternate #1 and #2 sign acknowledging their acceptance.

Thank you.

_____
Print Full Name

PRACTITIONER ALTERNATE #1

_____ _____
PRINT FULL NAME SIGNATURE

PRACTITIONER ALTERNATE #2

_____ _____
PRINT FULL NAME SIGNATURE

cc: Associate Administrator Medical Services
Department Chairperson

GUAM MEMORIAL HOSPITAL AUTHORITY

850 GOV. CARLOS G. CAMACHO ROAD
OKA, TAMUNING, GUAM 96911
TEL: 646-5801 thru 5; 646-6710 thru 19
FAX: (671) 649-0145

Date: _____

Dear Dr._____:

As a staff physician with the Guam Memorial Hospital Authority, please be advised that the following guidelines must be adhered to in utilizing GMHA Internal Controlled Substances Codes.

Practitioners under the employment of GMHA, acting in the usual course of his/her employment, may dispense, administer and prescribe controlled substances under the registrations of the hospital, provided that:

a. Such dispensing, administering or prescribing is done in the usual course of his/her professional practice as an employee of GMHA;

b. Such employed individual practitioner is authorized or permitted to do so by the laws of Guam;

c. Such individual practitioner is acting only within the scope of his/her employment in the hospital.

Frederick S Jestrab

Frederick S. Jestrab, R.Ph
Director of Pharmacy

ACKNOWLEDGED BY:

_____

A copy of this letter will be forwarded to the Pharmacy.

GUAM MEMORIAL HOSPITAL AUTHORITY

850 GOV. CARLOS G. CAMACHO ROAD
OKA, TAMUNING, GUAM 96911
TEL: 646-5801; 646-6876; 646-6711 thru 18
TELEX 671-6227, FAX 671-649-0145

I _____, acknowledge as a practitioner with clinical privi
Print or type name
at Guam Memorial Hospital that when I resign or take a Leave of Absence status that I will be responsible for cle
with the following Departments listed below. Please bear in mind that failure to comply may result with a neg
response to any future primary verification request(s) regarding hospital affiliation and/or clinical privileges.

_____ _____
SIGNATURE DATE

I _____, Practitioner # _____

THE SEPARATING PRACTITIONER MUST PERSONALLY CLEAR WITH THE FOLLOWING:

	YES	NO	CLEARED BY	DATE
1. MEDICAL STAFF OFFICE			_____	_____
Request for Leave of Absence	___	___		
Letter of Resignation	___	___		
Parking Decal No._____	___	___		

I am a Proctor for _____

I am a Sponsor for _____ (Name of AHP or SET)

I am an Alternate for _____

Forwarding Address/Phone No.:

_____

_____

_____

Telephone (_____)_____

	YES	NO	CLEARED BY	DATE
2. PHARMACY			_____	_____
Notify Pharmacy to flag signature card/prescriptions	___	___		

GUAM MEMORIAL HOSPITAL MEDICAL STAFF
Medical Records Subcommittee
Name:_____

	YES	NO	CLEARED BY	DATE
3. FISCAL/ACCOUNTING DEPARTMENT				
House Patients Accounts Cleared	___	___	_____	_____

	YES	NO	CLEARED BY	DATE
4. MEDICAL RECORDS DEPARTMENT				
Medical Records completed and up to date -	___	___	_____	_____
Library Clearance -				
Books Returned	___	___	_____	_____
Fines Paid	___	___		

	YES	NO	CLEARED BY	DATE
COMMUNICATION CENTER				
Inform Comm Center of your status and return Beeper/Radio:	___	___	_____	_____

	YES	NO	CLEARED BY	DATE
DEPARTMENT CHAIR				
Endorsement of Patients to Dr._____	___	___	_____	_____
Endorsement/Completion:				
Assigned Proctors	___	___		
Committee Duties	___	___		
Other _____	___	___		

undersigned practitioner hereby acknowledges the above certification to be true and correct.

_____ Date_____

titioner's Signature

n completion route to Medical Staff Office.

Credential file
Forms/MEDREC NOV 1, 91/Rev 4/93

GUAM NARCOTIC REGISTRATION NUMBER
GUAM MEMORIAL HOSPITAL PHARMACY
PHYSICIAN'S SIGNATURE CARD

PRINT NAME:_____ DATE:_____

SIGNATURE:_____

GUAM LICENSE NUMBER:_____ EXPIRES:_____

DEA LICENSE NUMBER:_____ EXPIRES:_____

DISTRIBUTION LIST:

Copy to Medical Records Department (Handcarry)
Copy to Practitioner's Credential's File
Original to Chief Pharmacist (Handcarry)

2/91

GUAM MEMORIAL HOSPITAL AUTHORITY
ADMINISTRATIVE MANUAL

APPROVED	RESPONSIBILITY	ORIGINATION DATE	NUMBER	PAGE
	Medical Staff Office Business Office	1/99	6170-5	1 of 2
TITLE: HOUSE PATIENT PAYMENT POLICIES				

PURPOSE:

To establish rules and regulation, and clarify procedures for the billing and payment of house patient claims.

POLICY:

The Guam Memorial Hospital Authority will accept and process claims for the reimbursement of professional fees for house patients in accordance with established Hospital Rules and Regulations and policies.

PROCEDURE:

I. House Patients will be limited to those covered by the Medical Staff Bylaws definition of such. House Patient Compensation will be made only to physicians participating in the Hospital' house call program.

II. Payment to remain at the present rate: 1970 RVS conversion factor 1.6 or 16. All services not on this fee schedule will be paid in accordance with the present MIP fee schedule at the participating provider rate.

III. Claims must be submitted **no later than 45 days** from the date of discharge of the patient in order to be paid. All physicians must have an Assignment Statement completed and filed with the Hospital in order to participate in the program. All necessary documentation must be filed prior to the payment of compensation by the Hospital. Any claims submitted beyond the 45-day deadline will **not** be honored.

IV. All claims must be billed in accordance with Medicare Part B billing rules and regulations. Claims for professional services will be reviewed and processed for payment in accordance with these guidelines. Claims that do not conform to the guidelines will be rejected and returned to the Physician for correction. Claims that continue to be out of conformance will **not** be paid.

V. Professional Service billings will be reviewed for compliance with Medicare Fraud and Abuse statutes. Physicians submitted billings found to be out of compliance maybe reported in accordance with the Medicare Fraud and Abuse Statutes, and such action will be reported to the MEC for disciplinary disposition.

VI. Claims written off by the Hospital due to the untimely processing of Medical Record documentation by the physicians may be presented to the Medical Director, President of the Medical Staff, and Department chairpersons to indicate the revenue losses experienced as a result of physician activities. This may result in recommendations for termination in participation in the

Guam Memorial Hospital Authority
Aturidåt Espetåt Mimuriåt Guåhan

850 GOV. CARLOS CAMACHO ROAD
OKA, TAMUNING, GUAM 96911
TEL: 647-2444 or 647-2330
FAX: (671) 649-0145

HOUSE PATIENT PROGRAM ASSIGNMENT CLAUSE

1. I acknowledge that under the terms of my participation in the Guam Memorial Hospital House Patient Program, that only the Guam Memorial Hospital will be entitled to claim or receive any fees or charges for my services furnished to House Patients of the Hospital. I am, by signing this form, assigning all of my rights to reimbursement under the Medicare Part B or any other third party payment program and from individual patients, to the Hospital.

2. I agree not to bill the patient for any and all services for which I receive House Patient Program compensation from the Hospital.

3. I also agree that it is the sole prerogative of the Hospital to determine the circumstances under which fees or charges for my services are to be claimed or received.

4. I also agree to prepare and submit my claims for House Patient Services in accordance with the established Medicare Part B rules and regulations governing the submission of claims for professional services.

5. I hereby authorize the Hospital to execute on my behalf complete reports of services rendered by me. The execution of these reports shall constitute certification that the professional services shown on the report were rendered by me at the Hospital, and that the charges indicated on the reports are proper and correct.

6. I also hereby agree to fully cooperate in all matters with regard to efforts by the Hospital to claim and receive fees and charges for my services. This includes reviewing all claims for validity, keeping appropriate records and reports, and providing the Hospital with my Medicare UPIN number for billing purposes or completing the Medicare UPIN and Provider Number application when necessary.

7. I hereby authorize the Hospital to obtain necessary medical licensure information from the Guam Board of Medical Examiners as may be necessary to complete the Medicare UPIN application forms.

8. This assignment to the Hospital shall continue for my term of employment or the term of my privileges as the Hospital. I understand that the termination of this clause will not be binding upon Medicare until after the Medicare claims period for services rendered to House Patients has expired.

Date:_____ Print Name: _____

Signature:_____

Reviewed: 1/99
Revised:
Approved by: MEC 1/99; EMC 3/99; JAC 3/99; BOT 3/99

CC: **Medical Director**
Comptroller/Acct.
Credentials File

COMMONWEALTH NOW!

GUAM MEMORIAL HOSPITAL AUTHORITY
MEDICAL STAFF

DEPARTMENT OF MEDICINES

NAME OF PHYSICIAN: _____
Last Name, First Name, Middle Initial

DATE OF APPLICATION: _____ MEDICAL STAFF STATUS: _____

TYPE: [ ] Initial [ ] Reappointment [ ] Addition(s)/Change(s)

CLINICAL AREA: Internal Medicine Delineation of Clinical Privileges

Current demonstrated competence and an adequate volume of current experience with acceptable results in the privileges requested. Privileges generally restricted to care of patients 16 years of age and older, patients between 12 and 16 years of age may be treated.

Please indicate qualification by placing your INITIALS by appropriate space.

	QUALIFICATIONS
	CATEGORY I - INTERNAL MEDICINE
_____	Board certification by, or current active participation in the examination process leading to certification by the American Board of Internal Medicine; or
_____	Successful completion of an approved three year residency in Internal Medicine and demonstrated acceptable practice in the privileges being requested for the last three (3) consecutive years; or
_____	A total of two (2) years of full-time postgraduate general medical training in a approved residency or fellowship prior to 1990 and demonstrated acceptable practices in the privileges being requested for the last three (3) consecutive years.
	CATEGORY II - INTERNAL MEDICINE
_____	Board certification by or current active participation in the examination process leading to certification by the American Board of Internal Medicine; or
_____	Successful completion of an approved 3 year residency program in Internal Medicine and demonstrated acceptable practice in the privileges being requested for the last three (3) consecutive years.
	CATEGORY III - INTERNAL MEDICINE
_____	Board certification in or current active participation in the examination process leading to certification by the American Board of Internal Medicine.
_____	AND/OR Acceptable prior and current practice experience at this level of care over a reasonable period of time/number of cases or recent formal training of sufficient length and breadth;
	CATEGORY IV - INTERNAL MEDICINE SUBSPECIALTY
_____	Board certification in or current active participation in the examination process leading to certification in the applicable subspecialty by the American Board of Internal Medicine; (i.e., subspecialty qualified/certified: Allergy/Immunology; Cardiovascular Medicine; Critical Care Medicine; Endocrinology; Gastroenterology; Gerontology; Hematology/Oncology; Infectious Disease; Nephrology; Pulmonary Disease; Rheumatology; etc;).
_____	AND/OR Successful completion of a approved Internal Medicine Subspecialty fellowship program in the applicable subspecialty
	Specify Subspecialty(ies) : _____

DEPARTMENT OF MEDICINE - Delineation of Privileges Internal Medicine

Name:

	SPECIAL PROCEDURES/TESTS
_____	Acceptable supervised training in the procedure/treatment as part of approved postgraduate training in a residency or fellowship or an approved, recognized course; and
_____	Certification of actual skill and the requisite number of procedures; and Demonstration of knowledge of indications of the procedure/test/therapy; and
_____	Satisfaction of such additional specific requirements as established by the Department/or other Departments

Please carefully select the privileges for which you apply for because if you are denied the denial may be reported to the National Practitioners Data Bank. Note that the following categories & lists are illustrative but not all inclusive. You may attach copies of continuing medical education (CME) to assist in granting of your privileges.

REQUESTED		PRIVILEGES	ACTION	
YES	No. Cases Past 2 yrs	**INTERNAL MEDICINE CATEGORY I**	Recommend	Not Recommended
		SCOPE OF PRIVILEGES: Admit, treat and consult on problems/conditions of minimal or moderate severity with no serious threat to life; may be local complications confined to affected organ or anatomical site but that are not major or severe - uncomplicated		
REQUESTED		**INTERNAL MEDICINE CATEGORY II**	ACTION	
YES	No. Cases Past 2 yrs		Recommend	Not Recommended
		SCOPE OF PRIVILEGES: Admit, treat and consult on problems/conditions of moderate or major severity, but not including ventilatory care or advanced life support; may be significant local and or systemic complications - complicated but non-life threatening illness		
YES	No. Cases Past 2 yrs	**INTERNAL MEDICINE CATEGORY III**	Recommend	Not Recommended
		SCOPE OF PRIVILEGES: Admit, treat and consult on problems/conditions of moderate or major severity, may be significant local and or systemic complications with potentially life-threatening illness, including ventilatory care, cardiac, and advanced life support		
YES	No. Cases Past 2 yrs	**INTERNAL MEDICINE SUBSPECIALTY CATEGORY IV**	Recommend	Not Recommended
		SCOPE OF PRIVILEGES: Consultation and care of patients with conditions relating to subspecialty.		
REQUESTED		**INTERNAL MEDICINE PRIVILEGES** (ALL the following lists are illustrative but not all inclusive)	ACTION	

DEPARTMENT OF MEDICINE - Delineation of Privileges Internal Medicine

Name:

YES	No. Cases Past 2 yrs	ALLERGY	Recommend	Not Recommended
		ALLERGY CATEGORY I: Differential Diagnosis		
		ALLERGY CATEGORY II: Urticaria		
		ALLERGY CATEGORY III: Serum Sickness		
		Asthma		
		Desensitization		
		OTHER_____		

REQUESTED		RHEUMATOLOGY/COLLAGEN DISEASES	ACTION	
YES	No Cases Past 2 yrs		Recommend	Not Recommended
		RHEUMATOLOGY/COLLAGEN - CATEGORY I: Differential Diagnosis		
		RHEUMATOLOGY/COLLAGEN - CATEGORY II: Rheumatoid		
		Osteoarthritis		
		Gout		
		Lupus erythematosus		
		Periarteritis nodosa		
		Scleredema		
		Other_____		
		RHEUMATOLOGY/COLLAGEN - CATEGORY III: Thrombotic thrombocytopenic purpura		
		Necrotizing Granulomatosis		
		OTHER_____		

YES	No Cases Past 2 yrs	CARDIAC DISEASES	Recommend	Not Recommended
		CARDIAC DISEASES CATEGORY I: Differential Diagnosis		
		CARDIAC DISEASES CATEGORY II: Rheumatic fever		
		Other		
		CARDIAC DISEASES CATEGORY III: Congestive Heart Failure Chronic & intractable		
		Congestive Heart failure Acute		
		Coronary heart disease with angina		

DEPARTMENT OF MEDICINE - Delineation of Privileges Internal Medicine

Name:

		Coronary heart disease with coronary insufficiency		
		Bacterial endocarditis		
		Cardiac arrhythmias		
		Myocardial Infarction with shock		
		Myocardial Infarction with serious arrythmia &/or cardiac arrest		
		Myocardial Infarction recurrent		
		Myocardial Infarction with congestive heart failure		
		Myocarditis/ Pericarditis		
		OTHER _____		
YES	No Cases Past 2 yrs	**GASTROINTESTINAL/HEPATIC DISEASE**	Recommend	Not Recommended
		GASTROINTESTINAL/HEPATIC DISEASES CATEGORY I: Differential Diagnosis		
REQUESTED		**GASTROINTESTINAL/HEPATIC DISEASE - Continued**	ACTION	
YES	No Cases Past 2 yrs		Recommend	Not Recommended
		GASTROINTESTINAL/HEPATIC DISEASES CATEGORY II: Intestinal Obstruction		
		Hepatitis		
		Differential Diagnosis of Jaundice		
		Other		
		GASTROINTESTINAL/HEPATIC CATEGORY III		
		Peptic ulcer bleeding, perforated, obstructed		
		Ulcerative colitis		
		Regional ileitis		
		Pancreatitis		
		Cholecystitis		
		Malabsorption		
		Cirrhosis with bleeding varices, or with coma, or decompensated		
		OTHER _____		
YES	No. Cases Past 2 yrs	**HEMATOLOGICAL DISEASES**	Recommend	Not Recommended
		HEMATOLOGICAL DISEASES CATEGORY I: Differential Diagnosis		
		HEMATOLOGICAL DISEASES CATEGORY II:		

DEPARTMENT OF MEDICINE - Delineation of Privileges Internal Medicine

Name:

		Primary Anemia		
		HEMATOLOGICAL DISEASES CATEGORY III: Leukemia, Acute/Chronic		
		Hemorrhagic diathesis		
		OTHER_____		
YES	No Cases Past 2 yrs	**HYPERTENSION**	Recommend	Not Recommended
		HYPERTENSION CATEGORY I Differential Diagnosis		
		HYPERTENSION CATEGORY II Essential, unresponsive		
		OTHER_____		
REQUESTED		HYPERTENSION CATEGORY III	ACTION	
YES	No. Cases Past 2 yrs		Recommend	Not Recommended
		Malignant hypertension		
		Hypertension complicated with cardiac insufficiency, and/ or with renal insufficiency		
		OTHER_____		
YES	No. Cases Past 2 yrs	**METABOLIC & ENDOCRINE DISEASES**	Recommend	Not Recommended
		METABOLIC/ENDOCRINE DISEASES CATEGORY I Differential Diagnosis		
		METABOLIC/ENDOCRINE DISEASES CATEGORY II Cushing's syndrome		
		Addison's disease		
		Aldosteronism		
		Sex Hormone abnormalities		
		OTHER_____		
		METABOLIC/ENDOCRINE CATEGORY III Diabetes mellitus with acidosis and or coma		
		Thyroid conditions with coma or with thyrotoxiccrisis		
		Radioactive isotopes for diagnosis & treatment of thyroid diseases		
		Parathyroid conditions		
		Pituitary conditions		
		Pheochromocytoma		

DEPARTMENT OF MEDICINE - Delineation of Privileges Internal Medicine

Name:

		OTHER_____		
YES	No. Cases Past 2 yrs	NEUROLOGICAL DISEASES	Recommend	Not Recommended
		NEUROLOGICAL DISEASES CATEGORY I Differential Diagnosis of neurological disorders		
		NEUROLOGICAL DISEASES CATEGORY II Investigation & management including drug therapy of uncomplicated convulsive disorders		
		Anticoagulant therapy of cerebrovascular		
		Treatment of uncomplicated meningitis/encephalitis		
		Treatment of migraine		
		OTHER_____		

REQUESTED		NEUROLOGICAL DISEASES CATEGORY III	ACTION	
YES	No. Cases Past 2 yrs		Recommend	Not Recommended
		Diagnosis and management of coma of uncertain origin		
		Complicated meningitis/ Encephalitis		
		Status epilepticus		
		Other_____		

YES	No. Cases Past 2 yrs	PULMONARY DISEASES	Recommend	Not Recommended
		PULMONARY DISEASES CATEGORY I Differential Diagnosis		
		PULMONARY DISEASES CATEGORY II Pneumonia uncomplicated		
		Other_____		
		PULMONARY DISEASES CATEGORY III Pneumonia Complicated		
		Emphysema with pulmonary insufficiency		
		Emphysema with coma		
		Pulmonary infarction		
		Pneumothorax, spontaneous		
		OTHER _____		

YES	No. Cases Past 2 yrs	NEPHROLOGY DISEASES	Recommend	Not Recommended
		NEPHROLOGY DISEASES CATEGORY I Differential Diagnosis		

DEPARTMENT OF MEDICINE - Delineation of Privileges Internal Medicine

Name:

		NEPHROLOGY DISEASES CATEGORY II Nephritis		
		Pyelonephritis		
		Other_____		
		NEPHROLOGY DISEASES CATEGORY III Nephrosis		
		Acute insufficiency conservative		
		Dialysis Hemodialysis		
		Dialysis Peritoneal Dialysis		
		OTHER _____		

REQUESTED		MISCELLANEOUS	ACTION	
YES	No. Cases Past 2 yrs		Recommend	Not Recommended
		MISCELLANEOUS CATEGORY III Cancer chemotherapy (other than Leukemia)		
		Thrombophlebitis		
		Acute peripheral embolism		
		OTHER _____		

YES	No. Cases Past 2 yrs	CATEGORY IV - INTERNAL MEDICINE SUBSPECIALTY/ & Other *Please list additional privileges desired as subspecialist and/or OTHER.	Recommend	Not Recommended

REQUESTED		SPECIAL PROCEDURES	ACTION	
YES	No. Cases Past 2 yrs		Recommend	Not Recommended
		GENERAL PROCEDURES		
		GENERAL - CATEGORY I Biopsy, Skin		
		Biopsy, superficial tumors (needle)		
		Incision & drainage of abscess & cysts		
		Other_____		
		GENERAL - CATEGORY II Arterial Cannulation		
		Lumbar puncture		

DEPARTMENT OF MEDICINE - Delineation of Privileges Internal Medicine

Name:

		endotracheal intubation		
		Sengstaken Blackmore tube placement for variceal bleeding		
		OTHER _____		
YES	No. Cases Past 2 yrs	**ASPIRATION PROCEDURES**	Recommend	Not Recommended
		ASPIRATION PROCEDURES - CATEGORY II Thoracentesis		
		Paracentesis		
		Joint aspiration		
		Other		
REQUESTED		**ASPIRATION PROCEDURES - Continued**	ACTION	
YES	No Cases Past 2 yrs		Recommend	Not Recommended
		ASPIRATION PROCEDURES - CATEGORY III Pericardiocentesis		
		Bone Marrow		
		Paracentesis		
		OTHER _____		
YES	No. Cases Past 2 yrs	**BIOPSY PROCEDURES**	Recommend	Not Recommended
		BIOPSY PROCEDURES - CATEGORY III Bone Marrow		
		Liver		
		Renal		
		Pleural		
		Lung		
		Peritoneal		
		Pericardial OTHER_____		
YES	No. Cases Past 2 yrs	**CARDIOLOGY PROCEDURES**	Recommend	Not Recommended
		CARDIOLOGY - CATEGORY I Electrocardiography (EKG,ECG) interpretation		
		CARDIOLOGY - CATEGORY II Central Venous Catheter Other_____		
		CARDIOLOGY - CATEGORY III Swan-Ganz catheter placement		

DEPARTMENT OF MEDICINE - Delineation of Privileges Internal Medicine

Name:

		Cardioversion - Medical/Elective		
		Temporary transvenous pacemaker placement		
		Pacemaker monitoring and rate adjustment		
		Holter Monitor Interpretation		
		Stress Test Monitoring (Tread Mill)		
		Echocardiograph interpretation - Adult ___; Pediatric ___;		
		CARDIOLOGY - CATEGORY IV Cardiac Catheterization OTHER_____		

REQUESTED		RHEUMATOLOGY PROCEDURES -	ACTION	
YES	No. Cases Past 2 yrs		Recommend	Not Recommended
		RHEUMATOLOGY PROCEDURES CATEGORY II Bursa aspiration & injection		
		Arthrocentesis, diagnostic		
		Joint Injection		
		Soft Tissue (muscle) injection		
		Tendon aspiration & injection		
		OTHER_____		

YES	No. Cases Past 2 yrs	HEMATOLOGY/ONCOLOGY PROCEDURES	Recommend	Not Recommended
		HEMATOLOGY/ONCOLOGY PROCEDURES CATEGORY III Chemotherapy, systemic for hematologic malignancies & solid tumors		
		Chemotherapy, local, intra-arterial		
		Chemotherapy, local, intraperitoneal		
		Chemotherapy, intrapleural		
		OTHER _____		

YES	No. Cases Past 2 yrs	NEPHROLOGY PROCEDURES	Recommend	Not Recommended
		NEPHROLOGY PROCEDURES CATEGORY III Tenckhoff catheter insertion		
		Acute peritoneal catheter insertion		
		OTHER _____		

YES	No. Cases Past 2 yrs	PULMONARY MEDICINE PROCEDURES	Recommend	Not Recommended

DEPARTMENT OF MEDICINE - Delineation of Privileges Internal Medicine

Name:

		PULMONARY MEDICINE CATEGORY III Chest tube placement		
		Ventilator management		
		Pulmonary Stress testing		
		Interpretation of standard pulmonary function		
		Provocholine challenge studies		
		OTHER _____		

REQUESTED		BRONCHOSCOPY PROCEDURES	ACTION	
YES	No. Cases Past 2 yrs		Recommend	Not Recommended
		BRONCHOSCOPY PROCEDURES CATEGORY III Note: All bronchoscopy privileges are under the supervision of the Surgery Department and the established criteria for credentialing as per the policy and procedure. Bronchoalveolar lavage		
		Rigid bronchoscopy		
		Bronchial biopsy using fiberoptic bronchoscopy		
		Endobronchial electrocauterization using fiberoptic bronchoscopy		
		OTHER_____		

YES	No. Cases Past 2 yrs	GASTROENTEROLOGY PROCEDURES	Recommend	Not Recommended
		GASTROENTEROLOGY PROCEDURES CATEGORY I Gastric lavage		
		GASTROENTEROLOGY PROCEDURES CATEGORY II Gastric analysis		
		Supervision of Total parenteral nutrition		
		OTHER _____		

YES	No. Cases Past 2 yrs	ENDOSCOPY PROCEDURES	Recommend	Not Recommended
		ENDOSCOPY PROCEDURES CATEGORY III Note: All endoscopy privileges are under the supervision of the Surgery Department and the established criteria for credentialing as per their department policy & procedure. Endoscopic foreign body removal		
		Endoscopic control of GI bleeding by electrocoagulation or		
		Endoscopic control of GI bleeding by sclerotherapy of esophageal varices		
		Colonoscopy, fiberoptic w/biopsy		
		Colonoscopy, fiberoptic w/ polypectomy		

DEPARTMENT OF MEDICINE - Delineation of Privileges Internal Medicine

Name:

		Esophagogastroduodenoscopy, w/biopsy		
		Esophagogastroduodenoscopy, w/polypectomy		
		Sigmoidoscopy, fiberoptic w/biopsy		
		Sigmoidoscopy, fiberoptic w/polypectomy		
		Proctosigmoidoscopy, rigid/with biopsy		
		Proctosigmoidoscopy, rigid/with polypectomy		
		OTHER_____		

REQUESTED		OTHER PROCEDURES	ACTION	
YES	No. Cases Past 2 yrs		Recommend	Not Recommended
		CATEGORY III Note: All anesthesia privileges are under the supervision of the Surgery Department via the Chief of Anesthesia. IV sedation		

I have submitted the following:

REQUIRED ALL PHYSICIANS:
*Current BCLS certification: Expiration Date:_____

REQUIRED for CCU: *Current ACLS certification: Expiration Date:_____

ADDITIONAL - PRIVILEGES:

Do you plan to work full time/part time in the Emergency Room? YES___ NO___

ADDITIONAL - ICU/CCU PRIVILEGES:

ICU Privileges requested: Consulting only ICU/CCU Privileges _____
Admitting & Consult ICU/CCU Privileges _____

REQUESTED		QUALIFICATIONS - ICU/CCU PRIVILEGES	ACTION
YES	NO	MEDICINE INTENSIVE/CARDIAC CARE UNIT	Acknowledged by:
_____		PLEASE CHECK YOUR QUALIFICATION FOR THIS CATEGORY Extensive training and/or documentable experience in the care of patients with conditions requiring ICU or CCU. Internal Medicine Board Certification/ Internal	

DEPARTMENT OF MEDICINE - Delineation of Privileges Internal Medicine

Name:

_____ _____ _____	Medicine Subspecialty Board; OR Internal Medicine/ Internal Medicine Subspecialty Board eligibility with active pursuit of certification. For new applicant to GMHA with less than five (5) years post residency training: At least (6) months training in critical care Internal Medicine ICU/CCU rotation; or For new applicants to GMHA five (5) years or more after residency: Current Internal Medicine ICU/CCU critical care experience and/or current CME certification in this area. For reappointment: At least documentation of continued Internal Medicine ICU/CCU privileges with satisfactory performance.

REQUESTED		INTERNAL MEDICINE ICU/CCU SCOPE OF PRIVILEGES	ACTION	
YES	No. Cases Past 2 yrs		Recommend	Not Recommended
		Category III - Treatment of major complicated illnesses, injuries, or performance of procedures that carry a significant threat to life, in Internal Medicine patients, and treatment of complex or critical illnesses, injuries, or conditions or the performance of procedures that carry serious threat to life for Medicine patients.		
		Category IV - Consult and or treatment of major complicated illnesses, injuries, or performance of procedures that carry a significant or serious threat to life, in Internal Medicine patients, as they apply to subspecialty. SUBSPECIALTY:_____		

REQUESTED		INTERNAL MEDICINE ICU/CCU PRIVILEGES	ACTION	
YES	No. Cases Past 2 yrs		Recommend	Not Recommended
		All category I/II/III/IV privileges & special procedures as requested above		
		Septic Shock		
		Hemodynamic shock		
		Cardiogenic Shock		
		Ventilator patients		
		Vasoactive drug drip		
		Consultation & management of patients with chronic illness		

YES	No. Cases Past 2 yrs	INTERNAL MEDICINE ICU/CCU SPECIAL PROCEDURES	Recommend	Not Recommended
		All special procedures previously requested		

DEPARTMENT OF MEDICINE - Delineation of Privileges Internal Medicine

Name:_____

FOR RE-APPOINTMENT ONLY:

I have (Please Check ONE):

[ ] Requested for Additional Privileges on this Delineation Form not granted during my previous appointment.

[ ] Deleted one or more privileges granted to me during my previous appointment.

[ ] Made NO changes to the privileges requested on this Delineation Form compared to my previous appointment.

ACKNOWLEDGEMENT OF THE PRACTITIONER

I have requested only those specific privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at GMHA; and

I understand that:

(a) In exercising any clinical privileges granted, I am constrained by all hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws.

Signed:_____ Date:_____

Conditions/Modifications:
The requested clinical privileges have been approved by the Board of Trustees with the following conditions, or modifications and the explanation for same.

GRANTED		PRIVILEGE	
YES	NO	INTERNAL MEDICINE	CONDITION/MODIFICATION

_____ Date:_____

Chair, Department of Medicines

_____ Date:_____

Chair, Anesthesia Service

_____ Date:_____

Chair, Department of Surgery

DEPARTMENT OF MEDICINE - Delineation of Privileges Internal Medicine
Name:_____

_____ Date:_____
Chair, Credentials Committee

_____ Date:_____
Chair, Medical Executive Committee

CERTIFICATION:

The above reflects the final action taken by the Board of Trustees of Guam Memorial Hospital Authority.

_____ Date:_____
HOSPITAL ADMINISTRATOR

APPROVED BOT:_____ Resolution No.:_____

Revised: Medicine Department, 6/17/93
Reviewed: Credentials Committee, 7/27/93
Medical Executive Committee,7/30/93
Approved Joint Advisory Committee, 8/17/93
BOT, 12/90 (No. 91-31); CCU-ICU - BOT, 6/19/91 (No. 91-94); BOT 8/30/93

Disk:WP#4/PRIV-MED 8/93