DISASTER/EMERGENCY PRIVILEGE CREDENTIALS APPLICATION

Navajo Area Office Indian Health Services

Application Use For All Navajo Area Service Units

DEMOGRAPHIC INFORMATION

(last name) (first name) (middle name) (degree)

(other name used/maiden name) (primary/sub-specialty) (npi number)

(date of birth) (social security number) (cell phone) (email address)

SPECIALTY IN WHICH EMERGENCY/DISASTER PRIVILEGES ARE DESIRED

_____ Medical Officer/Mid-Level Provider Specify Specialty: _____

_____ Allied Health Professionals Specify Specialty: _____

_____ Nursing Specify Specialty: ☐ RN ☐ Public Health Nurse ☐ Clinical Nurse Specialist ☐ Other:

_____ EMT Specify Rank ☐ EMT ☐ EMT – Advanced ☐ EMR ☐ Paramedics ☐ Other

_____ Respiratory Therapist Specify: ☐ RRT ☐ CRT ☐ Other

_____ Other Specify: _____

PRIMARY HOME / OFFICE ADDRESS

(home address) (city, state, zip) (home and non-work phone)

(work address) (city, state, zip) (work phone)

PRIMARY HOSPITAL AFFILIATION ADDRESS

(name of organization, hospital, office practice) (address, city, state, zip) (work phone)

From To (position)

STAFF MEMBER REFERENCE Name of current hospital or medical staff member(s) who possesses personal knowledge regarding ability to act as a licenses independent practitioner during a disaster

(Name with degree) (cell phone) (email address)

(relationship) (affiliation)

PROFESSIONAL LIABILITY INSURANCE CARRIER(S)

From: To:

(name of carrier) (policy number) (dates of coverage)

SPECIALTY BOARD STATUS List specialty board for which you are certified.

(name of board) (specialty name) (cert date) (last date cert) (expiration date)

(name of board) (specialty name) (cert date) (last date cert) (expiration date)

LICENSES List all professional current licenses. Please attach copies of all current licenses. (Medical Licenses, DEA, BLS, ACLS, PALS, ATLS)

License (state) (license number) (active or inactive) (issue date) (expiration date)

DEA (state) (license number) (active or inactive) (issue date) (expiration date)

OTHER CERTIFICATIONS: BLS (expires) ACLS (expires) PALS (expires) ATLS (expires)

RELEASE OF INFORMATION CONSENT/ATTESTATION

I understand and acknowledge that:

- Privileges are being granted only for the duration of the present emergency and shall terminate automatically when the state of emergency ends;
- Privileges shall be terminated immediately if I have misrepresented or withheld any information required by this application;
- Privileges may be denied or terminated at any time at the discretion of the person who has direct oversight;
- Denial or termination of disaster/emergency privileges, regardless of the circumstances, shall not give rise to the right for a hearing, review or appeal under the respective hospital medical staff bylaws or any other standard, regulation or law, and
- I am offering my services to the community on a completely voluntary basis and I am doing so without any expectation or promise of compensation or benefits including workers compensation or professional liability insurance coverage from all Navajo Area Office Indian Health Services, all Navajo Area Service Units or any affiliated organization in exchange for this service.

In the event of an emergency, please contact the following person: _____

List the address and phone number of your emergency contact: _____

I agree to defend, indemnify and hold harmless Navajo Area Office Indian Health Services, all Navajo Area Service Units and its affiliated hospitals and clinics for all acts and omissions. I understand that I shall not be granted the general privileges accorded to attending medical staff, but will adhere to the standards of patient care of the Hospital/Clinic and Medical/Dental Staff. I certify that I have not had a professional license that has been revoked or suspended in any State or possession of the United States.

_____ _____

Signature of Volunteer Date

****TO BE COMPLETED BY SITE CREDENTIALING OFFICE****

==========VERIFICATIONS==========

1	**Registered Nurse** – Valid State License	Verification Date:	☐ Copy Attached	Initial:
	Certification/License Number:		State:	Expiration Date:
	☐ Registered Nurse (RN) ☐ Clinical Nurse Specialist (CNS) ☐ Public Health Nurse (PHN) ☐ Other:			
2	**EMS** – Valid State Certification	Verification Date:	☐ Copy Attached	Initial:
	Certification/License Number:		State:	Expiration Date:
	☐ EMT ☐ EMT – Advanced ☐ Paramedic ☐ EMR Other:			
3	**Respiratory Therapist** – Valid State Certification	Verification Date:	☐ Copy Attached	Initial:
	Certification/License Number:		State:	Expiration Date:
	☐ RRT ☐ CRT Other:			
4	**Other Licenses** – Specify Type of License	Verification Date:	☐ Copy Attached	Initial:
	Certification/License Number:		State:	Expiration Date:
	Certification/License Number:		State:	Expiration Date:
5	**Employee Health - Immunizations**		☐ Copy Attached	Initial:
	☐ Hepatitis B Vaccine Series (3 injections), or ☐ Hepatitis B Signed Declination Statement		Date Series completed or date of Signed Declination Statement	
	Immunization Records On File At (be specific)			
	Verifier Signature	Title		Date:
6	**BLS/AED Certification**		☐ Copy Attached	Initial:
	☐ Cardiopulmonary Resuscitation (CPR) and/or ☐ Automated External Defibrillator (AED) capabilities		Expiration Date (CPR)	Expiration Date (AED)
7	**State Issued ID** (submit two: Driver License (required) and Passport, SSN card, etc.)		☐ Copy Attached	Initial:
	1st ID: Valid State Driver's License (DL number):		State:	Expiration Date:
	2nd ID: ID Type (ID Number):		State:	Expiration Date:

	Medical Officer and Mid-Level Verifications			
1	**Hospital Affiliation** – PSV Phone Verification			Initial/Date:
	Name/Title:	Department:	Phone Number:	
	Status:	Comments:		
2	**Medical Staff Competency/Reference** – PSV Phone Verification			Initial/Date:
	Name/Title:	Department:	Phone Number:	
	Comments:			
3	**Physician and Mid-Level License**	Verification Date:	☐ Copy Attached	Initial:
	Certification/License Number:		State:	Expiration Date:
	State Board Actions/Discipline:			
4	**Board Certification**	Verification Date:	☐ Copy Attached	Initial:
	Board / Certification Number:			Expiration Date:
	Board Actions/Discipline:			
5	**DEA**	Verification Date:	☐ Copy Attached	Initial:
	DEA Number/Schedule:		State:	Expiration Date:
6	**NPDB Query**	Query Date:		Initial:
	Results:			
7	**OIG Query**	Query Date:		Initial:
	Results:			

========== APPROVAL PROCESS FOR DISASTER CREDENTIALING==========

*****FOR OFFICIAL USE OF INCIDENT COMMAND SERVICES ONLY*****

Volunteer has been cleared by Incident Command Credentialing. Completed application along with copies of license(s), certification(s), and ID's have been submitted. All verifications are current and in good standings based on primary source verifications. All facility required trainings have been completed.

Print Name/Title:_____ Signature:_____ Date:_____

APPROVAL PROCESS FOR NON-MEDICAL & MID-LEVEL VOLUNTEERS

Application Status ☐ Approved ☐ Denied ☐ Pending

ICS Approving Signature: _____

Primary Approved Position: _____

Dates of Approval: _____

Notes: _____

APPROVAL PROCESS FOR MEDICAL & MID-LEVEL VOLUNTEERS

Clinical Director and/or Chief of Staff:_____ _____
Signature & Title Date

CEO or Designee:_____ _____
Signature & Title Date

Practitioner to be supervised by:_____ Department:_____

Date/Time Granted:_____ Date/Time Terminated:_____