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Dependent Healthcare Professional (DHP) Renewal Credentialing Application
Delta (MidAmerica) Division HCA Facilities

Applicant Name_____

Instructions:
Complete this application in full. Please type or legibly print all responses. Do not use abbreviations. This application is not complete until all information/documentation is received and verified. E-mail address listed will be used as primary communication. When submitting documentation via fax use the fax cover enclosed. When submitting documentation via email, write Delta in the subject line. You may be asked to resubmit documents that do not meet HCA requirements. HCIR Experience documentation (5cases), Tuberculosis testing and Certificate of Insurance requirements expire on an annual basis; they will be requested via email 90, 60 and 30 days before the expiration date. Our contact information is listed at the bottom of each application page

Include copies of the following documents with your completed application:

- ❒ Letter of Compliance – Document must state the DHP is currently employed and up to date with training/services as it pertains to their position. Letter must be on company letter head, signed and dated within the last months six (6) months of renewal application date
- ❒ Proof of Competency / Skills Check list of essential functions of your job along with corresponding performance standards

The following enclosed documents need to be returned with the completed application

- ❒ Scope of Service
- ❒ Packet B Addendum
- ❒ Current physician sponsor form (Tier 3 only)
- ❒ Application Fee

Personal Information

Name: _____
Last **First** **Middle**

Home Address: _____

City, State and Zip: _____

E-Mail Address: _____**Office Phone:** _____ **Cell Phone:**_____

Professional Information

Vendor/ Physician name: _____**Vendor/Physician Phone**: _____

Company Address: _____
Street City State Zip

Contact/Delegate Name (if someone other than you should contacted regarding the credentialing):_____

Contact/Delegate Contact Number(s): _____

DHP Classification (ex. Dialysis nurse; Surgical Tech; HCIR; Perfusionist): _____

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Dependent Healthcare Professional (DHP) Renewal Credentialing Application
Delta (MidAmerica) Division HCA Facilities

As a DHP I am requesting approval to provide services at the following Delta Division HCA Hospitals: (check all applicable)

- ❒ Garden Park Medical Center
- ❒ Lakeview Regional Medical Center
- ❒ Rapides Regional Medical Center
- ❒ Regional Medical Center of Acadiana
- ❒ Women's & Children's Hospital

As a DHP I am requesting the following patient care area(s)

- ❒ Cath Lab
- ❒ ER
- ❒ Operating Room
- ❒ Radiology Department
- ❒ Pharmacy
- ❒ Respiratory
- ❒ Nursing Stations (ICU, NSY, Med Surg)
- ❒ Other:_____

1. **Responsibilities of DHP:**
   I understand I must:
   a. Pledge that I will not participate in any patient care services if I have symptoms of any contagious disease or condition
   b. Submit a non-refundable renewal application fee of $225,
   c. Submit an annual credentialing fee of $225
   d. Wear a Photo ID with Company Reference at all times while in a hospital

2. **Parallon Workforce Management Solutions responsibilities:**
   The Parallon Workforce Management Solutions Regional Office where the application is submitted will:
   a. Query the Office of Inspector General (OIG); General Services Administration (GSA); and the Department of Health State Licensing Agency

3. **Delta Division Facilities' responsibilities:**
   a. Obtain approval from Administration and notify the DHP and appropriate staff of the approval for the DHP to be present in the appropriate settings
   b. Complete Annual Evaluation of Performance

4. **Acknowledgments/Attestations:**
   a. I understand that in making an application to provide services at any HCA Delta Division Facility, I agree to comply with all facility policies which apply to the provision of services that I am requesting.
   b. I understand that any of the Delta Division Facilities and/or Parallon Workforce Management Solutions may deny approval or revoke any approval it grants to me to attend procedures at any time without any due process.
   c. I attest that all information provided in this application is true and correct, and I understand that misrepresentation of information during the application process may disqualify me from providing services at any HCA Delta Division Facility.
   d. I agree to allow authorized representatives of Parallon Workforce Management Solutions to request the information needed to verify my qualifications and competence, and give permission to the authorized representatives of my Company, other Facilities where I provide services, and any other third parties to release this information upon request.

_____ _____
DHP Signature **Date**

_____
Printed Name

Delineation of Scope of Services & Qualifications

DHP Name_____

Healthcare Industry Representatives (HCIR's) are not permitted to provide hands on care to any patients.

Instructions

Please select the Tier of services you are requesting by initialing the Tier and checking the specific services to be provided. **Services shall not be provided until you are notified of approval**. For purposes of this request, the term "product" refers to any device, equipment, medical system, drug or any other FDA-regulated product which you are promoting, selling, providing training or services as described below. Sign and date 3th page. Return with credentialing application.

Tier 2	Description
	I request to provide services that require access to a patient care area. The services I provide may have indirect impact on patients and /or hands-on care which will require supervision from a member of the clinical staff of the facility (i.e. CNO/CNO designee) during any service at the facility. Services I am requesting to provide include the following (check all that are being requested): ❒ Deliver product to a patient care setting (e.g., nursing care unit) ❒ Repair or maintain a product ❒ Provide user training and product support ❒ Provide clinical assessment/care in a patient care setting ❒ Please list additional duties_____
	Credentials Required: ○ Provide evidence of current licensure, certification or registration when required by law or regulation to practice in your profession ○ Provide copy of a current photo identification ○ Provide evidence of training for all of the following: ▪ Certificate or confirmation on company letterhead that attests to the training in the medical system, device, treatment, procedure or drug for which approval is sought ▪ Evidence of completion of an Operating Room protocols course (such as the AORN course), to include: • The Joint Commission Universal Protocol and AAAHC • Aseptic principles and techniques • Appropriate donning and wearing of surgical attire • Fire prevention as related to heat sources • Sterile fields and traffic patterns ▪ Training in patient rights, specifically to include confidentiality, HIPAA compliance requirements, and requirements related to human subject experimentation if you shall be providing services in conjunction with a product that is experimental or "off-label" as defined by the FDA ○ Provide documentation of experience, specifically to include: ▪ Letter of reference & job description ▪ Evidence of having provided product support or services similar to what is being requested on at least five (5) occasions every 12 months (HCIR's only) ○ Provide documentation of applicable health screening and vaccinations, including: ▪ Tuberculosis testing ▪ Influenza and other vaccinations as required by the Facility ▪ By submitting an application, you agree not to participate in the delivery of services when experiencing symptoms of a contagious disease ○ Provide proof of professional services errors and omissions insurance in the amounts of $1 million/$3 million, or an acceptable alternative as specified in the DHP Policy ○ Submit a signed Confidentiality and Security Agreement ○ Submit a signed Packet B acknowledgement addendum ○ Consent for a criminal background check

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Delineation of Scope of Services & Qualifications

DHP Name_____

Tier 3	Description
	I request to provide services that require access to patient care areas. I will provide clinical services and/or direct hands on care which will require the involvement and supervision of a physician or other licensed independent practitioner (LIP). Services I am requesting to provide include the following (check all that are being requested): ❒ Deliver product to a procedural area (e.g., OR, cath lab) ❒ Demonstrate product usage on a patient ❒ Provide technical training to clinicians regarding the product ❒ Assist with clinical care in product use or set-up including calibration or performing as the primary user of the product in the care of a patient ❒ Assist with clinical care in a procedural / patient care area (e.g., OR, cath lab) ❒ Please list additional duties_____ Specify the device(s), equipment, or systems to be used in the provision of services: _____ Specify the operative or invasive procedure(s) involved in the provision of services: _____
	Credentials Required: ○ Provide evidence of current licensure, certification or registration when required by law or regulation to practice in your profession ○ Provide evidence of formal education (e.g., copy of degree, certificate, or equivalency) ○ Provide copy of a current photo id ○ Provide evidence of training for all of the following: ▪ Evidence of completion of an Operating Room protocols course (such as the AORN course), to include: ● The Joint Commission Universal Protocol and AAAHC ● Aseptic principles and techniques ● Appropriate donning and wearing of surgical attire ● Fire prevention as related to heat sources ● Sterile fields and traffic patterns ▪ Training in the medical system, device, treatment, procedure or drug for which approval is sought ▪ Training in patient rights, specifically to include confidentiality, HIPAA compliance requirements, and requirements related to human subject experimentation if you shall be providing services in conjunction with a product that is experimental or "off-label" as defined by the FDA ○ Provide documentation of experience, specifically to include: ▪ Letter of reference & job description ▪ Evidence of having provided product support or services similar to what is being requested on at least five (5) occasions every 12 months – must include the same procedures and devices/equipment specified above (HCIR's only) ○ Provide documentation of applicable health screening and vaccinations, including: ▪ Tuberculosis testing ▪ Influenza and other vaccinations as required by the Facility ▪ By submitting an application, you agree not to participate in the delivery of services when experiencing symptoms of a contagious disease ○ Provide proof of professional services errors and omissions insurance in the amounts of $1 million/$3 million, or an acceptable alternative as specified in the DHP Policy ○ Submit a signed Confidentiality and Security Agreement ○ Submit a signed Packet B acknowledgment addendum ○ Consent for a criminal background check

Delineation of Scope of Services & Qualifications

DHP Name_____

As a DHP I am requesting approval to provide services in the following patient care area(s): (check all applicable)

- ❒ Cath Lab
- ❒ Endoscopy Lab
- ❒ Operating Room
- ❒ Radiology Department
- ❒ ER
- ❒ Pharmacy
- ❒ Respiratory
- ❒ Nursing Stations (ICU, NSY, Med Surg)
- ❒ Other:_____

DHP Signature: _____ **Date:** _____

DHP Company/Vendor: _____

Facility Approval – (Parallon Workforce Management Solutions will obtain the signatures)	
Facility Name:	
Director Signature:	Area: Date:
Director Signature:	Area: Date:
Medical Staff Signature (Tier 3 only):	Date:
Administrator Signature (if applicable):	Date:

Facility Denial – (Parallon Workforce Management Solutions will obtain the signatures)	
Facility Name:	
Signature:	Job Title: Date:
Reason for Denial:	Date:
CEO Signature (if applicable):	Date:

Packet B Acknowledgement Addendum

You are attesting that you have reviewed the following information:

- Patient Rights
- Information Security
- Environment of care and Fire Safety
- Medical Emergency Care and Rapid Response Teams- (RRT)
- OSHA Safety Precautions
- Tuberculosis(TB) and Exposure Control Plan
- Bloodborne Pathogens/Compulsives Hand Hygiene
- MRSA-Methcillin Resistant Staphlacoccus Auerus/C Diff
- Hospital Acquired Conditions and Aim for Zero
- Serious Preventable Adverse Events (SPAEs)
- Team Communication and SBAR(R) Healthcare
- Back Safety/Body Mechanics
- Quality Indicators/Risk Management
- HCAHPS Survey
- National Patient Safety Goals (Joint Commission)
- Universal Protocol for Preventing Procedural Errors
- Population Served and Culture Competency
- Critical Thinking/Chain of Command/Report Adverse Events
- Letter to Dependent HealthCare Professionals (DHP)
- Summary of Key HCA Code of Conduct Information
- DHP Credentialing Policy
- False Claims Laws
- FCRA-Summary of Rights
- Critical Access Hospital National Patient Safety Goals

I certify that I have reviewed the Packet B information listed above and understand it represents mandatory policies of the HCA organization. Please return this form with the application packet to Parallon Workforce Management Solutions.

Print Name: _____

Applicant Signature: _____

Date: _____

CURRENT PHYSICIAN SPONSORS

DHP Name: _____ Date: _____

_____ _____
Printed Name of sponsoring or employing physician **Date**

_____
Signature of sponsoring or employing physician

_____ _____
Printed Name of sponsoring or employing physician **Date**

_____
Signature of sponsoring or employing physician

_____ _____
Printed Name of sponsoring or employing physician **Date**

_____
Signature of sponsoring or employing physician

_____ _____
Printed Name of sponsoring or employing physician **Date**

_____
Signature of sponsoring or employing physician

_____ _____
Printed Name of sponsoring or employing physician **Date**

_____
Signature of sponsoring or employing physician

We will send this notice at each reappointment for you to complete and return to our office or if changes occur. Parallon Workforce Management Solutions must be notified immediately of any changes that may occur between reappointments (additions or deletions).

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Credit Card Payment Authorization

Name as it appears on Card: _____ Date**:** _____/_____/_____

Print Name of Representative/DHP (if not the same as card holder) _____

Name of Company/Vendor _____

I, _____ hereby give my permission for Parallon Workforce

Management Solutions to charge a non-refundable processing fee of:

- ❒ **$225 Initial Credentialing Processing Fee**
- ❒ **$225 Annual Credentialing Fee**

_____ Visa _____ MasterCard _____ AMEX _____ Discover_____

Credit Card Number: _____

Expiration Date: _____/_____/_____

Billing Address on Credit Card Account: _____

_____

Cardholder's Signature: _____

Comments: _____

PERSONAL CHECKS ARE NOT ACCEPTED
Company Checks should be made payable to Parallon Workforce Management Solutions
1000 Sawgrass Corporate Parkway 6th Floor
Sunrise, Fl 33323

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FAX

To: Delta Division DHP Credentialing From:

Fax: 1-866-361-2812 D ate:

Phone: 1-800-737-8661 ext. 1440

Subject:

Comments: