ELDERWOOD ADMINISTRATIVE SERVICES
500 Seneca St., Suite 100 / Buffalo, New York 14204 / (716) 633-3900

MEDICAL PRIVILEGES APPLICATION AND AGREEMENT

PLEASE COMPLETE ALL SECTIONS AND RELEVANT CHECK BOXES

PRACTITIONER INFORMATION		
☐ MD ☐ DO ☐ NP ☐ PA ☐ DPM ☐ DDS/DMD		
First Name	M.I.	Last Name
Home Address		
City	State	Zip Code
Phone No.	Cell No.	
Email	Last 4 digit Soc.Sec	Tax ID No.
Date of Birth	State License No.	
NPI No.	DEA No.	
Roles:Check all that apply ☐ Attending ☐ Alternate ☐ Covering ☐ On-call ☐ Off Site Only ☐ Telemed/health ☐ Medical Director Other role: write in ☐ Supervising ☐ Auditor		
Are you Medicare Certified? ☐ Yes ☐ No	Are you Medicaid Certified? ☐ Yes ☐ No	

Practice/Group Name		
Practice Address		
City	State	Zip Code
Office Phone Number	Fax Number	

Alternate/Covering Practitioner		
Practice Address		
City	State	Zip Code
Office Number	Fax Number	

Name of Supervising Physician		
Practice Address		
City	State	Zip Code
Office Phone Number	Fax Number	

Send all required documents, completed applications and questions to Credentialing@Elderwood.com

EDUCATION		
School		
Address		
City	State	Zip Code
Phone Number	Year Graduated	

POST GRADUATE EDUCATION/TRAINING		
School	Type of Education/Training	
Address		
City	State	Zip Code
Phone Number	Year Graduated	

INTERNSHIP		
Place of Internship	Type of Internship	Year Completed
Address		
City	State	Zip Code

RESIDENCIES		
Place of Residency	Year Completed	
Address		
City	State	Zip Code
Place of Residency	Year Completed	
Address		
City	State	Zip Code

FELLOWSHIP TRAINING		
Place of Fellowship	Year Completed	
Address		
City	State	Zip Code

CERTIFICATION		
Board Certification		Year
Board Certification		Year
Recertification ☐ Yes ☐ No	Board Eligibility ☐ Yes ☐ No	Date of Application: ____/____/_____
Specialty		

Membership in Professional Societies/Organizations

HOSPITAL or FACILITIES – List all hospitals or facilities (in all states) you have been affiliated with over the past FIVE years. Provide dates of affiliation.

Hospital/Facility Name (no abbreviation)	City	State	Affiliation Start Date	Affiliation End Date

Have your privileges to practice ever been restricted, suspended, curtailed or discontinued at any of the above facilities? ☐ Yes ☐ No If answer is **yes**, please provide details of situation(s).

Are you involved in any pending malpractice professional actions or professional misconduct proceedings for your profession? ☐ Yes ☐ No If answer is **yes**, please provide details of situation(s).

Physician Signature Log is required to verify signature(s) of all physicians, nurse practitioners and physician assistants as identified on all documentation in the medical record. Please print and sign your name, professional designation and initials:

Name as it appears on Your professional license (please print)	Signature	Professional Designation	Initials

MEDICAL RECORDS SYSTEM – POINT CLICK CARE REQUIRED FOR ALL

Tiger Text User

Tiger Text is required for Secure Conversations if you service more than one organization with PointClickCare or if you prefer to receive all messages on your preexisting account. An information packet regarding setting up a Tiger Text account will be provided during training. A business email address is required for setup.

Do you currently have a Tiger Text Account? ☐ Yes ☐ No

If Yes, provide the email address associated with this account: _____

Controlled Substances are electronically prescribed through PointClickCare (EMR) by using a two factor authentication. (Password and Token). Select the appropriate statement:

- ☐ I already have a PointClickCare Token assigned by another organization (Record below, the Serial # from the back of token to be used for your security account.) Token Serial ID #: _____
- ☐ I have never had a PointClickCare Token assigned to me from any organization.
- ☐ I will not be prescribing controlled substances.

PointClickCare Training Needs

Elderwood offers medical providers basic Navigation and ePrescribing Training. Select what type of training you require and what method of training you prefer. If you do prefer training, our Instructional Support Specialist will be contacting you once the credentialing process and security setup is complete.

Select required training:

- ☐ I do not require any training
- ☐ I require basic navigation training
- ☐ I require ePrescribing training

Select preferred training method:

- ☐ I prefer self-learning materials
- ☐ I prefer live training by Elderwood

Privacy and Security Agreement

I understand and agree that I will be assigned a unique User ID and a temporary password. I agree to immediately select and enter a new password known only to me. I understand User IDs and passwords may not be shared. I understand I may change my password at anytime to maintain security. I am aware that I am responsible for any use of my User ID and password. This includes data received, viewed, copied, or printed. I will immediately report to credentialing@elderwood.com if I believe my User ID or password has been compromised, when becoming aware of any unauthorized use or disclosure of protected health information, and when I no longer require access. I further agree that I shall not leave a computer or device through which I am logged into the medical record unattended and I shall not use any User ID and/or password storage program which would allow for automatic population of the User ID and/or password fields when logging to the medical record.

The protection of health and other confidential information is a right protected by law. Safeguarding confidential information is a fundamental obligation for all persons accessing such information. My signature at the end of this statement will commit me to that obligation and will be used as confirmation that I understand and agree to the stated basic duties and privacy protections.

_____ _____

Applicant's Signature Date

CHECK ALL THAT APPLY

CODE OF CONDUCT AFFIRMATION STATEMENT — REQUIRED FOR ALL

- o I have received and reviewed a copy of the Companies Code of Conduct Principles, False Claims, and Deficit Reduction Act information, and compliance program overview. I have read, understand and acknowledge their contents and accept all the responsibilities they impose on my association with the company. I understand that I have the opportunity to ask questions and discuss any aspects of the Code of Conduct with the Compliance Officer or any member of the Companies management team if I am unsure of how the code applies in any situation.

- o I specifically acknowledge my affirmative obligation to adhere to the principles and standards of the Code of Conduct, and to report in good faith and in accordance with the Codes provisions, any violations or suspected violations of which I become aware.

HEALTH STATUS/MEDICAL SERVICES AGREEMENT — REQUIRED FOR ALL

TB Screening Per facility policy, initial and annual TB screening is required for all medical professionals. (Select one below)

- o I have attached the negative results of a completed TST test with in the last 12 months.
- o I have a history of a positive TST test and I have attached a negative Chest x-ray completed within the last 5 years or TB health Screen in last year.

Influenza Vaccination Per facility policy, if the annual influenza vaccination is not received, all medical professionals are required to wear a surgical mask during flu season.

- o I have attached proof of my current vaccination

- o I am unvaccinated and agree to wear a surgical mask during flu season.

Attestation **Check all that apply**

- o I attest that I am free of Illegal drug use, free of communicable disease and am capable of carrying out my duties with or without reasonable accommodation.

- o I have received a written summary of the facility provider requirement for my profession

- o I understand I am required to provide a current copy of the following:
  - § State professional registration certificate
  - § Controlled Substance Certificate
  - § Certificate of Professional Liability Insurance
  - § Surescripts Registration Receipt (if applicable)
  - § Current Board Certification (if applicable)
  - § Government issued Photo ID (Drivers license, passport, etc.)

I verify that the above information is true and accurate. I will comply with all applicable federal, state, and local laws or regulations, and facility policies that apply to providing medical services for Elderwood patients.

_____ _____/_____/_____

Signature of Medical Professional/Consultant **Date**

Residents are admitted and treated at this facility without regard to gender, race, color, national origin, creed, religion, age, sex, sexual preference, sponsor, blindness or other disability.

ELDERWOOD ADMINISTRATIVE SERVICES
AUTHORIZATION FOR RELEASE OF CREDENTIALING INFORMATION
and
WAIVER OF CONFIDENTIALITY REGARDING MEDICAL CREDENTIALS

I hereby authorize Elderwood Facilities, and its representatives to request and obtain all of my medical, school records and other pertinent information with respect to my performance in medical school, as an intern, resident or fellow, and in connection with my prior or current associations with or privileges at all health care facilities.

I also authorize Elderwood Facilities to consult with insurance companies who may have information bearing my competence, character and ethical qualifications. I authorize such health care facilities and insurance companies, their officers, employees, agents and representatives to release any information to any or all of the above mentioned facilities as will have bearing on my professional competence and character and my qualifications to perform the duties of the position for which I seek appointment privileges.

In connection with the release of such information, I hereby waive all rights as to confidentiality and I release all institutions, organizations and individuals who provide, receive and use such information, in good faith and pursuant to this application and to the request of Elderwood Facilities from liability or claim for damages in connection with that release of information. Such institutions, organizations, and persons providing, receiving, and using such information shall also be entitled to all the protection set forth in federal state and local laws and regulations regarding the release and use of information.

Pursuant to applicable provisions of the State Law, I hereby waive any liability on the part of any hospitals or facilities concerning information about my professional association or credentials.

A copy of this statement shall be as binding as the original.

_____ _____/_____/_____
Applicants Signature **Date**

_____
Print Applicants Name

Send all required documents, completed applications and questions to Credentialing@Elderwood.com