



Medical Staff Services
1414 Kuhl Ave. – MP 38
Orlando, FL 32806
407.841.5139 phone
407.841.5255 fax

orlandohealth.com

Dear Physician:

Thank you for your interest in Orlando Health (OH). In response to your request, we have enclosed our application packet, which includes the following items:

1. Application for Membership and clinical privileges on the OH Medical Staff: Arnold Palmer Medical Center (including Arnold Palmer Hospital for Children and Winnie Palmer Hospital for Women & Babies), Orlando Regional Medical Center (including Orlando Regional Lucerne), Dr. P. Phillips Hospital, and South Seminole Hospital.
2. Application forms/Attachments to Application as outlined on the application checklist.
3. Clinical Privilege Description(s): **NOTE:** If you are requesting expanded procedures in addition to CORE, please include the requirements for volume documentation as stated in the clinical privilege description. If the volume documentation is not included with your application you may not be granted the requested privileges.
4. Please click on the link below to access the OH Medical Staff Bylaws, Policies & Procedures, Rules & Regulations, Department Rules & Regulations.
<http://www.orlandohealth.com/orlandohealth/ForMedicalProfessionals/MedicalAffairsAdministration.aspx?pid=6129>
5. Instructions for Physician Orientation (HIM & Clinical Systems).
6. Instructions for Online Physician Orientation: **NOTE:** Both Orientation processes must be completed before clinical privileges are granted.

The application process consists of verification of all of your activities since completion of Medical School, as well as all licensures, certifications, affiliations, malpractice history, and obtaining peer references. If we are experiencing difficulty in the verification process or in obtaining references, you will be asked to intervene. Once the application process is complete your application will be referred to the respective Department Chairman for his/her review and recommendation. The Department Chairman may request to meet with you personally to discuss your application. Membership and privilege requests are referred to the OH Board of Directors for approval after recommendation by the Credentials Committee and the Medical Executive Committee.

To ensure a timely appointment process we ask that you carefully review the application packet materials, complete all forms as indicated, and return with all required documents along with a non-refundable \$500 application fee. If you have any questions or need assistance, please write or call Medical Staff Services at 407-841-5139.

Please note the timeframe for the credentialing of your application takes approximately 60-90 days to complete. Once the process is complete your entire application file will be forwarded to the appropriate committees for review and possible approval. A Credentialing Specialist will be in contact with you throughout the process.

Again, thank you for your interest in Orlando Health. We look forward to working with you.

Ameen Baker, Operations Manager
Medical Staff Services

Enclosures



MEDICAL STAFF SERVICES – MP 38

407.841.5139 phone • 407.841.5255 fax
orlandohealth.com

APPLICATION CHECKLIST

Mark those items listed below which you are returning to Medical Staff Services and sign and date this form.

APPLICATION FORMS TO BE COMPLETED AND RETURNED:

- Statement of Application** (Signed and Dated)
- Alternate Contact Phone Numbers Form**
- Medical Staff User Access Code (UAC) Confidentiality Agreement**
- Authorization Notice that a Consumer Report May be Obtained**
- Clinical Privilege Description**
- Medicare Acknowledgement Statement**

ATTACHMENTS TO APPLICATION:

- Current Photograph (2 x 2)**
- Current Curriculum Vitae** (Cannot be submitted in lieu of completing application.)
- Cross Coverage Arrangement** (If Solo Practitioner, attach letter from physician who will provide cross coverage.)
- FL License and all current/former State License(s)** (Include all current & former licenses, including other health related disciplines.)
- W-9 Form** (Current Practice Affiliation) OH Employees do NOT need to submit
- Malpractice Insurance Declaration Sheet** (Current Practice Affiliation) OH Employees do NOT need to submit
- Detailed Explanations For Questions Answered in Affirmative**
- Application Fee of \$500.00**
- Copies of Board Certification, DEA, & EDFMG**

ORIENTATION TO BE COMPLETED:

- HIM & Clinical Systems** (must be completed before membership & clinical privileges may be granted)
- Online Physician Orientation** (must be completed before membership & clinical privileges may be granted)

Applicant's Signature

Date

The Application Form, Attachments to the Application, and Signed Checklist must be mailed to above address.

GENERAL INSTRUCTIONS:

1. Type or print clearly.
2. Attach a recent color photograph (2"x 2") and your non-refundable application fee of \$500.00.
3. Your curriculum vitae cannot be submitted in lieu of completing in full this application form.
4. You must account for all times following completion of medical school.
5. If additional space is needed, attach additional sheets.



APPLICATION NUMBER

PERSONAL IDENTIFYING INFORMATION:

Last Name		First Name		Middle Name	Professional Designation
List all other names under which you have been enrolled, licensed, or known by:					Specialty
Social Security Number	Date of Birth	Place of Birth		Languages Spoken other than English	
Marital Status (Circle One): M, S, W, D		Spouse's Name: First		Last	
Home Street Address (Local):			City, State, Zip Code		Home Phone #:
					Home Fax #:
					Email:

GROUP PRACTICE/*SOLO PRACTICE INFORMATION:

Group Practice Name (if applicable):		Group Practice Associates:		
Solo Practice Name (if applicable):		*If Solo Practice, please complete attached Covering Provider Agreement. Covering provider must be a current medical staff member with like privileges.		
Office Primary Street Address:		City, State, Zip Code		Office Phone#:
				Office Fax #:
				Cell #:
				Beeper #:
Office Mailing Address (if different from above):		City, State, Zip Code		Office Phone #:
				Office Fax #:

BOARD CERTIFICATION: Attach evidence of Board certification or application to take Boards.

1. Are you board certified? YES –please list below NO

SPECIALTY AND SUB SPECIALTY	DATE CERTIFIED	EXPIRY DATE	DATE RECERTIFIED	EXPIRY DATE

2. If not board certified, have you applied for and been approved for admission? YES, list specialty, subspecialty, & expected completion: NO

Board Name:	Exam Dates: Oral:	Written:
Board Name:	Exam Dates: Oral:	Written:

3. Has your board status (on a voluntary or involuntary basis) ever been denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or relinquished for disciplinary reasons? YES – please attach a detailed explanation. NO

4. Have you ever been examined by a specialty board and failed to pass the examination? YES – please attach a detailed explanation. NO

DEA REGISTRATION: Attach all current & former DEA registration(s) to this application.

DEA Registration Number	DEA Issue Date	DEA Expiration Date
Does your DEA registration reflect schedules 2, 2N, 3, 3N, 4 and 5?		
<input type="checkbox"/> YES <input type="checkbox"/> NO – Please attach a separate detailed explanation		

ECFMG/UPIN/W-9 INFORMATION: Please attach copies of ECFMG and W-9

ECFMG Number	National Provider Identifier (NPI) Number	UPIN Number	Employer Identification Number
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MEDICAL LICENSE(S) TO PRACTICE: List all current and former licenses, including other health related disciplines, and attach copies of all licenses. If more than five (5) licenses, supply additional information on separate sheet.

STATE	LICENSE NUMBER	DATE OF ISSUE	EXPIRATION DATE	DATE

If you are currently in the process of obtaining a Florida license, state your expected issue date and method by which your license will be obtained:

Endorsement Examination Expected Issue Date: _____

MALPRACTICE INSURANCE: Attach current malpractice declaration sheet to this application.

1. Do you currently carry medical malpractice insurance? YES NO

Name of Malpractice Insurance Carrier:	Liability Limits:	Expiration Date:
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PROFESSIONAL REFERENCES: List 3 (three) professional references that have direct knowledge of your clinical background and can speak authoritatively regarding your professional qualifications and current clinical competence. Provide current complete addresses, & phone & fax numbers.

DO NOT list individuals who are program directors/department chairs or current partners, practice associates or relatives.

Name:	Complete Street Address:	Phone #:
Email:	City, State, Zip Code:	Fax #:
Name:	Complete Street Address:	Phone #:
Email:	City, State, Zip Code:	Fax #:
Name:	Complete Street Address:	Phone #:
Email:	City, State, Zip Code:	Fax #:

MEDICAL SCHOOL: Attach copy of Medical School Diploma

TYPE	SCHOOL NAME	ADDRESS	DEGREE	DATES ATTENDED	
Medical School		Street Address:		Fr (mo/yr)	To (mo/yr)
		City, State, Zip Code, or Country:			
		Office of the Registrar's Phone/Fax Numbers:			
Other Professional School		Street Address:		Fr (mo/yr)	To (mo/yr)
		City, State, Zip Code or Country:			

INTERNSHIP: If additional internships were started/completed, supply additional information on a separate sheet and attach copy(s) of certificate(s).

Institution #1	Street Address	City, State, Zip Code	Phone #
			Fax #
Dates Attended (month/year): From: _____ To: _____		Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No - Please Explain	Program Director: Internship Training Specialty:

RESIDENCY: If additional residencies were started/completed, supply additional information on a separate sheet and attach copy(s) of certificate(s).

Institution #1	Street Address	City, State, Zip Code	Phone #
			Fax #
Dates Attended (month/year): From: _____ To: _____		Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No - Please Explain	Program Director: Residency Training Specialty:

Institution #2	Street Address	City, State, Zip Code	Phone #
			Fax #
Dates Attended (month/year): From: _____ To: _____		Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No - Please Explain	Program Director: Residency Training Specialty:

FELLOWSHIP: If additional fellowships were started/completed, supply additional information on a separate sheet and attach copy(s) of certificate(s).

Institution #1	Street Address	City, State, Zip Code	Phone #
			Fax #
Dates Attended (month/year): From: _____ To: _____		Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No - Please Explain	Program Director: Fellowship Training Specialty:

PRECEPTORSHIP: If applicable and attach copy(s) of certificate(s).

Institution #1	Street Address	City, State, Zip Code	Phone #
			Fax#
Dates Attended (month/year): From: _____ To: _____		Type of Preceptorship:	Name of Department Chair or Program Director

1. Have you changed your specialty or your training location during your internship, residency, fellowship, or preceptorship? <input type="checkbox"/> YES, attach detailed explanation. <input type="checkbox"/> NO
2. Were you ever disciplined, suspended, placed on probation, formally reprimanded, or asked to resign for the period of your internship, residency, fellowship, or preceptorship? <input type="checkbox"/> YES, attach detailed explanation. <input type="checkbox"/> NO
3. Have you had a leave of absence for thirty (30) or more consecutive days during the period of your internship, residency, fellowship, or preceptorship? <input type="checkbox"/> YES - attach detailed explanation and reason for leave of absence. <input type="checkbox"/> NO

HOSPITAL/HEALTH CARE FACILITY AFFILIATIONS: List all current & previous Hospital/Medical Staff memberships/affiliations in chronological order beginning with most recent. If more than 5 (five) Institutions, attach a separate sheet and include all required information.

<u>Institution Name #1</u>	Complete Street Address	City, State, Zip Code	Phone #
			Fax #
From (MO/DD/YY):	To (MO/DD/YY):	Staff Status:	Department:
If No Longer Affiliated, Give Reason:			
<u>Institution Name #2</u>	Complete Street Address	City, State, Zip Code	Phone #
			Fax #
From (MO/DD/YY):	To (MO/DD/YY):	Staff Status:	Department:
If No Longer Affiliated, Give Reason:			
<u>Institution Name #3</u>	Complete Street Address	City, State, Zip Code	Phone #
			Fax #
From (MO/DD/YY):	To (MO/DD/YY):	Staff Status:	Department:
If No Longer Affiliated, Give Reason:			
<u>Institution Name #4</u>	Complete Street Address	City, State, Zip Code	Phone #
			Fax #
From (MO/DD/YY):	To (MO/DD/YY):	Staff Status:	Department:
If No Longer Affiliated, Give Reason:			
<u>Institution Name #5</u>	Complete Street Address	City, State, Zip Code	Phone #
			Fax #
From (MO/DD/YY):	To (MO/DD/YY):	Staff Status:	Department:
If No Longer Affiliated, Give Reason:			

DEPARTMENT CHAIRMAN/SECTION CHIEF: List most current/recent primary hospital affiliation Department Chairman/Section Chief. If current/prior partner, associate, relative, list Department/Section Vice-Chief or Chief of Staff

Name:	Hospital Name:	Phone #:	Fax #:
Title:	Dept./Section:	Email:	
Complete Address: (Street, City, State, & Zip):			

CLINICAL AND NON-CLINICAL EMPLOYMENT: LIST ALL CURRENT AND PAST MEDICAL PRACTICES Orlando Health requires all time from completion of medical degree to present be accounted for. List, in chronological order, all activities not otherwise accounted for since Medical School (e.g., teaching, military service, relocation, employment in another occupation(s), travel, and unemployment/time gaps, etc.). List contact name, complete address, telephone, and fax numbers of a responsible individual who can verify the activity and dates listed below. Please make additional copies of this page should you need more space.

NAME OF CONTACT AND/OR ORGANIZATION NAME – Please provide complete mailing address and phone & fax numbers

Activity #1:		Contact for Verification:	Relationship to You:	Phone #:
State of Activity:		Street Address:		Fax #:
From (MM/DD/YY):	To (MM/DD/YY):	City, State, Zip Code:		Email:
Activity #2:		Contact for Verification:	Relationship to You:	Phone #:
State of Activity:		Street Address:		Fax #:
From (MM/DD/YY):	To (MM/DD/YY):	City, State, Zip Code:		Email:
Activity #3:		Contact for Verification:	Relationship to You:	Phone #:
State of Activity:		Street Address:		Fax #:
From (MM/DD/YY):	To (MM/DD/YY):	City, State, Zip Code:		Email:
Activity #4:		Contact for Verification:	Relationship to You:	Phone #:
State of Activity:		Street Address:		Fax #:
From (MM/DD/YY):	To (MM/DD/YY):	City, State, Zip Code:		Email:
Activity #5:		Contact for Verification:	Relationship to You:	Phone #:
State of Activity:		Street Address:		Fax #:
From (MM/DD/YY):	To (MM/DD/YY):	City, State, Zip Code:		Email:
Activity #6:		Contact for Verification:	Relationship to You:	Phone #:
State of Activity:		Street Address:		Fax #:
From (MM/DD/YY):	To (MM/DD/YY):	City, State, Zip Code:		Email:

All time must be accounted for since medical school. Contacts listed must be able to verify the activities and dates listed. Failure to account for ALL TIME since medical school will result in your application being considered incomplete and your applications may be returned to you.

GENERAL INFORMATION:

	YES	NO
1. Are you currently capable of performing the privileges you have requested?	<input type="checkbox"/>	<input type="checkbox"/> *
2. Has your application for any professional license ever been denied, or has any of your professional licenses ever been suspended, revoked, limited, or otherwise acted against (whether voluntarily or involuntarily), or have any investigations or disciplinary actions ever been initiated and/or are any now pending against you by any state licensure board?	<input type="checkbox"/> *	<input type="checkbox"/>
3. Have you ever been denied membership or renewal thereof, had your membership revoked or otherwise acted against, or been subject to disciplinary proceedings in any professional organization?	<input type="checkbox"/> *	<input type="checkbox"/>
4. Has your application for a DEA registration number ever been denied, or has your DEA registration number ever been limited, suspended, revoked, voluntarily/involuntarily relinquished, or currently or previously successfully challenged or otherwise disciplined?	<input type="checkbox"/> *	<input type="checkbox"/>
5. Has your application for membership or clinical privileges ever been denied, or have your membership or clinical privileges ever been voluntarily or involuntarily limited, reduced, suspended, revoked, relinquished, or not renewed, by any health care facility (e.g., hospital) or managed care organization (e.g., HMO/PPO)?	<input type="checkbox"/> *	<input type="checkbox"/>
6. Has any liability insurance carrier canceled or refused coverage, or increased your rates because of unusual risk?	<input type="checkbox"/> *	<input type="checkbox"/>
7. Are any actions pending with regard to any of the above items?	<input type="checkbox"/> *	<input type="checkbox"/>
8. Have you ever been named as a defendant in any criminal proceeding or been convicted of a crime (including motor vehicle offenses but not including minor traffic or parking violations)?	<input type="checkbox"/> *	<input type="checkbox"/>

*** Please attach a detailed explanation.**

PROFESSIONAL LIABILITY EXPERIENCE: Answer the following regarding suits in which a judgement or settlement was made against you or a professional corporation of which you are/were a member, shareholder, or employee in any matter in which you were involved in a patient's care.

If the answer to any of the questions is YES please attach a separate sheet with detailed information which must include the following: Patient's name; Date and location (city/state) of incident; Date suit filed; Brief description of allegations; Insurance carrier and name of claims representative; Your attorney's name and address; and Current status of suit; if case is resolved, the details of the settlement.

	YES*	NO
1. Have any professional liability claims or suits ever been filed against you?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have any professional liability claims or suits been filed against you that are presently pending?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have any judgments been made against you in a professional liability case(s) or claim(s), or have you entered into any settlements, or has anyone entered into any settlements on your behalf?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have any claims been resolved prior to suit being filed?	<input type="checkbox"/>	<input type="checkbox"/>

*** Please attach a detailed explanation.**

The information provided is confidential to the fullest extent possible, pursuant to Florida Statute 766.101, and is being requested in order to comply with Florida Statute 766.110 which imposes liability upon hospitals for failure to exercise due care in the selection and review of the credentialing of its medical staff members.

OH AFFILIATION: Which Orlando Health (OH) facility listed below will be your primary hospital (CHECK ONE ONLY)

- Arnold Palmer Medical Center** (Arnold Palmer Hospital and Winnie Palmer Hospital)
 - Orlando Regional Medical Center**
 - Dr. P. Phillips Hospital**
 - South Seminole Hospital**
-

STAFF CATEGORY: Which staff category best describes your intended activity at OH

- Active** (minimum of 12 patient contacts per year)
 - Associate** (less than 12 patient contacts per year)
 - Active Affiliate** (No Clinical Privileges, Do not admit or treat patients in the hospital)
 - Locum Tenens ONLY** (Maximum of 120 Days only)
 - Telemedicine** (Contracted Physicians Only)
-

AFFIRMATION

I represent that the information provided in or attached to this application is current, complete, accurate and true to the best of my knowledge and belief, and is furnished in good faith. I understand that my application will not be processed until application is deemed complete by the healthcare organization. I understand that a condition of this application is that any misrepresentation, misstatement, or omission from this application, whether intentional or not, may result in rejection of this application and/or denial of appointment.

Applicant's Signature: _____

Printed Name: _____

Date Signed _____

STATEMENT OF APPLICATION – Please read carefully before signing

I fully understand that any misstatements in or omission from the “Application for Appointment to the Medical Staff”, which is submitted with this statement, constitute cause for denial of appointment or cause for summary dismissal from the Medical Staff. All information submitted by me in said appointment is true to the best of my knowledge and belief.

In making application for appointment to the Medical Staff of Orlando Health, I acknowledge my obligation to provide continuous care and supervision of my patients, to accept committee assignments and consultation assignments and such other reasonable duties and responsibilities as shall be assigned by the Board of Directors of the Hospital and by the Medical Staff. I acknowledge that I have received and read the bylaws, rules and regulation and policies and procedures of the Medical Staff and of the Hospital and agree to be bound by and comply with the applicable terms and requirements thereof if I am granted staff privileges. I further agree to be bound by the terms thereof without regard to whether or not I am granted staff privileges in all matters relating to the consideration of my application for appointment to the Medical Staff. I agree to practice with in the limitations and scope of privileges granted to me by the Board of Directors.

By applying for appointment to the Medical Staff, I hereby signify my willingness to appear for interviews in regard to my application. I hereby authorize the Hospital, its Medical Staff and their representatives to consult with administrators and members of the medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the hospital, its Medical Staff and its representatives of all documents, including medical records at other hospitals that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges as requested as well as my moral and ethical qualifications for staff membership.

I hereby release from liability and suit all representatives of the Hospital and its Medical Staff for their acts performed with evaluating my application, and I hereby release from liability and suite any and all individuals in connection with evaluating my application, and I hereby release from liability and suit any and all individuals and organizations who provide information to the hospital and its Medical Staff concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges and I hereby consent to the release of such information. Specifically, I hereby agree to the release and immunity from liability provisions as set forth in Medical Staff Policies and Procedures, 1. Appointment to the Medical Staff, A, 4, incorporated herein by reference.

I hereby further authorize the Hospital to communicate to other hospitals and to other persons or organizations with an interest therein any information concerning my professional competence, character and ethics that the Hospital may have to acquire.

I understand and agree that, as an applicant for Medical Staff membership and privileges, I have the burden of documenting my background, experience and demonstrated competence, my adherence to the ethics of the medical profession, my good reputation and character, and my ability to work with others so that, if granted privileges, all patients treated by me in the hospital will receive a high quality of medical care. I WILL SUBMIT A COPY OF MY CURRENT LICENSE (S) WITH MY APPLICATION.

I particularly agree to subject my clinical performance to and faithfully participate in such professional review programs as are from time to time established by the Medical Staff of the Hospital. I agree to hold members of the Medical Staff and other authorized representatives of the Hospital engaged in these activities free of all liability for their actions performed in connection therewith.

Signature

Date

Printed Name (as it appears on application)

ALTERNATE CONTACT PHONE NUMBERS

In an effort to improve physician communication and hospital response in case of emergency situations, the Orlando Health (OH) Medical Executive Committee has agreed that alternate contact phone numbers are **required** for all physicians on staff at OH.

This information will be stored in the medical staff credentialing database and will be used only in situations where physicians are unavailable in the most conventional way, i.e., via office and/or answering service. In addition, only the OH Administrative Supervisors will be given authorization to use these alternate numbers.

Therefore, please provide the Medical Staff Services with alternate contact phone numbers which may be used when all other efforts to contact you have failed. These contact numbers may include your home phone number, cell phone, and pager numbers. Please list these numbers in order of preference in the table provided for you below, and return this information with your application:

Preference	Contact Telephone Number	Indicate Home, Cell, Office, Answering Service, Ect...
1 st Choice		
2 nd Choice		
3 rd Choice		

MEDICARE ACKNOWLEDGEMENT STATEMENT

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 or 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.”

I, _____, the undersigned, acknowledge having received
(Print or type full name)
the above notice.

Legal Signature

Date

(Legal signature means that which you would normally use on documents such as a will, checks, etc. Initials are not acceptable.)

UPIN No. _____

Do not plan using UPIN No. _____
(Check if applicable)

AUTHORIZATION TO OBTAIN/RELEASE CONSUMER REPORT

NOTICE THAT A CONSUMER REPORT MAY BE OBTAINED

This Notice is to inform you that Orlando Health, Inc. may obtain a consumer report from a consumer reporting agency for use in connection with your application for appointment to the medical staff. A consumer report may contain information bearing on your character, general reputation, personal characteristics, and/or mode of living. It may include a criminal background check.

Please read the “Authorization to Obtain/Release Consumer Report” below. This authorizes Orlando Health, Inc. to obtain a consumer report concerning you and authorizes consumer reporting agencies to provide a consumer report to Orlando Health.

Your application for appointment to the Medical Staff of Orlando Health, Inc. will not be considered complete and will not be processed without this signed authorization.

AUTHORIZATION TO OBTAIN/RELEASE CONSUMER REPORT

I have been notified that Orlando Health, Inc. will obtain a consumer report on me for use in connection with my application for appointment to the Medical Staff.

I hereby authorize Orlando Health, Inc. to obtain a consumer report on me.

I hereby authorize and instruct any consumer reporting agency to furnish Orlando Health, Inc. a consumer report concerning me upon request. I agree that a photocopy of this authorization may be accepted with the same authority as the original.

Printed Name (as it appears on the application)

Signature

Date

The following is requested for identification purposes:

Social Security Number _____

Date of Birth: _____

PHYSICIAN ORIENTATION (HIM & CLINICAL SYSTEMS)

Please take a moment to schedule your orientation. Your HIM and Clinical Systems Physician Orientation must be completed before completion of credentialing. To assist you, listed below are contact numbers the hospitals in the Orlando Health. Please bring this form with you at the time of your scheduled orientation.

ORMC
321-843-3167

APMC-APH/ WPH
321-841-1379

SO. SEMINOLE
321-842-5968

DR. P. PHILLIPS
321-842-8212

LUCERNE
321-841-4445

Print your full name: _____

Signature: _____ Specialty: _____

TO BE COMPLETED BY HIM:

<input type="checkbox"/> SOVERA FOR HIM: (How to sign on) (Password) (Review Patient Chart)	<input type="checkbox"/> SUSPENSION PROCESS: (Delinquent Charts) (Suspension Date/Time) (Weekly Notice) (Revocation Process) (Phone call prior to suspension)
<input type="checkbox"/> DICTATION SYSTEM: (How to use Hospital Based System) (Work Types) (Auto Fax)	<input type="checkbox"/> HANDOUTS: (Physician's Guide) (Dictation Card) (Abbreviation List)
<input type="checkbox"/> NATIONAL PATIENT SAFETY GOALS: (Use of Physician 4-Digit ID No.) (Use of Prohibited Abbreviations) (Read Back Procedure)	

Driver's License Copied/Attached: _____

Date: _____

HIM Authorization: _____

Date: _____

TO BE COMPLETED BY CLINICAL SYSTEMS:

SUNRISE XA	PACS
PHYSICIAN PORTAL	

Clinical Systems Authorization: _____

Date: _____

COVERING PHYSICIAN ARRANGEMENT AGREEMENT – For Solo Practitioners ONLY

As a physician in a solo practice, you must provide Medical Staff Services with an agreement from a physician(s), who agrees to provide patient coverage when necessary. That physician(s) must be a member of the Orlando Health staff.

Your application for appointment/reappointment is not complete until the below information has been received by Medical Staff Services.

Applying Physician Information:

As a physician in a **Solo practice**, I agree that the physician(s) listed below will provide patient coverage in my absence, and that the physician(s) listed below is a member(s) of the Orlando Health medical staff.

Name: _____

Primary Office Address: _____

Telephone Number: _____

Fax Number: _____

Covering Provider Information and Agreement:

I agree to provide patient coverage for the above named physician during his/her absence, and I am a member of the Orlando Health medical staff:

Name: _____

Primary Office Address: _____

Telephone Number: _____

Fax Number: _____

Signature & Date: _____



Medical Staff Services – MP 38
1414 Kuhl Ave.
Orlando, FL 32806
407.841.5139
407.841.5255
orlandohealth.com

Dear Medical Staff Applicant:

As a member of our medical staff, we want you to know that we are committed to our Mission Statement and to the delivery of nothing less than the highest quality care. We take pride in being part of a team of healthcare workers and in working together as a team to deliver the highest quality, most cost-effective and evidence-based care with extraordinary skill and compassion. In order to communicate to physicians wishing to join the Orlando Health Medical Staff, we have developed an on-line Physician Orientation which outlines some of the expectations of being a member of the Orlando Health Medical Staff.

Your application will not be considered complete until this process has been completed. During your application process, please set aside some time to complete the Physician Orientation by using the following instructions:

1. Point your browser to the following link: <https://physcomm.orhs.org>
2. Once you are at the orientation course, click continue to begin the login process.
3. In the login box, input your full name in the field labeled “Name:” and type in “applicant” in the field labeled “Member ID”. Then click the “login” button.
4. Navigate through the course using the provided “Continue” buttons. There are approx. 46 slides that you must read and go through. The course can take approx. 45 min. to complete. Please note that the course must be completed in one session.
5. Once you have finished the course, you will be directed to a 10 question quiz.
6. Please read and answer each question using the “A,B,C or D” buttons provided.
7. Once you have completed the quiz, the system will grade your quiz.
8. Depending on the number correct, it will either direct you to a final screen where your status is recorded for course completion verification, or allow you to review the course again and retake the quiz. (An 80% Pass Rate is required)
9. On the final screen, if you would like to provide feedback on this course, there will be a “Feedback” button provided to give you the opportunity to do so.

Once you have completed the on-line Physician Orientation, Medical Staff Services will receive notification that you have met this requirement. They will also make arrangements to have your CME credit forwarded to you.

If you have any questions or do not have access to a computer, please call Medical Staff Services Department at 407 841-5139 and ask for the Department Information Systems Consultant.

Sincerely,

Jamal Hakim, M.D.
Chief of Staff

Last Name:	First:	MI:
Phone Number:	Title:	
Company:	Phone Number:	
Date of Birth:	(Used in resetting passwords)	

As a non-employee performing services for Orlando Health, you may have access to confidential information including patient, financial or business information obtained through your association with Orlando Health. The purpose of this agreement is to help you understand your personal obligation regarding confidential information. **Signed acknowledgement of this form is required prior to issuance of computer network or application credentials (user ID and password) and prior to commencement of any services for Orlando Health.**

Confidential information is valuable and sensitive and is protected by law and by strict Orlando Health policies. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires protection of confidential patient information contained within a healthcare information system. Inappropriate disclosure of patient data may result in the imposition of fines up to \$250,000 and 10 years imprisonment per incident. Information made available through the Orlando Health computer network, the internet or by any other means is not to be discussed, replicated, or disseminated in any manner to anyone who is not officially and directly given access to this data. In addition to patient data this includes but is not limited to: financial information, business information (such as contracts, business strategies and plans, etc.), personnel information and other information of a sensitive or confidential nature.

Accordingly, as a condition of my access to confidential information, I acknowledge and agree that:

1. I will not access confidential information for which I am not an authorized user and for which I do not have a legitimate "need to know", whether on the computer system, in files, or in any other location. This includes accessing my own, my family members', my friends' and my co-workers' medical or other confidential information without proper access permission.
2. I will not in any way divulge, copy, disclose, sell, loan, review, alter or destroy any confidential information unless expressly permitted by existing policy or except as properly approved in writing by an authorized individual within the scope of my duties at Orlando Health.
3. I will not utilize another user's password in order to access any system nor will I reveal my computer user access code to anyone for any reason. I understand that I am personally responsible for all transactions and information entered into the computer under my assigned user access code.
4. If I observe or become aware of any unauthorized disclosure of confidential information, I will report it immediately to my Orlando Health supervisor or contact person.
5. If I observe or become aware of a security breach (any incident in which there occurs an attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system), I will contact my Orlando Health supervisor or contact person, or the Orlando Health Information Services Help Desk at 321.841.7378.
6. I will not seek personal benefit or permit others to benefit personally from any confidential information to which I may have access.
7. I understand that all information medium is the property of Orlando Health and it shall not be used inappropriately or for personal gain regardless of:
 - a. The medium on which it is stored (i.e., paper, computer, videos, recorders).
 - b. The system which processes it (i.e., computers, voicemail, telephone systems, facsimiles).
 - c. The methods by which it is moved (i.e., electronic mail, over the internet, face to face conversation, facsimiles).
 I also understand that Orlando Health reserves the right to inspect or monitor any company owned, leased or controlled computer, computer device, network, computer facility, storage device, voicemail or telephone system at any time for any reason and that Orlando Health may divulge any information found during such inspections or monitoring to any party it deems appropriate. I understand that I should not consider electronic communications (including the internet, email, telephone, voice mail, facsimile, interactive pager, etc.) to be either private or secure, nor have an expectation of privacy in anything I create, store, send or receive on the computer and the network or any other electronic communications medium.
8. I will not use patient names within the body of an email; I will use names only in an attachment to the email.
9. I understand that if I am transferred to another department, my user access code may not necessarily be appropriate for the new area and may be changed or deleted.
10. I understand that if my association with Orlando Health terminates for any reason; my user access code will be deleted immediately.
11. I agree to abide by all Orlando Health rules and regulations as specified unless altered by a separate contractual agreement.
12. I understand that my failure to comply with this agreement may result in action against me personally and/or against the business or individual with which Orlando Health contracts for my services, which action may include but is not limited to my being removed from performing services for Orlando Health, as well as potential civil or criminal penalties.

Signature _____ Date _____

Signature and Department at Orlando Health Sponsoring Representative _____

Request for Taxpayer Identification Number and Certification

**Give form to the
requester. Do not
send to the IRS.**

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
	List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number
or
Employer identification number

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,