PAJARO VALLEY HEALTH CARE DISTRICT
HOSPITAL CORPORATION

Supplemental Board Report

Meeting Date: May 31, 2023
Report Type: Discussion

Title: Medical Committees Reports May 2023

Recommendation: Pass a **Motion** approving 1) the Medical Executive Committee (MEC) Report, the Credentials Report and the Interdisciplinary Practice Credentials Report of May 2023.

Contact: Clay Angel, M.D., Vice Chief of Staff Chair, Medical Executive Committee

Analysis
At each board meeting the board receives reports from the Medical Executive Committee including the Credentials Report and the Interdisciplinary Practice Credentials Report.

Financial Impact: None.

Attachments:
A-Medical Executive Committee Reports

WATSONVILLE COMMUNITY HOSPITAL

Memo

May 18, 2023

TO: Board of Directors

FROM: Clay Angel, M.D., Chief of Staff
Chair, Medical Executive Committee

SUBJECT: Chief of Staff Report – May 2023, MEC

ACTION ITEMS FOR APPROVAL

1. Credentialing Actions:

1.1 Credentials Report: May 2023
1.2 Interdisciplinary Practice Credentials Report: May 2023

2. Medical Staff Action Items:

2.1 Updated Medical Staff Privilege Lists
- a) Emergency Medicine Privilege List
- b) General Surgery Privilege List
- c) Obstetrics for Family Medicine Privilege List
- d) Moderate / Deep Procedural Sedation Privilege List

2.2 Medical Staff Updated Initial Application Attachments
- a) Attestation Questions – major change
- b) Consent and Release - minor change
- c) Claims Reporting - minor change
- d) Medicare Physician Acknowledgement - minor change
- e) Statement of Continuing Education - minor change
- f) Conflict of Interest Disclosure - no change
- g) HIPAA Confidentiality - no change
- h) Peer Review & Confidentiality - New
- i) Credentials Release - New
- j) Disclosure regarding background investigation - New
- k) Alternate Coverage Form for Initial and Reappointment Applications - New

2.3 Surgery Quality Review Committee Membership, Updates
- a) Addition of Sarah Brant, MD, Jessica Santillano, MD
- b) Removal of Paul Nguyen, DO

WATSONVILLE COMMUNITY HOSPITAL

Medical Executive Committee Summary – May 16, 2023
ITEMS FOR BOARD APPROVAL

Credentials Committee

INITIAL APPOINTMENTS: (11)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
Ahn, Johan, MD	Radiology / Provisional	Medicine	Diagnostic Radiology	06/01/2023 – 05/31/2025
Acevedo Ramirez, Nattasha, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	06/01/2023 – 05/31/2025
Behravan, Vahid, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	06/01/2023 – 05/31/2025
Chumble, Shubhangi, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	06/01/2023 – 05/31/2025
Floyd, Jessica P., MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	06/01/2023 – 05/31/2025
Lee, Nathanael J., MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	06/01/2023 – 05/31/2025
Misulis, Edward N., MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	06/01/2023 – 05/31/2025
Mukundan, Lakshmi, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	06/01/2023 – 05/31/2025
Nordloff, Timothy, MD, DMD	Oral and Maxillofacial Surgery / Provisional	Surgery	Oral Surgery, Dentistry, Sedation	06/01/2023 – 05/31/2025
Sinha, Nupur, MD	Critical Care Medicine / Provisional	Medicine	Critical Care, Sedation	06/01/2023 – 05/31/2025
Yarlagadda, Ravi, MD	Teleneurology / Provisional	Medicine	Telemedicine Neurology	06/01/2023 – 05/31/2025

REAPPOINTMENTS: (7)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
Claypool, David J., MD	Emergency Medicine / Active	Emergency Medicine	Emergency Medicine; Sedation	06/01/2023 – 05/31/2025
Harbison, Anna L., MD	Pediatric Cardiology / Consulting	Pediatrics	Pediatric Cardiology	06/01/2023 – 05/31/2025
Klein, Joseph R., MD	Pain Medicine / Active	Surgery	Pain Medicine; Fluoroscopy; Sedation	06/01/2023 – 05/31/2025
Klein, Stefan F., MD	Orthopedic Hand Surgery / Active	Surgery	Orthopedic Surgery; Fluoroscopy	06/01/2023 – 05/31/2025
Minazad, Yafa, DO	Teleneurology / Telemedicine	Medicine	Teleneurology	06/01/2023 – 05/31/2025
Nagamine, Janet M., MD	Hospice and Palliative Care / Active	Medicine	Hospice and Palliative Care	06/01/2023 – 02/28/2025
Williams, Richard A., MD	Radiology / Active	Medicine	Diagnostic Radiology	06/01/2023 – 05/31/2025

MODIFICATION / ADDITION OF PRIVILEGES:

NAME	SPECIALTY	Privileges
None		

STAFF STATUS MODIFICATIONS:

NAME	SPECIALTY / DEPARTMENT	RECOMMENDATION
Knight, Justin, MD	Emergency Medicine / Emergency Medicine	Release from Proctoring. Proctoring requirement met.
Nagamine, Janet, MD	Palliative Care, Hospice / Medicine	Release from Proctoring. Proctoring requirement met.
Moreno-Ruiz, Nilda, MD	OBGYN / OBGYN	Release from Cesarean Section proctoring; requirement met.
Hsei, Rex, MD	Ophthalmology / Surgery	Voluntary Resignation
Ohanian, Arbi G., MD	Teleneurology / Medicine	Voluntary Resignation

TEMPORARY PRIVILEGES:

NAME	SPECIALTY / DEPARTMENT	DATES
Ahn, Johan, MD	Radiology / Medicine	05/01/2023 - 05/06/2023 & 05/15/2023 - 05/20/2023
Acevedo Ramirez, Nattasha, MD	Teleneurology / Medicine	05/15/2023- 06/01/2023
Behravan, Vahid, MD	Teleneurology / Medicine	05/15/2023- 06/01/2023
Chumble, Shubhangi, MD	Teleneurology / Medicine	05/15/2023- 06/01/2023
Floyd, Jessica P., MD	Teleneurology / Medicine	05/15/2023- 06/01/2023
Lee, Nathanael J., MD	Teleneurology / Medicine	05/15/2023- 06/01/2023
Misulis, Edward N., MD	Teleneurology / Medicine	05/15/2023- 06/01/2023
Mukundan, Lakshmi, MD	Teleneurology / Medicine	05/15/2023- 06/01/2023
Yarlagadda, Ravi, MD	Teleneurology / Medicine	05/15/2023- 06/01/2023

INTERDISCIPLINARY PRACTICE COMMITTEE

Initial Appointment: (0)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
None				

REAPPOINTMENT: (3)

APPLICANT	SPECIALTY / STATUS	DEPT	PRIVILEGES	Effective Date
Levitan, Sarah H., CNM	Certified Nurse Midwife / Allied Health Professional	OBGYN	Certified Nurse Midwife	06/01/2023 – 05/31/2025
Redzovic, Halil, PA-C	Physician Assistant / Allied Health Professional	Surgery	Physician Assistant General Surgery	06/01/2023 – 04/30/2025
Tahmassebi, Victoria, PA-C	Physician Assistant / Allied Health Professional	Surgery	Physician Assistant General Surgery	06/01/2023 – 04/30/2025

Temporary Privileges: (2)

NAME	SPECIALTY / DEPARTMENT	DATES
Redzovic, Halil, PA-C	Physician Assistant / Surgery	5/27/2023 – 5/31/2023
Tahmassebi, Victoria, PA-C	Physician Assistant / Surgery	5/27/2023 – 5/31/2023

PROPOSED APPLICATION ATTESTATION QUESTIONS, May 2023

If the answer to the below is YES, please provide additional detailed information

LICENSURE / CERTIFICATION ATTESTATION

1. **Has your professional** license to practice medicine, or registration in any jurisdiction, ever been challenged, voluntarily or involuntarily relinquished, suspended, limited, revoked, denied, restricted, non-renewed, surrendered or subjected to probationary conditions or have your voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions or have you been fined or received a letter of reprimand or is such action pending?

2. **Has your DEA license** or state narcotics registration ever been voluntarily or involuntarily relinquished, suspended, limited, revoked, denied, or restricted for reasons other than non-completion of medical records or are any such actions pending?

APPOINTMENT / PRIVILEGES ATTESTATION

3. **Has your application for appointment or reappointment** to the medical staff or any other health care facility ever been denied?

4. **Have you ever surrendered**, allowed to expire, voluntarily or involuntarily withdrawn or had terminated a request for membership or clinical privileges, terminated contractual participation or employment, or voluntarily or involuntarily resigned from any medical organization, including while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?

5. **Has your medical** staff membership ever been voluntarily or involuntarily terminated, suspended, limited, revoked, denied or surrendered for any reason, including reasons related to professional competence or conduct or are any such actions pending?

6. **Have your clinical privileges at** any medical organization ever been voluntarily or involuntarily terminated, suspended, limited, restricted, revoked, denied or surrendered for any reason, including reasons related to professional competence or conduct or are any such actions pending?

7. **Have you ever been subject** to a Focused Professional Practice Review for cause at any medical organization, or subject to probationary conditions other than for non-completion of medical records or are any such actions pending?

MEDICARE / MEDICAL / ETHICAL SANCTIONS

8. **Have you ever been charged**, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily

relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence, or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, or any federal program or is any such action pending?

9. **Have you** ever been disciplined for a violation of ethical standards by a professional organization?

TRAINING ATTESTATION

10. **During your internship**, residency, fellowship and/or formal clinical appointment were you ever disciplined, suspended, placed upon probation, formally reprimanded, requested or compelled to relinquish your status as a student in good standing or asked to resign? During training, did you incur a leave for thirty (30) or more consecutive days?

BOARD CERTIFICATION

11. **Have you ever been denied** certification or recertification by a specialty board or chosen not to recertify, or have you ever voluntarily or involuntarily surrendered your board certification while under investigation?

LEGAL ATTESTATION

12. **Have you ever been arrested**, accused or convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense? Or are any such actions pending?

INSURANCE MALPRACTICE ATTESTATION

13. **Have any judgments** been entered against you, or settlements been agreed to by you in any professional liability cases? Or are there any professional liability lawsuits and/or arbitrations against you that have been dismissed or are currently pending? If yes, please complete the attached form

14. **Has your professional liability** insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?

15. **Has your professional** liability insurance been in continuous coverage for the prior 5-years?

HEALTH ATTESTATION

Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner? (Yes/No)

****For ADA compliance, *If YES, please describe any accommodations that could reasonably be made to facilitate your practice without risk of compromise to patients or staff.***

APPLICANT'S CONSENT AND RELEASE FOR APPLICATION

I hereby apply for medical staff appointment **to Watsonville Community Hospital Medical Staff / Allied Health Professional Staff** and, whether or not my application is accepted, I acknowledge, consent, and agree as follows:

As an applicant for appointment, I have the burden for producing adequate information for proper evaluation of my qualifications. I also agree to update the facility/network with current information regarding all questions contained in this application as such information becomes available and any additional information as may be requested by the facility/network or its authorized representatives. Failure to produce any such information will prevent my application for appointment from being evaluated and acted upon. I hereby signify my willingness to appear for the interview, if requested in regard to my application.

Information given in or attached to this application is accurate and complete to the best of my knowledge. I fully understand and agree that as a condition to making this application, any misrepresentations or misstatement in, or omission from it, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of appointment and clinical privileges.

If granted appointment, I accept the following conditions:

A. I extend immunity to, and release from any and all liability, the facility/network, its authorized representatives and any third parties, as defined in Subsection C below, for any acts, communications, recommendations or disclosures performed without intentional fraud or malice involving me; performed, made, requested or received by this facility/network 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; 3) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary action; 4) summary suspensions; 5) hearings and appellate reviews; 6) medical care evaluations; 7) utilization reviews; 8) any other facility/network, medical staff, department, service or committee activities; 9) matters to 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 impact or reflect on my competence, on patient care or on the orderly operation of this or any other facility/network or health care facility/network.

B. I specifically authorize the facility/network 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 other matter bearing on my satisfaction of the criteria for continued appointment to the medical staff, as well as to inspect or obtain any and all communications, reports, records, statements, documents, recommendations and/or disclosures of said third parties relating to such questions. I also specifically authorize said third parties to release said information to the facility/network and its authorized representatives upon request.

C. The term "facility/network and its authorized representatives" means the facility/network corporation, the facility/network(s) to which I am applying 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 facility/network; the members of the facility/network's Board and their appointed representatives, the Chief Executive Officer or his designees, other facility/network employees, consultants to the facility/network, the facility/network's attorney and his/her partners, associates or designees, and all appointees to the medical staff. The term "third parties" means all individuals, including appointees to the facility/network's medical staff, and appointees to the medical staffs of other facility/networks or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether facility/networks, health care facilities or not, from whom information has been requested by the facility/network or its authorized representatives or who have requested such information from the facility/network and its authorized representatives.

I acknowledge that (1) medical staff/network appointments at this facility/network are not a right; (2) my request will be evaluated in accordance with prescribed procedures defined in the facility/network and medical staff bylaws, rules, and regulations; (3) all medical staff recommendations relative to my application are subject to the ultimate action of the facility/network Board whose decision shall be final; (4) if appointed, my appointment and clinical privileges shall be provisional; (5) I have the responsibility to keep this application current by informing the facility/network through the Chief Executive Officer, of any change in the areas of inquiry contained herein; and (6) appointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the facility/network 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 that are relevant to the effective and efficient operation of the facility/network. Appointment and continued clinical privileges shall be granted only on formal application, according to the facility/network and medical staff bylaws, rules and regulations, and upon final approval of the facility/network Board.

I understand that before this application will be processed that (1) I will be provided a copy of the medical staff bylaws and such facility/network policies and directives as are applicable to appointees to the medical staff, including the bylaws and rules and regulations of the medical staff presently in force, and (2) I must sign a statement acknowledging receipt and an opportunity to read the copies and agreement to abide by all such bylaws, policies, directives and rules and regulations as are in force, and as they may thereafter be amended, during the time I am appointed to the medical staff or exercise clinical privileges at the facility/network.

If appointed 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 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; (5) abide by generally recognized ethical principles applicable to my profession; (6) provide continuous care and supervision as needed to all patients in the facility/network/health plan for whom I have responsibility; and (7) accept committee assignment and such other duties and responsibilities as shall be assigned to me by the facility/network Board and medical staff.

APPLICANT'S SIGNATURE (stamped signature not accepted) **DATE**

WCH MEDICAL STAFF APPLICATION

MALPRACTICE CLAIMS REPORT FORM

Complete one form for each claim

Physician (Applicant) Name: _____

Specialty: _____

Name of Patient: _____

Allegation: _____

_____

_____

Your Relationship to Patient (attending physician, surgeon, assistant surgeon, consultant, etc.):

Date of Incident: _____ **Date Reported:** _____

Location of Incident: _____

Insurance Carrier: _____

Additional Defendants: _____

Claim Status: Open ☐ Closed ☐

If Closed Indicate Method of Closing:

Date of Closing: _____

Amount of Settlement or Judgement: _____

Describe your care and treatment of the patient. (If additional space is necessary, use the reverse side or attach additional sheets.) Your narrative must provide adequate clinical detail to allow proper evaluation by a committee of physicians and include the following information:

Condition and Diagnosis at Time of Incident _____

_____

_____

Describe Treatment Rendered (Including Dates): _____

_____

_____

Condition of Patient Subsequent to Treatment (Including Dates): _____

_____

_____

_____ _____

Physician Signature Date

PHOTOCOPY IF NEEDED

PLEASE ATTACH COMPLETED FORM TO APPLICATION

WATSONVILLE
COMMUNITY HOSPITAL

MEDICARE/CHAMPUS ACKNOWLEDGEMENT STATEMENT

As a condition for payment by the Medicare/Champus programs, Watsonville Community Hospital (WCH) is obligated to contact all physicians who are being granted admitting privileges at WCH to ensure that they review the Physician Acknowledgment Statement (below), sign the acknowledgment of this review, and return the acknowledgement as part of the Medical Staff Application. The acknowledgment indicates that the physician has receive this notice. If this form is absent, your application will be considered incomplete.

NOTICE TO PHYSICIANS

Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his of her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

ACKNOWLEDGMENT OF RECEIPT AND REVIEW OF PHYSICIAN MEDICARE ACKNOWLEDGMENT STATEMENT

By signing this form, I acknowledge that I have read and will comply with this Notice to Physicians.

Applicant Signature: _____

(Stamped signature is not acceptable)

Print Name: _____ **Date:** _____

WATSONVILLE COMMUNITY HOSPITAL

Application for Medical Staff
STATEMENT OF CONTINUING EDUCATION

Each member of the **Medical Staff and Allied Professional Staff** must provide documentation of Continuing Education. **Please provide either:**

1. A list the courses taken, dates of attendance, program sponsor and the number of CME credits earned. **You do not need to provide copies of Certificates of Attendance;**

OR

2. Complete the Attestation Statement below.

I hereby certify that within the past two (2) years I have completed the necessary Continuing Education requirements as required by the Medical Board of California (during each 2-year renewal period). If audited, I will be able to provide documentation of Certificates of Attendance that are appropriate for the practice privileges that I am requesting. I recognize that failure to produce documentation upon request could jeopardize my membership and practice privileges on the Medical Staff or Allied Health Professional Staff of ***Watsonville Community Hospital.***

Signature **Printed Name** **Date**

Activity Dates	Accredited Sponsor	Activity Title	Credits

Please use additional sheets if needed

WATSONVILLE
COMMUNITY HOSPITAL

MEDICAL STAFF / ALLIED HEALTH MEMBER CONFLICT OF INTEREST DISCLOSURE FORM

Medical Staff / AHP Member Name: _____

Date: _____

The purpose of this form is to allow all Medical Staff / Allied Health Practitioner members to disclose any actual or potential conflict of interest, as required by Joint Commission Leadership Standard LD.02.02.01 and as outlined in the Medical Staff Bylaws or applicable medical staff policy. When a relationship or potential relationship may present a conflict, such should be disclosed at the earliest possible date.

****

A. Please discuss all business or financial relationships or interests with (i) the Hospital or any affiliate; (ii) any entity in competition with the Hospital, or (iii) any third party entity which currently provides good and services to, or may seek to provide goods or services to the Hospital or any related or affiliated entity of the Hospital. ***(The CMS Open Payments database will be queried to obtain information about financial relationships with health care manufacturing companies and to confirm accuracy of the response to this inquiry.)***

_____

_____

B. Please list any leadership position on another Medical Staff / AHP or educational institution that creates a fiduciary obligation on your behalf, including, but not limited to membership on the governing body, executive committee or service or department chairmanship with an entity or facility that competes directly or indirectly with the Hospital.

_____

_____

C. Please describe all relationships not disclosed above which might in any way bear on your opinions or decisions as a medical staff / AHP member or, as applicable, medical staff leader.

_____

_____

I hereby certify the foregoing information is true, correct and complete to the best of my knowledge and belief. I further certify that should I become aware of any other potential conflict of interest from the time of this disclosure until my next regular periodic disclosure; I will disclose such potential conflict within thirty days of becoming aware of same.

Signature: _____ Date: _____

WATSONVILLE COMMUNITY HOSPITAL MEDICAL STAFF
HIPAA Workforce Confidentiality & Information Security Agreement

I understand the facility or business entity, Watsonville Community Hospital, (the "Company") in or for which I work, volunteer or provide services (contractual or otherwise) has a legal and ethical responsibility to safeguard protected health information ("PHI"). In the course of my employment, assignment, or affiliation with the Company, I understand that I may come into contact with PHI. I will access and use this information only when it is necessary to perform my job-related duties in accordance with the Company's Privacy and Security Policies, which are available on the Company intranet.

1. I will act in the best interest of the Company and in accordance with its policies, procedures, and Code of Conduct at all times during my relationship with the Company.
2. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
3. I understand that I have no right to any ownership interest in any intellectual property, ideas, inventions, or work product developed during work time by me during my relationship with the Company.
4. I will practice good workstation security measures such as positioning screens away from public view, logging off the system when not in use, and securely storing removable media when not in use.
5. I will only access or use records, documents, systems, or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
6. I shall:
   a. use only my officially assigned user ID and password.
   b. use only approved licensed software.
   c. use devices with virus protection software.
   d. report theft or loss of mobile devices (cell phones, USB drives, laptops, etc.) that store PHI immediately.
7. I am personally responsible for transactions under my user ID and password.
8. I shall not:
   a. share or disclose user IDs or passwords, make them discoverable to others, ask others to share their passwords, or utilize another individual's passwords.
   b. use tools or techniques to break or exploit security measures.
   c. connect to unauthorized networks through the Company's systems or devices.
   d. knowingly include, or cause to be included, any false, inaccurate or misleading entry in any record or report.
   e. use a workstation without logging out another user.
9. I will not disclose or discuss any PHI with others, including friends or family, who do not have a business need to know it.
10. I will not in any way use, access, copy, release, sell, loan, alter, remove, or destroy any PHI except as properly authorized.
11. I will not make unauthorized transmissions, inquiries, modifications, or purgings of PHI.
12. I will practice secure electronic communications by transmitting PHI only to authorized entities, in accordance with approved security standards.
13. I will only access electronic systems to review patient records for which my job responsibilities have a legitimate need to access for treatment, payment or healthcare operations.
14. I will notify my manager or appropriate Information Services person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy or security policies, or any other incident that could have any adverse impact on PHI.
15. Upon termination, I will immediately return any documents or media containing PHI to the Company.
16. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
17. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, termination of authorization to work within the Company, in accordance with the Company's policies, and/or legal action against the organization and/or myself.

The following statements apply to non-employed physicians and independent contracted entities and/or persons using Company systems containing patient identifiable health information:

1. I will ensure that only appropriate personnel in my office will access the Company's electronic systems and I will annually train such personnel on issues related to patient confidentiality and access.
2. I will accept full responsibility for the actions of my employees who may access the Company's electronic systems and PHI.

I acknowledge that I have read this Agreement and I agree to comply with the terms and conditions stated above in order to obtain authorization for access to protected health information.

Signature (Employee, Consultant, Contractor, Physician)	Facility Name	Date
Printed Name	Department	

WATSONVILLE
COMMUNITY HOSPITAL

MEDICAL STAFF PEER REVIEW ACTIVITY CONFIDENTIALITY AGREEMENT

As a member of the Medical Staff or Allied Health Practitioner Staff, I recognize that I may be requested to take part in a committee involved in or otherwise participate in the evaluation and improvement of the quality of care rendered in the hospital. I recognize that confidentiality is vital to the free and candid discussions necessary to effective peer review activities. Therefore, I agree to respect and maintain the confidentiality of all discussions, deliberations, records, and other information generated in connection with these activities, and to make no voluntary disclosures of such information except to persons authorized to receive it in the conduct of Medical Staff affairs.

Furthermore, my participation in peer review and performance improvement activities is in reliance on my belief that the confidentiality of these activities will be similarly preserved by every other member of the Medical Staff or other individual involved. I understand the hospital and the Medical Staff are entitled to undertake such action as it deems appropriate to ensure that this confidentiality is maintained, including application to a court for injunctive or other relief in the event of a threatened breach of this agreement.

Applicant Signature: _____
(Stamped signature is not acceptable)

Print Name: _____ **Date:** _____

WATSONVILLE
COMMUNITY HOSPITAL

CREDENTIALS RELEASE CONSENT FORM

I, the undersigned, hereby give my consent for Watsonville Community Hospital (WCH) to release the following information and credentials from my WCH credentials file to the WCH Business Office and WCH Managed Care Department for the purpose of provider enrollment.

I further give my consent for WCH to release the following information and credentials from my WCH credentials file to the Coastal Health Partners Clinic Services Division for the purpose of provider enrollment and/or credentialing should I be or become affiliated with these entities.

- Current Curriculum Vitae
- Copy of WCH credentials application, demographics, training, affiliation and licensure sections
- All State Medical Licenses
- Drug Enforcement Administration Certificate
- American Board of Medical Specialties (ABMS) Certification
- Malpractice, General Liability, and/or Automobile Insurance Face Sheet
- Medical School Diploma
- Post Graduate Training (Internship, Residency, Fellowship) Diplomas and/or Certificates
- Education Commission on Foreign Medical Graduates (ECFMG) Certificate

If at any point I wish to withdraw this consent for WCH to release this information and credentials on an ongoing basis for purposes of re-credentialing to any or all of the entities noted above, a written notice must be submitted by me to the WCH Medical Staff Office.

Applicant Signature: _____
(Stamped signature is not acceptable)

Print Name: _____ **Date:** _____

WATSONVILLE
COMMUNITY HOSPITAL

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Watsonville Community Hospital (WCH) may obtain information about you from a consumer reporting agency made in connection with your application for Medical Staff membership and/or privileges. Thus, you may be the subject of a "consumer report" and/or "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews. These reports may contain information regarding your criminal history, Social Security number verification, verification of your employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for Medical Staff and Allied Professional Staff membership and privileges is an investigation into your criminal background currently conducted by an outside organization – Sterling Talentwise Solutions. The scope of this notice and authorization is all-encompassing, however, allowing WCH to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your appointment to the extent permitted by law.

WATSONVILLE COMMUNITY HOSPITAL

WCH Medical Staff

ALTERNATIVE COVERAGE FORM

Please list the physician(s) who will provide cross coverage when you are not available. Note the physician(s) must be members of WCH medical staff

NAME		
ADDRESS		
PHONE	**Office:**	**Cell:**
SPECIALTY		

NAME		
ADDRESS		
PHONE	**Office:**	**Cell:**
SPECIALTY		

Signature: _____

Date: _____

WATSONVILLE COMMUNITY HOSPITAL
DEPARTMENT OF EMERGENCY MEDICINE
DELINEATION OF PRIVILEGES FORM

NAME:_____

	QUALIFICATIONS/CRITERIA
	USUAL AND CUSTOMARY PRIVILEGES
EMERGENCY DEPARTMENT PRIVILEGES	**ELIGIBILITY CRITERIA** 1. The applicant must hold an unrestricted MD or DO California State license. 2. Applicant must hold a current, unrestricted DEA certificate. ~~3. Applicant must have current Advanced Cardiac Life Support (ACLS) certification (required for procedural sedation privileges).~~ ~~4.~~3. Applicant must provide evidence of current professional liability coverage with limits as defined by the Medical Executive Committee and Board of Trustees. ~~5.~~4. Initial applicants must have successfully completed an approved ACGME or AOA training program in Emergency Medicine~~, with Board eligibility or Board certification preferred~~. If not Emergency Medicine Board certified at time of appointment, the applicant will need to achieve such certification within four (4) years of initial appointment. ~~6.~~5. Applicant must have demonstrated acceptable competence in the privileges requested (i.e. evidence of training, experience, and current clinical competence in an Emergency Department setting). ~~7.~~6. Active practice in an Emergency Department, reflective of the scope of privileges requested, in the past 24 months, or recent completion of an ACGME or AOA-accredited residency or clinical fellowship within the past 12 months. Applicants have the burden of producing information deemed adequate by the Medical Staff for a proper evaluation of current competence, and other qualifications and for resolving any doubts. ~~8.~~7. Privileges do not include care of patients on an inpatient basis at WCH.
REAPPOINTMENT CRITERIA	**REAPPOINTMENT CRITERIA** Applicant must demonstrate current clinical competence and adequate volume of experience with acceptable results, reflective of the scope of privileges requested for the previous twenty-four (24) months, based upon Ongoing Professional Practice Evaluation (OPPE) and outcomes.
PROCTORING	**PROCTORING REQUIREMENTS** 1. Proctoring requirements will be in accordance with established Medical Staff policy, including ~~five (5) concurrent cases observed, two (2) procedures concurrently observed, and eight (8) retrospective~~ fifteen (15) retrospective cases reviewed. A new physician will be under the direct supervision of the assigned proctor or his/her designee. 2. Established procedures as outlined in the Medical Staff Bylaws, Rules and Regulations will be followed for requests for release from proctoring, or if continued proctoring is recommended. 3. Additional proctoring may be required at any time, if deemed necessary.

WATSONVILLE COMMUNITY HOSPITAL
DEPARTMENT OF EMERGENCY MEDICINE
DELINEATION OF PRIVILEGES FORM

NAME:_____

	EMERGENCY DEPARTMENT CORE PRIVILEGES
CORE PRIVILEGES REQUESTED ☐	Assess, evaluate, diagnose, and initially treat patient of all ages who present to the Emergency Department with any symptom, illness, injury, or condition. To provide immediate recognition, evaluation, care, stabilization, and disposition in response to acute illness or injury. Privileges include the performance of history and physical examination, the ordering and interpretation of diagnostic studies, including laboratory, diagnostic imaging, and electrocardiographic examinations, and the administration of medications normally considered part of the practice of emergency medicine. This list is a sampling of procedures included in the core, and is not intended to be all-encompassing, but rather reflective of the categories of procedures included in the core.
If you wish to exclude any procedures, please strike through the procedures that you do not wish to request, initial and date.	Performance of history and physical exam Incision and drainage of abscess Airway management and intubation including the use of medications used for rapid sequence intubation (RSI) Administration of thrombolytic therapy for MI and Stroke Anoscopy Arthrocentesis Anesthesia- local, field, and blocks Bladder catheterization and supra-pubic taps Blood component therapy Burn management Cardiac pacing- external, intra thoracic, transvenous Cardiac massage- open or closed Cardioversion Central venous access- femoral, jugular, subclavian Chemical restraint of agitated patient Cricothyrotomy Defibrillation Delivery of newborn, emergency, perimortem c-section Dental anesthesia block Dental injury management Dislocation/ fracture management Electrocardiogram interpretation Epistaxis management Fracture/Dislocation management and immobilization GI decontamination

WATSONVILLE COMMUNITY HOSPITAL
DEPARTMENT OF EMERGENCY MEDICINE
DELINEATION OF PRIVILEGES FORM

NAME:_____

If you wish to exclude any procedures, please strike through the procedures that you do not wish to request, initial and date.	Incision and drainage of thrombosed hemorrhoids Irrigation and management of caustic exposures Intraosseous insertion and removal Laryngoscopy, direct and indirect Lumbar puncture Nail removal and trephination Nasal gastric intubation Ocular tonometry Paracentesis Pericardiocentesis Percutaneous transtracheal ventilation Procedural sedation, to include moderate, dissociative, deep sedation, as per Watsonville Community Hospital Procedural Sedation policy (Advanced Cardiac Life Support [ACLS] certification required only for NON-Boarded ED Physicians) Preliminary interpretation of imaging studies Removal of foreign bodies- airway, nose, ear, eye, soft tissue Repair of lacerations Respirators- initial management in the ED/ICU Resuscitation Skull trephination- Gardner Well tongs Slit lamp for diagnostic exam and for removal of corneal foreign body Spine immobilization Thoracentesis Thoracostomy tube insertion Thoracotomy Tooth stabilization (Extremity) variceal hemostasis Ventilation non- invasive (BiPAP) Wound debridement and repair Use of ultrasound for emergency screening

WATSONVILLE COMMUNITY HOSPITAL
DEPARTMENT OF EMERGENCY MEDICINE
DELINEATION OF PRIVILEGES FORM

NAME:_____

ATTESTATION OF APPLICANT

I certify that I have had the necessary education, training and experience to perform the procedures I have requested, and that I have performed the minimum number of patient care activities in the last two years as shown on the Qualifications/Criteria. I agree to abide by the Medical Staff Bylaws, Rules and Regulations, and other organizational policies and provide only services within the scope of my licensure and/or clinical privileges.

APPLICANT'S SIGNATURE: _____ **DATE:** _____

MEDICAL STAFF APPROVALS

_____ _____
DEPARTMENT CHAIR/DESIGNEE **DATE**

_____ _____
CREDENTIALS/IDP COMMITTEE CHAIR/DESIGNEE **DATE**

_____ _____
MEDICAL EXECUTIVE COMMITTEE CHAIR/DESIGNEE **DATE**

_____ _____
BOARD OF TRUSTEES CHAIR/DESIGNEE **DATE**

Approved: ER: 12/8/20 – Credentials: 12/11/20 – MEC: 12/15/20 – BOT: 12/23/20

Name: _____

Watsonville Community Hospital
DEPARTMENT OF SURGERY
General Surgery Clinical Privileges

❑ ☐Initial privileges (initial appointment) ❑ Renewal of privileges (reappointment)

All new applicants must meet the following requirements as approved by the Board of Trustees, effective December 26, 2018.

If any privileges are covered by an exclusive contract or an employment contract, practitioners who are not a party to the contract are not eligible to request the privilege(s), regardless of education, training, and experience. Exclusive or employment contracts are indicated by [EC].

Applicant: Check the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

Department Chair (Designee): Check the appropriate box for recommendation on the last page of this form and include your recommendation for focused professional practice evaluation.[1] If recommended with conditions or not recommended, provide the condition or explanation on the last page of this form.

Other requirements

- Note that privileges granted may only be exercised at the site(s) and/or setting(s) that have sufficient space, equipment, staffing, and other resources required to support the privilege.
- This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

Qualifications for General Surgery

Initial privileges: To be eligible to apply for privileges in general surgery, the applicant must meet the following criteria:

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA)–accredited residency in general surgery.

AND

Current certification or eligibility to complete the Qualifying Exam and/or Certifying Examination portions of the Board certification process (with achievement of certification within – 7 years) leading to certification in general surgery by the American Board of Surgery or the American Osteopathic Board of Surgery.

[1] 1. For Joint Commission-accredited hospitals only.

Name: _____

~~AND~~

~~Completion of certification in advanced cardiac life support, and fundamentals of laparoscopic surgery.[2]~~

AND

Required current experience: At least 100 general surgery procedures, reflective of the scope of privileges requested, during the past 12 months or demonstrated successful completion of an ACGME- or AOA-accredited residency or clinical fellowship within the past 12 months.

Renewal of privileges: To be eligible to renew privileges in general surgery, the applicant must meet the following criteria:

Current demonstrated competence and an adequate volume of experience (12 general surgery procedures) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.

Core privileges: General surgery

☐ **Requested** Admit, evaluate, diagnose, consult, and provide pre-, intra-, and postoperative care and perform surgical procedures to patients of all ages to correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract; skin, soft tissues, and breast; endocrine system; head and neck; surgical oncology, trauma, and nonoperative trauma; and the vascular system. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services.

The core privileges in this specialty include the procedures on the attached procedures list and such other procedures that are extensions of the same techniques and skills.

Special Non-core Privileges (See Specific Criteria)
Non-core privileges are requested individually in addition to requesting the core. Each individual requesting non-core privileges must meet the specific threshold criteria as applicable to the applicant.

~~[2] Required by the American Board of Surgery as of July 1, 2009, for those surgeons who have completed residency training after the 2009–2010 academic year and are seeking board certification. Hospitals should decide whether to adopt this as criteria.~~

Name: _____

Non-core privileges: Use of laser

❑ **Requested**

Initial privileges: Successful completion of an approved residency in a specialty or subspecialty that included training in laser principles or completion of an approved 8- to 10-hour minimum continuing medical education (CME) course that included training in laser principles. In addition, an applicant for privileges should spend time after the basic training course in a clinical setting with an experienced operator who has been granted laser privileges acting as a preceptor. Practitioner agrees to limit practice to only the specific laser types for which he or she has provided documentation of training and experience. The applicant must supply a certificate documenting that he or she attended a wavelength and specialty-specific laser course and also present documentation as to the content of that course.

AND

Required current experience: Demonstrated current competence and evidence of the performance of at least 4 procedures in the past 12 months or completion of training in the past 12 months.

Renewal of privileges: Demonstrated current competence and evidence of the performance of at least 3 procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Source: American Society for Laser Medicine and Surgery, April 2008.

Non-core privileges: EGD with and without biopsy

❑ **Requested**

Initial privileges: Successful completion of an accredited residency in general surgery that included training in upper endoscopy procedures with a minimum of 35 procedures performed during training or equivalent training and/or experience obtained outside a formal program that is at least equal to that obtained within the formal residency program.

AND

Required current experience: Demonstrated current competence and evidence of the performance of at least 4 esophagogastroduodenoscopy (EGD) procedures in the past 12 months or completion of training in the past 12 months.

Renewal of privileges: Demonstrated current competence and evidence of the performance of at least 3 procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Name: _____

Non-core privileges: Colonoscopy with polypectomy

❑ **Requested**

Initial privileges: Successful completion of an accredited residency in general surgery that included training in lower endoscopy procedures with a minimum of 50 procedures performed during training or equivalent training and/or experience obtained outside a formal program that is at least equal to that obtained within the formal residency program.

AND

Required current experience: Demonstrated current competence and evidence of the performance of at least 4 colonoscopy procedures in the past 12 months or completion of training in the past 12 months.

Renewal of privileges: Demonstrated current competence and evidence of the performance of at least 3 procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Non-core privileges: Laparoscopic nissen fundoplication (antireflux surgery)

❑ **Requested**

Initial privileges: Successful completion of an accredited ACGME or AOA residency in general surgery that included advanced laparoscopic training or completion of a hands-on CME course in laparoscopic Nissen fundoplication that included preceptorship by a surgeon experienced in the procedure.

AND

Required current experience: Demonstrated current competence and evidence of the performance of at least 4 laparoscopic Nissen fundoplication procedures in the past 12 months or completion of training in the past 12 months.

Renewal of privileges: Demonstrated current competence and evidence of the performance of at least 4 laparoscopic Nissen fundoplication procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Source: HCPro's Clinical Privilege White Paper: Laparoscopic Nissen Fundoplication—Procedure 85.

~~Non-core privileges: Stereotactic breast biopsy~~

~~❑ Requested~~

Name: _____

~~**Initial privileges:** Successful completion of training in the stereotactic- and ultrasound-guided technique of breast biopsy during residency or in an accredited course or institution and possession of privileges for breast imaging interpretation.~~

~~AND~~

~~**Required current experience:** Demonstrated current competence and successful completion of at least 15 hours of category 1 CME in stereotactic breast biopsy or performance of at least 36 stereotactic breast biopsies in the past three years; successful evaluation of at least 480 mammograms per year in the past two years in consultation with a physician who is qualified to interpret mammography under the Mammography Quality Standards Act (MQSA); successful completion of at least 4 hours of category 1 CME in medical radiation physics; performance of either at least 12 stereotactic breast biopsies or at least three hands-on procedures with a physician who is qualified to interpret mammography under the MQSA and has performed at least 24 procedures.~~

~~**Renewal of privileges:** Demonstrated current competence and evidence of the performance of at least 24 stereotactic breast biopsies in the past 24 months and continued evaluation of at least 480 mammograms every two years in consultation with a physician who is qualified to interpret mammograms under MQSA. In addition, at least three hours of category I CME in stereotactic breast biopsy every three years is required or requalification of those requirements specified under the criteria and required current experience for new applicants.~~

~~Source: ACS and ACR Stereotactic Breast Biopsy Physician Qualifications for Stereotactic Breast Biopsy, 1998.~~

Non-core privileges: Administration of sedation and analgesia

☐ **Requested**

See "Hospital Policy for Procedural Sedation"

Fluoroscopy Privileges

☐ **Requested**

Criteria: Documentation of California State Fluoroscopy X-Ray Supervisor and Operator Permit

Core Procedures List

This is not intended to be an all-encompassing procedures list. It defines the types of activities/procedures/privileges that the majority of practitioners in this specialty perform at the organization and inherent activities/procedures/privileges requiring similar skill sets and techniques.

To the applicant: If you wish to exclude any procedures, please strike through the procedures that you do not wish to request, and then initial and date.

Name: _____

- Performance of history and physical exam

Trauma, abdomen, alimentary

- Abdominoperineal resection
- Amputations, above and below the knee, toe, transmetatarsal, digits
- Anoscopy
- Appendectomy
- Circumcision
- Colectomy (abdominal)
- Colon surgery for benign or malignant disease
- Colotomy, colostomy
- Correction of intestinal obstruction
- Decortication or pleurectomy procedures
- Diagnostic procedures, including cervical and mediastinal exploration, parasternal exploration, and mediastinoscopy
- Distal esophagogastrectomy
- Drainage of intra-abdominal, deep ischiorectal abscess
- Emergency thoracostomy
- Endoscopic procedures, including bronchoscopy, esophagoscopy, and mediastinoscopy
- Endoscopy (intraoperative)
- Enteric fistulae, management
- Enterostomy (feeding or decompression)
- Esophageal resection and reconstruction
- Excision of fistula in ano/fistulotomy, rectal lesion
- Excision of pilonidal cyst/marsupialization
- Gastric operations for cancer (radical, partial, or total gastrectomy)
- Gastroduodenal surgery
- Gastrostomy (feeding or decompression)
- Genitourinary procedures incidental to malignancy or trauma
- Gynecological procedure incidental to abdominal exploration
- Hepatic resection
- Hemorrhoidectomy, including stapled hemorrhoidectomy
- Incision and drainage of abscesses and cysts
- Incision and drainage of pelvic abscesses
- Incision, excision, resection, and enterostomy of small intestine
- Incision/drainage and debridement, perirectal abscesses
- Insertion and management of pulmonary artery catheters
- IV access procedures, central venous catheter, and ports

Name: _____

- Laparoscopic procedures (advanced) (e.g., colectomy, splenectomy, adrenalectomy, common duct exploration/stone extraction
- Laparoscopy, diagnostic, appendectomy, cholecystectomy, lysis of adhesions, mobilization, and catheter positioning
- Laparotomy for diagnostic or exploratory purposes or for management of intra-abdominal sepsis or trauma
- Liver biopsy (intraoperative), liver resection
- Lymph node and superficial biopsy procedures
- Management of burns
- Management of chest and neck trauma
- Management of intra-abdominal trauma, including injury, observation, paracentesis, lavage
- Management of multiple trauma
- Operations for achalasia and for promotion of esophageal drainage
- Operations on gallbladder, biliary tract, bile ducts, hepatic ducts, including biliary tract reconstruction
- Pancreatectomy, total or partial
- Pancreatic sphincteroplasty
- Panniculectomy
- Pericardiocentesis, pericardial drainage procedures, and pericardiectomy
- Procedures upon the chest wall, pleura, and lungs, including wedge resections, segmentectomy, lobectomy, and pneumonectomy
- Proctosigmoidoscopy, rigid with biopsy, with polypectomy/tumor excision
- Pyloromyotomy
- Radical regional lymph node dissections
- Removal of ganglion (palm or wrist; flexor sheath)
- Repair of perforated viscus (gastric, small intestine, large intestine)
- Resection, reconstruction, or repair of the trachea and bronchi
- Resection, reconstruction, repair, or biopsy of the lung and its parts
- Scalene node biopsy
- Selective vagotomy
- Sentinel lymph node biopsy
- Sigmoidoscopy, fiberoptic with or without biopsy, with polypectomy
- Small-bowel surgery for benign or malignant disease
- Splenectomy (trauma, staging, therapeutic)
- Surgery of the abdominal wall, including management of all forms of hernias, including diaphragmatic and inguinal hernias, and orchiectomy in association with hernia repair
- Surgery on the esophagus, mediastinum, and diaphragm, including surgery for diverticulum, as well as perforation, resections, transhiatal esophagectomy, surgery for benign esophageal disease, and surgery on mediastinum for removal of benign or malignant tumors

Name: _____

- Thoracentesis
- Thoracoabdominal exploration
- Thoracotomy for trauma, hemorrhage, rib biopsy, drainage of empyema, or removal of foreign body
- Tracheostomy
- Transhiatal esophagectomy
- Tube thoracostomy
- Video-assisted thoracoscopic surgery

Breast, skin, and soft tissue

- Complete mastectomy with or without axillary lymph node dissection
- Excision of breast lesion
- Breast biopsy
- Incision and drainage of abscess
- Management of soft-tissue tumors, inflammations, and infection
- Modified radical mastectomy
- Operation for gynecomastia
- Partial mastectomy with or without lymph node dissection
- Radical mastectomy
- Skin grafts (partial thickness, simple)
- Subcutaneous mastectomy
- Endocrine system
- Excision of thyroid tumors
- Excision of thyroglossal duct cyst
- Parathyroidectomy
- Thyroidectomy and neck dissection

Vascular surgery

- Hemodialysis and central vein access procedures
- Sclerotherapy
- Vein ligation and radiofrequency ablation (RFA)

Acknowledgment of practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at Watsonville Community Hospital, and I understand that:

Name: _____

a. In exercising any clinical privileges granted, I am constrained by 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 or related documents.

Signed _____ Date _____

Department Chair (Designee) recommendation

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and:

❑ Recommend all requested privileges

❑ Recommend privileges with the following conditions/modifications:

_____

_____

❑ Do not recommend the following requested privileges:

_____

_____

Privilege condition/modification/explanation

_____

_____

Notes: _____

_____

Department Chair (Designee) signature _____ Date _____

FOR MEDICAL STAFF USE ONLY

Name: _____

Credentials Committee Action Date: _____

Medical Executive Committee Action Date: _____

Board of Trustees Action Date: _____

Name _____

Effective _____ / _____ / _____ to _____ / _____ / _____

Watsonville Community Hospital

Clinical Privileges in Obstetrics for Family Medicine

☐ Initial Appointment
☐ Reappointment

Applicants have the burden of producing information deemed adequate by the Medical Staff for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

Initial Appointment Requirements
To be eligible to initially apply for core privileges in Family Medicine and Obstetrics, the M.D. or D.O. applicant must demonstrate successful completion of an ACGME- or AOA-accredited postgraduate training program in Family Medicine **and** current board certification or active participation in the examination process (with achievement of certification within 3 years of postgraduate training) leading to certification in Family Medicine by either the American Board of Family Medicine or the American Osteopathic Board of Family Physicians. In addition, completion of advanced post-graduate fellowship training in obstetrics or maternal child health is required; exceptions may be considered at the discretion of the Chair of the OBGYN Department. The successful applicant must be able to demonstrate provision of care, reflective of the scope of privileges requested, or demonstrate successful completion of postgraduate training program within the past 24 months.

~~***Recredentialing Requirements***~~
~~To be eligible for reappointment, the applicant must demonstrate current competence and an adequate volume of experience with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.~~

To be eligible to apply for privileges in the specialty of Family Medicine with Obstetrics, the applicant must also meet the following criteria:

- ~~Met all criteria to apply for privileges in specialty of Family Medicine~~
- If less than 2 years from training completion, must have a minimum of 40 deliveries and letter from residency program director or fellowship director certifying competence in uncomplicated obstetrics; and in any requested supplemental privileges (if applicable).
- If more than 2 years from training completion will need documented competency with at least 12 normal deliveries in the last 24 months. In the event that longer time has elapsed, the ability to apply will be at the discretion of the Chair of the Obstetrics Department.

Recredentialing Requirements
To be eligible for reappointment, the applicant must demonstrate current competence and an adequate volume of experience **(provision of care to at least 12 inpatients in the past 24-months)** with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

Name _____

Effective ____ / _____ / _____ to _____ / _____ / _____

❑ I REQUEST OBSTETRICAL CORE PRIVILEGES APPROVED DENIED

_____ _____

Core privileges: Obstetrics

❑ **Requested** Admit, evaluate, diagnose, treat, and provide consultation to adolescent and adult female patients and/ or provide medical and surgical care of the female reproductive system and associated disorders, including major medical diseases that are complicating factors in pregnancy. May provide care to patients in the intensive care setting in conformance with unit policies. Assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedures list and such other procedures that are extensions of the same techniques and skills.

Core procedures list

This is not intended to be an all-encompassing procedures list. It defines the types of activities/procedures/privileges that the majority of practitioners in this specialty perform at this organization and inherent activities/procedures/privileges requiring similar skill sets and techniques.

To the applicant: If you wish to exclude any procedures, please strike through the procedures that you do not wish to request, and then initial and date.

Obstetrics

- Performance of history and physical exam
- Amnioinfusion
- Amniotomy
- Application of internal fetal and uterine monitors
- Augmentation and induction of labor
- Immediate care of the newborn (including resuscitation and intubation)
- Interpretation of fetal monitoring
- Management of high-risk pregnancy*
- Management of patients with or without medical, surgical, or obstetrical complications in labor
- Manual removal of placenta
- Excision of vulvar lesion at time of delivery
- Medication to induce fetal lung maturity
- Spontaneous vaginal delivery

Name _____

Effective _____ / _____ / _____ to _____ / _____ / _____

- Obstetric Ultrasound
- Management of postpartum care
- Repair of 1st, 2nd degree perineal lacerations following vaginal delivery
- Pudendal and paracervical blocks
- Management of medical and surgical complications of pregnancy when not in labor
- Management of postpartum hemorrhage
- Surgical Assist when requested

*Refer to Family Medicine - OBGYN Consultation guidelines

Non-Core Obstetric Privileges

Special Procedures/Techniques:	APPROVED	DENIED
❑Cesarean Section	_____	_____
❑Cesarean Section with concurrent tubal sterilization	_____	_____

Must qualify for Family Medicine obstetric core privileges AND must provide documented evidence of:

Initial Appointment: 50 Cesarean-Sections performed as primary surgeon. Must be proctored on first ten (10) cases by OB/GYN. If requesting tubal sterilization privileges must provide evidence of 10 prior procedures as primary surgeon. 10 Cesarean sections must have been performed in the last 24 months. If concurrent tubal sterilization requested at least 5 procedures in the last 24 months. In the event that longer time has elapsed, the ability to apply will be at the discretion of the Chair of the Obstetrics Department.

Reappointment: 10 Cesarean-Sections in past two (2) years as primary surgeon. If requesting tubal sterilization privileges must demonstrate 5 procedures in prior 2 years as primary surgeon, or at the discretion of the Chair of the Obstetrics Department.

❑ Vaginal birth after cesarean section (VBAC)	_____	_____

Must qualify for Cesarean-Section privileges

❑ Vacuum-assisted delivery	_____	_____

Must provide documented evidence of at least 12 procedures performed at initial appointment. In the event that significant time has elapsed, the ability to apply will be at the discretion of the Chair of the Obstetrics Department. Low volume within the prior 24 months may be considered and competence may be demonstrated through simulation training at the discretion of the Chair of the Obstetrics Department.

Name _____

Effective _____ / _____ / _____ to _____ / _____ / _____

❑ **Third Degree Perineal Laceration Repair**

Must provide evidence of clinical competence; low volume within the prior 24 months may be considered and competence may be established through proctoring at the discretion of the Chair of the Obstetrics Department.

❑Dilation and Curettage (D&C) [<13 weeks by ultrasound or postpartum] _____ _____

Must provide documented evidence of at least 12 procedures performed at initial appointment. Must perform at least 3 procedures in past two (2) years for reappointment. In the event that longer time has elapsed, the ability to apply will be at the discretion of the Chair of the Obstetrics Department.

Proctoring for FP/OB

1. Proctored by OB GYN MD/DO:
    a. 10 cesarean sections (concurrent)
    b. 5 vaginal deliveries
    c. 2 retrospective operative deliveries
    d. 2 retrospective patients undergoing trial of labor after cesarean section
    e. 3 concurrent dilation and curettage
    f. 3 concurrent or retrospective 3rd degree laceration repair

---

Name_____

Effective from_____ to _____

Acknowledgment of Practitioner

I have requested only those specific privileges for which by education, training, current experience and demonstrated competence I am qualified to perform and for which I wish to exercise at Watsonville Community Hospital, and;
I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any 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 the applicable section of the Medical Staff Bylaws governs my actions.

Signed_____ Date_____

Department Chair (or designee) Recommendation

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

Name _____

Effective _____ / _____ / _____ to _____ / _____ / _____

- ☐ Recommend all requested privileges
- ☐ Recommend privileges with the following conditions/modifications
- ☐ Do not recommend the following requested privileges

PRIVILEGE	CONDITION/MODIFICATION
COMMENTS	

_____ _____

OB Department Chair (or designee) Signature Date

******For Medical Staff Office Use Only******

Credentials Committee Action _____
Date

Medical Executive Committee Action _____
Date

Board of Trustees Action _____
Date

Approvals:
FP:
Credentials:
MEC:
BOT:

WATSONVILLE COMMUNITY HOSPITAL

~~ADULT~~ MODERATE / DEEP SEDATION

PRIVILEGE REQUEST FORM

Practitioner Name: _____

INITIAL APPOINTMENT CRITERIA:	1) Documentation of training, experience and current clinical competence related to the use of procedural sedation of at least ten (10) moderate/deep sedation cases within the last two (2) years. **OR** 2) If the applicant is unable to provide documentation of successful performance of at least ten (10) cases within the prior two (2) year period, the applicant will be required to take and successfully pass the Procedural Sedation Test Module. Applicants must achieve a 90% or above passing score on the test module. **AND** **ADULT SEDATION:** Applicants must be ACLS certified. ACLS training shall be obtained from the American Heart Association or other vendor that includes "hands on" training and skills demonstration of airway management and automated external defibrillator (AED) use. Physicians certified by the American Board of Emergency Medicine Physicians (ABEM/AOBEM) are exempt from the ACLS Requirement. **PEDIATRIC SEDATION**: Applicants must be PALS and NRP certified. PALS training shall be obtained from the American Heart Association or other vendor that includes "hands on" training and skills demonstration of airway management and automated external defibrillator (AED) use. Physicians certified by the American Board of Emergency Medicine Physicians (ABEM/AOBEM) are exempt from the PALS and NRP Requirement. **AND** Applicants must read and agree to abide by all requirements as outlined in the Procedural Sedation Policy (#0210). **Deep Sedation Privileges** will be limited to those physicians certified by the American Board of Emergency Medicine Physicians (ABEM/AOBEM) meeting the above requirements.
REAPPOINTMENT CRITERIA:	1) Documentation of training, experience and current clinical competence related to the use of procedural sedation of at least five (5) moderate/deep sedation cases within the last two (2) years. **OR** 2) If the applicant is unable to provide documentation of successful performance of at least five (5) cases within the prior two (2) year period, the applicant will be required to retake and successfully pass the Procedural Sedation Test Module. Reappointment: Cases will be monitored via the OPPE process. Current ACLS certification (adult sedation) and current PALS and NRP (pediatric sedation) is required except for those physicians certified by the American Board of Emergency Medicine Physicians (ABEM/AOBEM).

= TO BE COMPLETED BY APPLICANT =

MODERATE SEDATION REQUEST:

_____**I am requesting Adult Moderate ~~and Deep~~ procedural sedation privileges.**

_____**I am requesting Pediatric Moderate procedural sedation privileges.**

Approved: Surgery: 11.05.20 – Credentials: 11.13.20 - MEC: 11.17.20 - BOT: 11.25.20

DEEP SEDATION REQUEST:

_____**I am ~~NOT~~ requesting Adult ~~Moderate and~~ Deep procedural sedation privileges.**

_____**I am requesting Pediatric Deep procedural sedation privileges.**

~~**If yes, please review Policy and Procedure and complete the qualifying examination.**~~

_____**Please ~~check if~~ include documentation of cases OR completed test as indicated ~~is attached~~.**

Upon request of this privilege and by my signature below, I am attesting that I have read, understand and agree to abide by the provisions of the policy entitled "Procedural Sedation"

_____ _____

Practitioner Signature **Date**

DEPARTMENT CHAIR / SECTION CHIEF APPROVAL

I certify that I have reviewed and evaluated the applicant's request for clinical privileges, verified credentials and other supporting information, and recommend approval of procedural sedation privileges.

_____ **Date** _____

Anesthesia ~~Division~~ Section Chief (or designee)

Reference on Board of Trustees Approval

Medical Staff Bylaws, Article 14.1-5 Approval by Board of Trustees

Bylaws changes adopted by the Medical Staff and Rules and/or policies adopted by the Medical Executive Committee on behalf of the Medical Staff or by the voting Medical Staff members directly, pursuant to the procedures of this Article, shall become effective following approval by the Board of Trustees which approval shall not be withheld unreasonably.

Adopted changes shall be submitted to the Board of Trustees for consideration at its next regularly scheduled meeting.

The Board of Trustees shall take action on such proposed Bylaws, Rules or policy changes within sixty (60) days of receipt of request for such change.

If no action is taken within sixty (60) days, the Bylaws, Rules, or policy change shall be deemed automatically approved except in extraordinary circumstances in which the Board was unable to review the matter and the Chair provides written reasons therefore, in which case an additional thirty days shall be allowed.

For purposes of this section, Board of Trustees action may include approval, rejection, or deferral of action pending receipt of additional information or clarification concerning the proposed changes.

In any event, the Board of Trustees may not defer approval or rejection beyond one hundred twenty (120) days of receipt of the request for change absent a showing that relevant information reasonably requested by the Board has been unreasonably withheld.

If approval is withheld, the reasons for doing so shall be specified by the Board of Trustees in writing, and shall be forwarded to the Chief of Staff, the Medical Executive Committee and, if a proposed change to the Bylaws, the Bylaws Committee.