Physician Associated Health Professional

APPLICATION PACKET

PHYSICIAN ASSOCIATED HEALTH PROFESSIONALS (PAHP)
APPLICATION INSTRUCTIONS & CHECKLIST

The Physician Associated Health Professional (PAHP) category (formerly termed Affiliate Health Professionals) includes the following disciplines: Registered Nurses, Licensed Vocational Nurses, Surgical Technicians, Medical Assistants, Dental Assistants, and Certified Nurse Assistants.

Thank you for your interest in joining the Physician Associated Health Professional staff. This packet includes an application and related documents. Please review the materials thoroughly and provide complete information as requested.

Please return completed application to CovenantHR@stjoe.org

I. This checklist will assist you in including all required documentation with your application.

- ☐ **APPLICATION FORM completed, signed, and dated by applicant *and* supervising physician(s)**. It is the responsibility of the applicant to obtain the signature(s) of the supervising physician(s) *prior* to submitting the completed application to Medical Staff Services. **(enclosed)**
- ☐ **COMPETENCY EVALUATION FORM** (position-based) **completed, signed, and dated by applicant and supervising physician. (enclosed)**
- ☐ **"*Guidelines for all Physician Associated Health Professionals*"**- Signed and dated **(enclosed)**
- ☐ **BACKGROUND CHECK AUTHORIZATION FORM completed, signed, and dated (enclosed)**
- ☐ **PAHP IMMUNIZATIONS / HEALTH ATTESTATION completed, signed, and dated (enclosed)**
  - ☐ Current Immunization Record: MMR (Measles, Mumps & Rubella) and Varicella **(Blood titer results are required for both if no records are available)**
  - ☐ One (1) TB tests within the last 12 months **or** Positive Reactor Form if previously tested positive **(provided upon request)**
  - ☐ Documentation of Hepatitis B and Tdap vaccinations (or signed declination forms **(provided upon request)**
  - ☐ Proof of current flu vaccine or signed declination form **(provided upon request)**

Please Note: Covenant Employee Health does not provide any immunizations or services for non-hospital employees.

- ☐ **ONLINE EDUCATION ATTESTATION FORM - Complete training included in packet as well as at *http://bit.ly/2ouGvDU* and sign and submit attestation with this application.**
- ☐ **ADDITIONAL DOCUMENTS completed, signed, and dated (enclosed)**
  - ☐ Proof of current Texas licensure for verification (if applicable)
  - ☐ Proof of current certification (if applicable)
  - ☐ **Proof of current liability insurance coverage**: the physician's insurance policy face sheet *must* list the applicant's name **OR** the applicant must provide proof of his/her own liability coverage.
  - ☐ Notarized copy of your Texas or New Mexico driver's license
  - ☐ Proof of current CPR certification (BLS, ACLS, or PALS)

- ☐ **APPLICATION FEE** of $50.00 (Check or money order made out to Covenant Health and delivered to Human Resources Department) **The application will not be considered complete unless the fee is paid.**

PHYSICIAN ASSOCIATED HEALTH PROFESSIONALS (PAHP) APPLICATION FORM

PERSONAL INFORMATION

Full Name (Printed):

_____
First Middle Last Maiden/Other Name

Title/Credentials: _____ **Date of Birth:** _____

_____-_____-_____ (____)_____ (____)_____ _____
Social Security # Home Phone Cell phone E-mail address

_____
Home Street Address City State Zip

_____
Post Office Box (if applicable) City State Zip

Employed by: _____ _____
(Print) Physician Name Partnership/Group Name

INSURANCE INFORMATION

Professional liability insurance is required and must be current at all times.

_____
Liability Insurance Carrier Name Policy Expiration Date

*Please furnish the face sheet from your policy **or** your physician's policy **that lists your name** as an insured.

EDUCATION (attach additional sheet, if needed)

High School Graduate: Yes☐ No☐ High School Equivalency: Yes☐ No☐

Technical / Professional School:_____ Dates attended: _____

_____ _____ _____ (___)_____ (___)_____
Address City State Phone Fax

Degree received: Yes☐ No☐ Degree/Certification Type: _____

College/University:_____ Dates attended: _____

_____ _____ _____ (___)_____ (___)_____
Address City State Phone Fax

Degree received: Yes☐ No☐ Degree/Certification Type: _____

CHRONOLOGICAL REPORT OF PROFESSIONAL EMPLOMENT (attach additional sheet, if needed)

Current Employer:_____Dates of Employment:_____
Address:_____
Name of Immediate Supervisor:_____Phone#:_____Fax#:_____

Previous Employer:_____Dates of Employment:_____
Address:_____
Name of Immediate Supervisor:_____Phone#:_____Fax#:_____

Previous Employer:_____Dates of Employment:_____
Address:_____
Name of Immediate Supervisor:_____Phone#:_____Fax#:_____

LICENSES AND CERTIFCATIONS (Please attach a current copy)

Type: _____ _____ _____
License Certificate No. Issue Date & Expiration Date

Type: _____ _____ _____
License Certificate No. Issue Date & Expiration Date

QUESTIONS

1. Has your license to practice in any state ever been denied, limited, suspended, revoked or have you voluntarily or involuntarily relinquished such? Yes ☐ No☐

2. Have any disciplinary actions been initiated or are any currently pending against you by any state licensing board? Yes ☐ No ☐

PHYSICIAN SUPERVISORS:

Applicant: Please provide the requested information for each of your supervising physicians.
Supervising physician(s): Please review the supervisory responsibilities as described, and **sign and date** in acknowledgement.

As the physician supervisor, I have evaluated this applicant and am knowledgeable of his/her physical and emotional health, clinical competence, and professionalism. I understand that I am completely responsible for all actions/procedures of said employee while at a Covenant Health facility. I understand that this individual may only practice as a Physician Associated Health Professional at the Covenant facilities for which I am credentialed. To the best of my knowledge, the information provided in this application is accurate and complete. I recommend this applicant as a Physician Associated Health Professional at Covenant Health. **I further agree that should this applicant leave my employment or should I no longer be his/her supervisor I will immediately so advice the Medical Staff Services Department**.

Name:_____
Practice Address:_____
Phone:_____ Fax:_____

_____
Physician Supervisor Signature **Date**

Name:_____
Practice Address:_____
Phone:_____ Fax:_____

_____
Physician Supervisor Signature **Date**

Name:_____
Practice Address:_____
Phone:_____ Fax:_____

_____
Physician Supervisor Signature **Date**

PHYSICIAN ASSOCIATED HEALTH PROFESSIONAL
CONSENT TO RELEASE STATEMENT AND CONFIDENTIALITY STATEMENT

PLEASE READ EACH STATEMENT CAREFULLY BEFORE SIGNING

Standard Authorization, Attestation and Release (Not for Use for Employment Purposes)
I understand and agree that, as part of the credentialing application process for participation as a member of the Covenant Health Physician Associated Health Professional staff, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, certification, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by Covenant Health for determining initial and ongoing eligibility for participation. I understand that any false information or omission may disqualify me from further consideration for membership to the CH Physician Associated Health Professional staff. Covenant Health, its representatives, employees, and agents(s) acknowledge that he information obtained relating to the application process will be held confidential to the extent permitted by law.

Authorization of Investigation Concerning Application for Participation: I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation: I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Release from Liability: I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities.

In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide consent may be grounds for termination/participation in accordance with the applicable bylaws, rules, and regulations, and requirements of CH. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s).

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Consent to Background Check: I understand that part of the credentialing process requires CH to conduct a criminal background check for the purpose of determining my eligibility for affiliation or continued affiliation. Therefore, I consent to a background check. I also consent to additional background checks when applicable. I understand that if the background check reveals adverse information, I will not be eligible for Physician Associated Health Professional staff membership at Covenant Health.

Privacy: I understand and agree that in the performance of my duties at either/or Covenant Medical Center/ Covenant Children's Hospital I may become aware of information that could be considered confidential. It is my responsibility to protect the privacy of patients, employees and the hospital. I understand that my failure to comply may result in termination of my membership to the Physician Associated Health Professional staff.

Change of Employer: I will notify Covenant Medical Staff Services immediately upon leaving the employment of the supervising physician noted in this application.

Covenant Name Badge responsibility: I will abide by the Covenant Health policy regarding proper identification and will have the CH name badge visible while at CH facilities. **I understand that immediately upon leaving the employment of the supervising physician noted herein, I will notify CH-Medical Staff Services and return my CH badge to this employer or to Covenant Medical Staff Services.**

By my signature below, I acknowledge that have read, understand, and consent to the above statements.

_____ _____

Applicant's Signature Date

_____

Printed Name of Applicant

Physician Associated Health Professional

COMPETENCY EVALUATION FORMS (By Position)

CovenantHealth

Physician Associated Health Professionals (PAHP)

COMPETENCY EVALUATION FORM

DENTAL ASSISTANT

PAHP Staff Member Name: _____

The addressed employee is competent to perform the following duties and responsibilities:
**If the Dental Assistant will not be performing one of the essential functions, please mark N/A. If he or she will be performing additional responsibilities, please write in the blank spaces below. Please attach an additional sheet, if necessary.

Essential Function	Yes	No	N/A
Taking Dental Radiographs	◯	◯	◯
Taking Dental Intraoral Photographs	◯	◯	◯
Follows procedures and protocol while passing instruments during dental procedures	◯	◯	◯
Assures implementation of infection control, properly disposes of hazardous wastes and sharp materials.	◯	◯	◯
Assists Dentist in charting of completed procedure in appropriate charts.	◯	◯	◯
Assists Scrub technician with turnover of the room between cases.	◯	◯	◯
Maintains established standards of neatness and cleanliness in all patient care environments	◯	◯	◯
Monitors and maintains supplies and supply inventory as needed for the delivery of patient care.	◯	◯	◯
Responsible for obtaining and updating basic patient information, including any required documentation of financial eligibility, as requested.	◯	◯	◯
Assists with clerical duties related to patient care, as needed.	◯	◯	◯
Maintains a professional demeanor with dental professional staff members, patients, and administrative staff.	◯	◯	◯
Utilizes courteous and age-appropriate language in dealing with patients, family members and staff members in person or on the phone.	◯	◯	◯
Additional Responsibility:	◯	◯	◯
Additional Responsibility:	◯	◯	◯
Additional Responsibility:	◯	◯	◯

Verification of Competency Evaluation (to be completed by Supervising Physician):

Physician Supervisor Signature Date

Physician Associated Health Professional Signature Date

CovenantHealth

Physician Associated Health Professionals (PAHP)

COMPETENCY EVALUATION FORM

LICENSED VOCATIONAL NURSE (LVN)

PAHP Staff Member Name: _____

The addressed employee is competent to perform the following duties and responsibilities:
**If the LVN will not be performing one of the essential functions, please mark N/A. If he or she will be performing additional responsibilities, please write in the blank spaces below. Please attach an additional sheet, if necessary.

Essential Function	Yes	No	N/A
Performs duties under the direction of the supervising physician.	○	○	○
Demonstrates the ability to transfer scientific knowledge from social, biological, and physical sciences in applying the nursing process.	○	○	○
Demonstrates knowledge and competency in performing baseline nursing skills. Maintains clinical competencies according to required standards.	○	○	○
Identifies information necessary to plan and administer care.	○	○	○
Identifies and determines priority of patient's needs/problems, anticipates emergencies, complications of pathology, and assists others in implementing complex care.	○	○	○
Administers medications and treatments according to policy and procedure, accepted standards of care, and guidelines.	○	○	○
Communicates effectively with the clinical team, patients, families, and physicians. Documents patient status, patient needs/problems, nursing intervention/patient response, safety interventions, and education/teaching.	○	○	○
Assists in the development of a plan of care that includes discharge planning, realistic and measurable goals, and appropriate nursing interventions to produce desired outcomes with the patient.	○	○	○
Maintains a safe working environment by adhering to JCAHO and other regulatory requirements. Reports untoward incidents per policy.	○	○	○
Maintains a committed and cooperative attitude with staff, promoting teamwork and harmony within the clinical team.	○	○	○
Additional Responsibility:	○	○	○
Additional Responsibility:	○	○	○
Additional Responsibility:	○	○	○

Verification of Competency Evaluation (to be completed by Supervising Physician):

Physician Supervisor Signature Date

Physician Associated Health Professional Signature Date

CovenantHealth

Physician Associated Health Professionals (PAHP)
COMPETENCY EVALUATION FORM
MEDICAL ASSISTANT

PAHP Staff Member Name: _____

The addressed employee is competent to perform the following duties and responsibilities:
**If the Medical Assistant will not be performing one of the essential functions, please mark N/A. If he or she will be performing additional responsibilities, please write in the blank spaces below. Please attach an additional sheet, if necessary.

Essential Function	Yes	No	N/A
Responsible to supervising physician and working under his/her direction performing only those functions specifically stated in a manner consistent with his/her training.	○	○	○
Greets patients during physician's examination.	○	○	○
Communicates effectively with nursing staff, patients, and families.	○	○	○
Must be accompanied by supervising physician on hospital rounds at all times.	○	○	○
May scribe/write legibly in physician progress notes for supervising physician as long as physician is present and dictating what should be written (scribed). Physician must verify and sign scribed entry immediately.	○	○	○
Maintains professionalism and courteousness in all hospital staff interactions and observes the Standards of Behavior and Conduct.	○	○	○
Additional Responsibility:	○	○	○
Additional Responsibility:	○	○	○
Additional Responsibility:	○	○	○

Verification of Competency Evaluation (to be completed by Supervising Physician):

Physician Supervisor Signature Date

Physician Associated Health Professional Signature Date

CovenantHealth

Physician Associated Health Professionals (PAHP)
COMPETENCY EVALUATION FORM
NURSING ASSISTANT

PAHP Staff Member Name: _____

The addressed employee is competent to perform the following duties and responsibilities:
**If the Nursing Assistant will not be performing one of the essential functions, please mark N/A. If he or she will be performing additional responsibilities, please write in the blank spaces below. Please attach an additional sheet, if necessary.

Essential Function	Yes	No	N/A
Demonstrates knowledge, judgment, and observational abilities needed to meet patient care needs under the direction of their supervising physician employer.	○	○	○
Provides patient care related to personal care/hygiene, ambulation, and comfort.	○	○	○
Assists in preparing patients for meals, delivery of meals, feeding of patients when necessary, and providing fresh water.	○	○	○
Accurately performs and reports vital signs.	○	○	○
Assists in maintaining a clean environment for patients.	○	○	○
Accountable for reporting untoward incidents.	○	○	○
Accurately and efficiently reports data.	○	○	○
Maintains a committed and cooperative attitude with other members of the health care team.	○	○	○
Additional Responsibility:	○	○	○
Additional Responsibility:	○	○	○
Additional Responsibility:	○	○	○

Verification of Competency Evaluation (to be completed by Supervising Physician):

Physician Supervisor Signature Date

Physician Associated Health Professional Signature Date

CovenantHealth

Physician Associated Health Professionals (PAHP)
COMPETENCY EVALUATION FORM
REGISTERED NURSE (RN)

PAHP Staff Member Name: _____

The addressed employee is competent to perform the following duties and responsibilities:
**If the RN will not be performing one of the essential functions, please mark N/A. If he or she will be performing additional responsibilities, please write in the blank spaces below. Please attach an additional sheet, if necessary.

Essential Function	Yes	No	N/A
Directly responsible to the supervising physician under whose direction he/she works.	○	○	○
Provides direct nursing care in selected situations for the purposes of patient and family education.	○	○	○
Scribe/write legibly in physician progress notes for supervising physician as long as the physician is present and dictating what is to be written (scribed). The supervising physician must verify and sign the scribe entry immediately.	○	○	○
May not independently diagnose and prescribe.	○	○	○
At all times, must be accompanied by the supervising physician.	○	○	○
Adheres to state laws concerning licensed registered nurses.	○	○	○
Communicates effectively with the nursing staff, patients, and families.	○	○	○
Utilizes the nursing process in patient assessment, planning patient care, initiating nursing interventions, and evaluating response to nursing care.	○	○	○
Provides a safe environment specific to age and development of the patient.	○	○	○
Maintains professionalism and courtesy in all hospital staff interactions and observes the hospital Standards of Behavior and Conduct.	○	○	○
Additional Responsibility:	○	○	○
Additional Responsibility:	○	○	○
Additional Responsibility:	○	○	○

Verification of Competency Evaluation (to be completed by Supervising Physician):

Physician Supervisor Signature Date

Physician Associated Health Professional Signature Date

CovenantHealth

Physician Associated Health Professionals (PAHP)
COMPETENCY EVALUATION FORM
SURGICAL TECHNICIAN

PAHP Staff Member Name: _____

The addressed employee is competent to perform the following duties and responsibilities:
**If the Surgical Technician will not be performing one of the essential functions, please mark N/A. If he or she will be performing additional responsibilities, please write in the blank spaces below. Please attach an additional sheet, if necessary.

Essential Function	Yes	No	N/A
Scrubs hands and arms; dons sterile operating room attire; organizes the sterile field; passes instruments, suture, and other sterile items to surgeon, anticipating the need. Holds retractors and cuts suture.	○	○	○
Selects supplies and equipment for case cart based on surgeon's preference card; organizes supplies, equipment, and instruments in operating room.	○	○	○
Checks, adjusts, and operates equipment such as sterilizers, lights, suction, electrosurgical units, and diagnostic equipment.	○	○	○
Helps prepare and care for specimens identified for laboratory analysis; applies dressings as directed.	○	○	○
Identifies, prepares, and labels medications given to the sterile field.	○	○	○
Additional Responsibility:	○	○	○
Additional Responsibility:	○	○	○
Additional Responsibility:	○	○	○

Verification of Competency Evaluation (to be completed by Supervising Physician):

Physician Supervisor Signature Date

Physician Associated Health Professional Signature Date

GUIDELINES FOR ALL PHYSICIAN ASSOCIATED HEALTH PROFESSIONALS

COVENANT HEALTH SYSTEM

1. Covenant Health System will not maintain liability Insurance for any actions/procedures performed by a Physician Associated Health Professional member because Covenant Health System does not retain the right to control the actions of the PAHP staff.
2. Privileges will terminate with either cessation of employment by the physician listed on the Physician Associated Health Professional Application or the loss of staff privileges by the physician. If the PAHP should leave the supervising physician's employment, Medical Staff Services will be notified immediately by the physician.
3. PAHP staff must wear Covenant Health System photograph identification badge while on hospital premises.
4. The physician's employee, while working on the premises of Covenant Health System, will conform to the hospital dress code currently in force for hospital employees.
5. Abide by all Covenant Health policies and procedures, as they relate to surgery technologists and nursing staff.

GUIDELINES FOR PHYSICIAN ASSOCIATED HEALTH PROFESSIONALS IN NURSING UNITS

1. The Physician Associated Health Professionals will be able to perform only actions/procedures authorized by the physician employer and approved by the hospital, as defined in this application.
2. Authorized actions/procedures are subject to the Covenant Health Rules and Regulations of Covenant Administration, Medical Staff Office Policies and Procedures, and applicable state statutes.
3. Performance of all actions/procedures will be completed in accordance with the policies/procedures of Nursing Service and applicable state statutes.
4. A physician's order will be on the chart prior to the performance of any procedures by a PAHP (physician's employee).
5. Documentation will be made in the nurse's notes portion of the patient's medical record by the PAHP after completion of all procedures.
6. A PAHP will not be authorized to give or transmit orders to hospital nursing employees.

GUIDELINES FOR PHYSICIAN ASSOCIATED HEALTH PROFESSIONALS IN SURGERY

1. The Physician Associated Health Professional is under the direct supervision of his/her employer who must accept the legal responsibility for all operating room activities of the employee.
2. PAHP shall be able to perform such delegable functions as designated by the physician employer under her/her supervision, as long as the performance of these functions does not constitute any violation of the Medical Rules and Regulations or applicable state statues. If, in the opinion of the Director of Surgery, the physician employee is not competent or violates standard operating room procedures, the Director of Surgery, with the concurrence of the Section Chief, shall have the responsibility of denying entrance of the employee to the operating room pending resolution of the assessment of the employee's competence.
3. Complaints concerning the propriety of acts by a private staff physician's employee shall be made in writing to the Section Chief or section in which the staff physician practices. The Section Chief will investigate these complaints and report directly to the Chief of Staff.
4. In instances where the surgeon has privately owned instruments, these instruments will be the responsibility of the private physician's surgical employee to set up cleaning and storage of privately owned surgical instrumentation.
5. The physician's employee, while in Surgery, will not be delegated tasks, which require the exercise of medical judgment.

ALL APPLICANTS:
I have read and agree to abide by the Guidelines for Physician Associated Health Professionals at Covenant Health System To the best of my knowledge, the above information I have supplied is accurate and complete.

_____ _____

Signature and Title of Applicant Date

BACKGROUND CHECK RELEASE AUTHORIZATION AND FAIR CREDIT REPORTING ACT DISCLOSURE [FOR EMPLOYMENT PURPOSES]

The applicant for employment acknowledges that this company may now, or at any time while employed, verify information within the application, resume or contract for employment. In the event that information from the report is utilized in whole or in part in making an *adverse decision*, before making the adverse decision, we will provide to you a copy of the consumer report and a description in writing of your rights under the Fair Credit Reporting Act,15 U.S.C. § 1681 *et seq.*

Please be advised that we may also obtain an *investigative consumer report* including information as to your character, general reputation, personal characteristics, and mode of living. This information may be obtained by contacting your present and previous employers or references supplied by you. Please be advised that you have the right to request, in writing, within a reasonable time, that we make a complete and accurate disclosure of the nature and scope of the investigation requested.

Additional information concerning the Fair Credit Reporting Act, 15 U.S.C. § 1681 *et seq*., is available at the Federal Trade Commission's web site (~~http://www.ftc.gov~~). For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

By signing below, I hereby authorize all entities having information about me, including present and former employers, personal references, criminal justice agencies, departments of motor vehicles, schools, licensing agencies, and credit reporting agencies, to release such information to the company or any of its affiliates or carriers. I acknowledge and agree that this Release and Authorization shall remain valid and in effect during the term of my contract.

****California Applicants who will require credit report review:** Please be advised that your credit will be reviewed for as part of this application process. Specifically, the basis for review pursuant to California law (Section 1024.5(a) of the Labor Code) is: _____ [*SEE ATTACHED NOTICE FOR CATEGORIES*]

Signature of Applicant: _____

Print Name: _____

Date:_____

For Maine Applicants Only
Upon request, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, the name and address of the consumer reporting agency furnishing the report. You may request and receive from us, within 5 business days of our receipt of your request, the name, address and telephone number of the nearest unit designated to handle inquiries for the consumer reporting agency issuing an investigative consumer report concerning you. You also have the right, under Maine law, to request and promptly receive from all such agencies copies of any reports.

For New York Applicants Only
You have the right, upon written request, to be informed of whether or not a consumer report was requested. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report.

For Washington Applicants Only
If we request an investigative consumer report, you have the right, upon written request made within a reasonable period of time, to receive from us a complete and accurate disclosure of the nature and scope of the investigation. You have the right to request from the consumer reporting agency a summary of your rights and remedies under state law.

For California*, Minnesota, and Oklahoma Applicants Only: A consumer credit report will be obtained through Certiphi Screening, Inc., P.O. Box 541, Southampton, PA 18966. Telephone (800) 260-1680. **www.certiphi.com**.

If a **consumer credit report** is obtained, I understand that I am entitled to receive a copy. I have indicated below whether I would like a copy. Yes _____ No_____
Initials Initials

If an **investigative consumer report** and/or consumer report is processed, I understand that I am entitled to receive a copy. I have indicated below whether I would like a copy. Yes _____ No_____
Initials Initials

*__California Applicants__: If you chose to receive a copy of the consumer report, it will be sent within three (3) days of the employer receiving a copy of the consumer report and you will receive a copy of the investigative consumer report within seven (7) days of the employer's receipt of the report (unless you elected not to get a copy of the report). **Certiphi Screening's privacy practices with respect to the preparation and processing of investigative consumer reports may be found at www.certiphi.com (link at bottom of page entitled, "Legal/Privacy").**

Special Notice for Consumer Credit Report Review
CALIFORNIA LABOR CODE SECTION 1024.5

California's new labor code provision severely restricts an employer's ability to conduct credit checks on employees. Labor Code 1024.5only allows employers to conduct credit checks for employees who meet one of the following categories:

- A managerial position.
- A position in the State Department of Justice.
- That of a sworn peace officer or other law enforcement position.
- A position for which the information contained in the report is required by law to be disclosed or obtained.
- A position that involves regular access, for any purpose other than the routine solicitation and processing of credit card applications in a retail establishment, to all of the following types of information of any one person:
    - (A) Bank or credit card account information.
    - (B) Social security number.
    - (C) Date of birth.
- A position in which the person is, or would be, any of the following:
    - (A) A named signatory on the bank or credit card account of the employer.
    - (B) Authorized to transfer money on behalf of the employer.
    - (C) Authorized to enter into financial contracts on behalf of the employer.
- A position that involves access to confidential or proprietary information, including a formula, pattern, compilation, program, device, method, technique, process or trade secret that (i) derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who may obtain economic value from the disclosure or use of the information, and (ii) is the subject of an effort that is reasonable under the circumstances to maintain secrecy of the information.
- A position that involves regular access to cash totaling ten thousand dollars ($10,000) or more of the employer, a customer, or client, during the workday.

EXEMPT INDUSTRIES: This section does not apply to a person or business subject to Sections 6801 to 6809, inclusive, of Title 15 of the United States Code and state and federal statutes or regulations implementing those sections if the person or business is subject to compliance oversight by a state or federal regulatory agency with respect to those laws. Sections 6801 to 6809 include the following industries (which are excluded from this law):

- National banks, Federal branches and Federal agencies of foreign banks, and any subsidiaries of such entities (except brokers, dealers, persons providing insurance, investment companies, and investment advisers), by the Office of the Comptroller of the Currency;

- Member banks of the Federal Reserve System (other than national banks), branches and agencies of foreign banks (other than Federal branches, Federal agencies, and insured State branches of foreign banks), commercial lending companies owned or controlled by foreign banks, organizations operating under section 25 or 25A of the Federal Reserve Act [12 U.S.C. 601 et seq., 611 et seq.], and bank holding companies and their nonbank subsidiaries or affiliates (except brokers, dealers, persons providing insurance, investment companies, and investment advisers), by the Board of Governors of the Federal Reserve System;

- Banks insured by the Federal Deposit Insurance Corporation (other than members of the Federal Reserve System), insured State branches of foreign banks, and any subsidiaries of such entities (except brokers, dealers, persons providing insurance, investment companies, and investment advisers), by the Board of Directors of the Federal Deposit Insurance Corporation; and

- Savings associations the deposits of which are insured by the Federal Deposit Insurance Corporation, and any subsidiaries of such savings associations (except brokers, dealers, persons providing insurance, investment companies, and investment advisers), by the Director of the Office of Thrift Supervision.

- Under the Federal Credit Union Act [12 U.S.C. 1751 et seq.], by the Board of the National Credit Union Administration with respect to any federally insured credit union, and any subsidiaries of such an entity.

- Under the Securities Exchange Act of 1934 [15 U.S.C. 78a et seq.], by the Securities and Exchange Commission with respect to any broker or dealer.

- Under the Investment Company Act of 1940 [15 U.S.C. 80a–1 et seq.], by the Securities and Exchange Commission with respect to investment companies.

- Under the Investment Advisers Act of 1940 [15 U.S.C. 80b–1 et seq.], by the Securities and Exchange Commission with respect to investment advisers registered with the Commission under such Act.

- Under State insurance law, in the case of any person engaged in providing insurance, by the applicable State insurance authority of the State in which the person is domiciled, subject to section 6701 of this title.

- Under the Federal Trade Commission Act [15 U.S.C. 41 et seq.], by the Federal Trade Commission for any other financial institution or other person that is not subject to the jurisdiction of any agency or authority under paragraphs (1) through (6) of this subsection.

CovenantHealth

PHYSICIANS ASSOCIATED HEALTH PROFESSIONAL IMMUNIZATIONS / HEALTH ATTESTATION

ATTENTION: Failure to submit required documentation will result in an incomplete application and delay of approval process.

Note that Covenant Employee Health does not provide any immunizations for non-hospital employees.

It is now a state requirement per TX Senate Bill 1177 sec. 224.002 to show ***proof of immunization*** for the following vaccine preventable diseases before Appointment or Reappointment.

- ***1 TB Test*** **–** Must have one TB test **within** the last year. If you have had a TB test done in the past year, provide proof of that test. If you are a known positive TB reactor, please complete the TB positive reactor form and provide a copy of your letter from the Texas Department of Health. If you do not already have a letter from the TDH, you must attach a copy of your chest X-Ray that was performed within the last year.

- **MMR** – Two Measles, Mumps and Rubella or laboratory proof of immunity (positive titer)*. Childhood records may be submitted, as well. If born before 1957 one MMR vaccination required or one positive titer is sufficient.

- **Varicella (chickenpox)** –Vaccination, laboratory proof of positive titer*, or verified history of illness by a physician. Childhood records may be submitted, as well.

- **Hepatitis B** – This is not required but strongly recommended for those working in clinical areas where there is the possibility of exposure to blood or body fluids
  If a vaccine is refused, a declination form must be signed.

- **Tetanus, diphtheria and pertussis (Tdap)** – Action is required every 10 years. The vaccine may be declined.
  If a vaccine is refused, a declination form must be signed.

- **Influenza Vaccination** – Action is required yearly. The vaccine may be declined. If the individual declines the vaccine they must wear a mask during flu season if they are within 6 feet of a patient. **Flu season – September through May**.
  If a vaccine is refused, or out of season a declination form must be signed.

***Please Note: If proof of immunizations is unavailable, you may have a *Blood Titer* done to show immunities. Please complete titers a minimum of two weeks prior to application deadline. Declination forms available by request for Flu, Tdap or Hep B only. All others are mandatory.**

Physician Associated Health Professional

Education Packet

INSTRUCTIONS FOR ONLINE EDUCATION

You may access this at:

http://bit.ly/2ouGvDU

Please be sure to print the attestation (last page of the presentation) and sign, date, and print your name legibly.

Last Revised: October 2015

TABLE OF CONTENTS

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This will be the first of two education/orientation documents that you will need to return to Medical Staff Services. Fax (806) 723-7146

In addition to the online education, Joint Commission standards require that our Physician Associated Health Professionals receive education on selected topics. This packet has been developed to meet these requirements.

Please review the information contained in this packet. Upon conclusion, please sign the accompanying attestation record, indicating that you have reviewed and understand the information contained herein. Return the signed attestation along with your application /yearly evaluation.

This will be the second of two education/orientation documents that you will need to return to Medical Staff Services.
Questions? Phone (806) 725-0566

INFECTION PREVENTION/CONTROL & HAND HYGIENE

Standard Precautions
Standard precautions are those precautions that are to be taken with any patient to prevent the spread of infection. Standard precautions consist of: gloves; masks and eye protection (goggles /face shields), and fluid-resistant gowns/jumpsuits to protect from exposure to body fluids. (See Administrative Policy IC 1.8 Standard Precautions /Respiratory Hygiene)

Isolation
Certain patients may require isolation. The following list indicates the various types of isolation used in our organization: Contact Precautions; Special Contact Precautions; Droplet Precautions; Airborne Infection Isolation (AII); TB-Specific Airborne Infection Isolation. (See Administrative Policy IC 1.5, Isolation Precautions)

Hand Hygiene
Washing your hands is the single most effective way of preventing the spread of infection among staff and patients. Our organization adheres to the CDC recommendations for good hand hygiene. Wash hands with soap and water when visibly dirty or contaminated with blood or body fluids, if exposure to potential spore-forming organisms is strongly suspected or proven, after using the restroom, before placing or removing contact lenses.

If hands are not visibly soiled, an alcohol-based, waterless cleanser may be used in the following situations: before and after having direct contact with any patient; before handling any invasive device for patient care, regardless of whether or not gloves are used; before performing or assisting with invasive procedures; after contact with a patient's intact skin; after contact with body fluids or excretions, mucus membranes, non-intact skin or wound dressings; if moving from a contaminated body site to a clean body site during patient care; after contact with inanimate objects that are in the immediate vicinity of the patient; before and after handling drains and drainage equipment; after sneezing or coughing; before donning gloves and after removing gloves; before preparing and serving food; before preparing or administering medications and IV solutions. (See Administrative Policy IC 1.4, Hand and Fingernail Hygiene)

PREVENTING INFLUENZA

Vaccination against influenza is the most effective means of spreading the disease. The influenza vaccine will be administered at no cost annually, October through December.

Anyone choosing not to receive the vaccination must sign a Declination form and will be required to wear a mask during the influenza (flu) season. The mask will be required when within 6 feet of a patient, regardless of where you work.

Infection Control in conjunction with the Infectious Disease Physicians and the laboratory will determine when Flu is active in our area. This will be when 10% (percent) of the flu tests we perform are positive and will continue until less than 10% (percent) of all flu tests are positive. Infection Control will notify Leadership that flu season has started.

PREVENTING THE SPREAD OF MULTI-DRUG RESISTANT ORGANISMS

Periodic assessments are performed to identify the risk of acquisition and transmission of multi-drug resistant organisms (MDRO). Based on this assessment, the organization has identified the following MDROs to be of epidemiologic significance:

- *Acinetobacter baumannii*
- VRE (*vancomycin resistant Enterococcus*)
- *Pseudomonas aeruginosa*

To effectively reduce the risk of transmitting or acquiring an infection from these organisms, the following measures have been employed:

Hand Washing
Staff and physicians should adhere to appropriate CDC recommendations on hand hygiene consistent with organization policy. Touching environmental surfaces such as bedside rails and other patient equipment after hand washing should be avoided.

Isolation Precautions
Patients (both colonized and infected) with these organisms shall be placed on contact isolation (precautions). Droplet isolation (precautions) should be instituted if the patient has known or suspected positive respiratory cultures.

Patients with positive cultures should remain in appropriate isolation (precautions) for the duration of their present admission and any future admissions to the hospital. Patients may be removed from isolation with the approval of the treating physician or Infection Preventionist.

Use of Personal Protective Equipment
Gloves, gowns, and masks should be worn as appropriate to the specific MDRO being treated. Consult appropriate infection prevention policy if you have any questions.

Use of Antibiotics
The selection and ordering of antibiotics may be restricted as determined by the organization and medical staff. Adherence to these restrictions is expected.

Patient Transport
As much as possible, necessary treatments and procedures should be performed at the patient's bedside. If essential tests must be performed in another area, the department should be notified that the patient has an MDRO prior to transporting the patient to the department.

PREVENTING CENTRAL LINE INFECTIONS

It is the policy of Covenant Health to implement practices consistent with evidence-based standards of care to reduce the risk of central venous catheter associated blood stream infections. These practices include, but are not necessarily limited to, the following:

Equipment & Supplies
The organization has assured that equipment and supplies are available when a central line is inserted. At a minimum this includes:

- Central venous catheter
- Central venous catheter insertion kit
- Sterile drapes
- Barrier protection as outlined in this policy
- Chlorhexidine based antiseptic skin preparation (not required for patients < 2 months of age)
- Local anesthetic
- Line maintenance anticoagulant appropriate to the line type and patient age / presentation
- Site dressing

Central Venous Catheter Insertion

Whenever a central venous catheter is inserted, the following shall occur:

1. If possible, the procedure should be explained to the patient and family. Appropriate consent – if required – should be obtained for non-emergent need.
2. Hand hygiene must be performed by all staff involved in the procedure prior to catheter insertion
3. Maximum barrier precautions shall be deployed, including hair cover, masking, and sterile gowning / gloving of all personnel involved in the procedure, as well as head-to-toe draping of the patient.
4. If body hair needs to be removed, it should be clipped rather than shaved if possible
5. Only approved antiseptic skin preparations should be used.
6. Catheters should not be inserted into the femoral vein unless other sites are not available
7. Catheters should be secured in place, BIOPATCH® Disk (Protective Disk with CHG) applied to insertion site, and a sterile occlusive dressing applied following insertion.
8. Confirmation of proper placement (e.g. x-ray or other test) may be performed.

Accessing Central Venous Catheters

To reduce the risk of infection, accessing central venous catheters should be limited to necessary use. Catheter hubs and injection ports must be appropriately disinfected prior to use.

Dressing Changes

Dressing changes are to occur as required by policy.

Removal of Central Venous Catheters

Catheters should be evaluated routinely and removed as soon as the patient's clinical status and needs will allow. Non-essential catheters should be removed.

PREVENTING SURGICAL SITE INFECTIONS

Our organization is committed to reducing the incidence of surgical site infections. Please note the following evidence-based practices:

Preparation of the Patient

Whenever possible, infections remote to the surgical site should be identified and treated before elective procedures. Elective procedures should be postponed – if necessary – until the remote infection has resolved.

Patients should shower or bathe with an antiseptic agent on at least the night before the operative day. Showering/bathing with an antiseptic agent the morning of the operation is recommended. An antiseptic bathing product is provided to all patients who are seen in the SAS pre-operatively.

Hair should not be removed preoperatively unless the hair at or around the incision site will interfere with the operation. If hair must be removed, it should be done in accordance with accepted standards of care.

The area around the intended incision site should be thoroughly washed and cleaned to remove gross contamination before performing antiseptic skin preparation. When an antiseptic agent is applied, the prepared area must be large enough to extend the incision or create new incisions or drain sites, if necessary.

Alcohol-based Chlorhexidine Gluconate (CHG) is the expected antiseptic for skin preparation. Iodine-based skin antiseptics are available for use when CHG is contraindicated or if the patient is allergic.

Administration of Prophylaxis Antimicrobial Therapy
Prophylactic antimicrobial agents should be administered only when indicated, and selected based on its efficacy against the most common pathogens causing SSI for a specific operation and published recommendations.

Antisepsis for Operative Personnel
Nails should be kept short. Artificial nails should not be worn. Personnel should perform a preoperative surgical scrub for at least 2 to 5 minutes using an appropriate antiseptic. Hands and forearms should be scrubbed up to the elbows. After performing the surgical scrub, hands should be kept up and away from the body (elbows in flexed position) so that water runs from the tips of the fingers toward the elbows. Hands should be dried with a sterile towel and staff should then don a sterile gown and gloves.

Surgical Attire and Drapes
A surgical mask that fully covers the mouth and nose must be worn when entering the operating room if an operation is about to begin or already under way, or if sterile instruments are exposed. The mask is to be worn throughout the operation. A cap or hood to fully cover hair on the head and face must be worn when entering the operating room. Sterile gloves must be worn by all scrubbed surgical team members. Surgical gowns and drapes that are effective barriers when wet (i.e., materials that resist liquid penetration) should be used. Scrub suits that are visibly soiled, contaminated, and/or penetrated by blood or other potentially infectious materials should be changed.

Asepsis and Surgical Technique
Principles of asepsis should be adhered to when placing intravascular devices (e.g., central venous catheters), spinal or epidural anesthesia catheters, or when dispensing and administering intravenous drugs. Tissue should be handled gently, maintain effective hemostasis, minimize devitalized tissue and foreign bodies (i.e., sutures, charred tissues, necrotic debris), and eradicate dead space at the surgical site. A delayed primary skin closure should be used or leave an incision open to heal by second intention if the surgeon considers the surgical site to be heavily contaminated (e.g., Class III and Class IV). If drainage is necessary, a closed suction drain should be used. The drain should be placed through a separate incision distant from the operative incision, and removed as soon as possible.

Postoperative Incision Care
For an incision that has been closed primarily, the site should be protected with a sterile dressing for 24 to 48 hours postoperatively. When a dressing must be changed, sterile technique should be used. Staff should follow appropriate hand hygiene practices when checking or changing dressings.

PREVENTING VENTILATOR-ASSOCIATED PNEUMONIA (VAP)

Ventilator-associated pneumonia (VAP) is an airway infection that must have developed more than 48 hours after the patient was intubated. The Ventilator Bundle is a series of interventions. Key components are listed below:

- *o Elevation of the head of the bed*
- *o Peptic Ulcer Disease Prophylaxis*
- *o Deep Venous Thrombosis Prophylaxis*
- *o Daily Oral Care with Chlorhexidine*
- *o Daily "Sedation Vacations" and Assessment of the Readiness to Extubate*

USE OF RESTRAINT OR SECLUSION

Policy Statement & Patient Rights
All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a convenience, or retaliation by staff.

Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

The organization will work to actively decrease the use of restraint or seclusion. When restraint or seclusion is necessary, such activity will be undertaken in a manner that protects the patient's health and safety and preserves his or her dignity, rights, and well being. The use of restraint/seclusion is a last resort, after alternative interventions have either been considered or attempted.

Training Requirements for LIP's and AHP's
All licensed independent practitioners or allied health professionals that manage patients placed in restraint or seclusion will have a working knowledge of the hospital policy. Reference Administrative policy #PC 07 (Medical/Surgical Restraints) for more information.

Prohibitions to Use of Restraint or Seclusion
The use of restraint or seclusion for the following reasons is strictly prohibited:

- Use that is based solely on a patient's prior history and/or behavior.
- Use as a convenience to staff.
- Use as a method of coercion or as punishment.
- Use as a method for the prevention of a fall.

Requirements for Patient Assessment & Ordering of Restraint or Seclusion
The use of restraint or seclusion must be in accordance with the order of a physician or other LIP who is responsible for the care of the patient. The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.

Orders for the use of restraint or seclusion

must never be written as a

standing order, nor on an as-needed basis (PRN).

Each order for restraint or seclusion must contain at least the following information:

- The name of the patient being restrained or placed into seclusion
- The date and time of the order
- The name of the LIP ordering the restraint or seclusion
- The type of restraint or seclusion to be applied
- The time limit (duration) of the restraint or seclusion

If there is to be any variation from this policy for monitoring of the patient and/or release from restraint before the order expires, then the rationale for such variation must be contained in the order.

The initial order for violent/self-destructive (behavioral) restraint must be time limited and shall not exceed 24 hours.

Renewal orders for non-violent/non-self destructive (medical) restraint shall be obtained at least each calendar day. Renewal orders shall be based on an examination of the patient by an LIP.

Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be ordered / renewed in accordance with the following limits for up to a total of 24 hours:

- Four (4) hours for adults age 18 and older;
- Two (2) hours for children and adolescents ages 9 to 17;
- One (1) hour for patients under age 9.

After 24 hours, before writing a new order a physician or other LIP who is responsible for the care of the patient must see and assess the patient.

When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within one (1) hour after the initiation of the intervention by a Physician or other LIP; or RN or PA who has been trained in accordance with the requirements of this policy. The purpose of the face-to-face evaluation is to assess; the patient's immediate situation; the patient's reaction to the intervention; the patient's medical and behavioral condition; and the need to continue or terminate the restraint or seclusion.

PAIN MANAGEMENT

Patient Rights

Patients have the right to pain management. It is the policy of our organization to do the following:

1. Conduct an appropriate assessment and/or reassessment of a patient's pain consistent with the scope of care, treatment, and service provided in the specific care setting in which the patient is being managed.
2. Require that methods used to assess a patient's pain are consistent with the patient's age, condition, and ability to understand
3. Assess the patient's response to care, treatment, and service implemented to address pain.
4. Treat the patient's pain or refer the patient for treatment.

Treatment of Pain

In general, inpatients shall receive treatment for any active pain issue (acute or chronic), when intensity exceeds their acceptable level. Treatment shall be consistent with the patient's clinical presentation and objective findings. The treatment modality selected shall be appropriate for the patient's needs. Treatment is to be provided in a timely manner.

Patient Refusal of Pain Management

Patients have the right to refuse pain management in any care setting. Such refusal should be documented in the patient's medical record.

Decision not to Treat Pain

If a decision is made not to treat a patient's pain and/or refer the patient for treatment, then the clinical justification for that decision should be documented in the patient's medical record.

(See Administrative Policy PC 06, Management of Pain)

ANTICOAGULANT THERAPY

Establishment of an Anticoagulant Management Program

Patients receiving anticoagulant therapy shall have these medications ordered, prepared, dispensed, administered, and monitored in accordance with guidelines and requirements established in this policy. The following requirements govern the overall approach to managing patients on anticoagulant therapy:

- There must be a clear and appropriate indication for use

- The particular type of anticoagulation used shall be the most appropriate and clinically indicated for the condition or reason for use.
- Where appropriate, patients laboratory values will be monitored while on anticoagulant therapy
- Pharmacy will review orders for anticoagulant therapy against normative and patient specific information regarding indications for use, dosage, route, frequency, contraindications, duplicative therapy, and drug/drug interactions. Issues or concerns will be brought to the attention of the prescribing practitioner for appropriate resolution (unless in emergent situations) before the medication is dispensed.

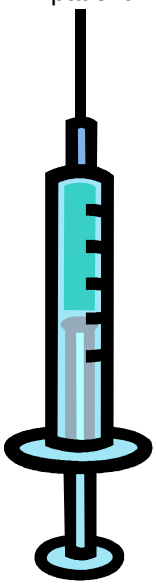
Management of Patients Placed on Warfarin Therapy

The following shall be required for patients placed on warfarin:

- The patient shall have a baseline International Normalized Ratio (INR) measured at the start of therapy.
- There shall be a current INR for the duration of therapy which shall be used to monitor and adjust therapy as warranted.
- The patient's baseline and current INR shall be available to Pharmacy for the duration of therapy and shall be reviewed prior to dispensing of warfarin. Issues or concerns will be addressed with the prescribing practitioner prior to the medication being dispensed.
- Authoritative resources shall be used in managing potential food / drug interactions

Management of Patients Placed on Heparin & LMWH

- As per Heparin protocol, an initial baseline PTT will be drawn. A subsequent PTT will be drawn every 6 hours, for 48 hours. If two consecutive PTTs are therapeutic after day one, then PTT may be checked daily.
  - This does not apply to the use of heparin for the purpose of maintaining patency of lines and catheters
- A baseline platelet count should be obtained on patients placed on LMWH. Further monitoring of a patient's platelet count should be based on the clinical circumstances and presentation of the patient.



Education of Patients and Families

Patients and – as appropriate – families will be educated on anticoagulant therapy. This education shall include – but not necessarily be limited to – the following:

- Importance of follow-up monitoring,
- Compliance issues,
- Dietary restrictions,
- Potential for adverse drug reactions and interactions.

Evaluation of the Anti-Coagulant Therapy Program

The organization shall – at least annually – evaluate safety practices associated with the management of patients placed on anticoagulant therapy. This evaluation may take the form of:

- Analyzing medication errors and adverse drug reactions associated with the use of anticoagulant therapy
- Adherence to protocols developed to address specific conditions or indications for use
- Provision of education to patients / families
- Other measures as may be deemed appropriate

DOWNTIME PROCEDURE
FOR ELECTRONIC DOCUMENTATION

The hospital's Information Management Plan describes the process for maintaining documentation when there is either an interruption in power or information system components. The plan includes the use of downtime forms created to facilitate paper documentation until systems can be restored. These forms are located in each nursing unit and ancillary department. Information regarding the status of the electronic systems will be communicated should an outage occur.

Physician Associated Health Professional Education Packet Attestation Statement

Please sign, date and return this form with your application.

My signature indicates that I have received and reviewed the information provided below as part of my initial application or re-application to the Covenant Health System PAHP staff.

MULTI-DRUG RESISTANT ORGANISMS

PREVENTING CENTRAL LINE INFECTIONS

PREVENTING SURGICAL SITE INFECTIONS

VENTILATOR-ASSOCIATED PNEUMONIA (VAP) PREVENTION

USE OF RESTRAINT OR SECLUSION

PAIN MANAGEMENT

ANTICOAGULANT THERAPY

DOWNTIME PROCEDURE FOR ELECTRONIC DOCUMENTATION

_____ _____
Signature Date

_____
Print Name

Include this signed page with your initial PAHP application packet - emailing into CovenantHR@stjoe.org

Return this page To Covenant Health Medical Staff Services Fax (806) 723-7146 Phone (806) 725-0566