PROVIDENCE
Sacred Heart Medical Center
Sacred Heart Children's Hospital
Holy Family Hospital

TITLE: Credentialing Health Care Providers in the Event of Disaster

Revised	Reviewed
9/07	1/01
12/08	7/04
1/10 – SHMC	3/11
2/10 – HFH	8/14

Approval Date:
PHFH MEC 7/2014
PSHMC MEC – 6/2014

Effective Date: January 2000

New Policy: No (Replaces 'Credentialing Health Care Practitioners in the Event of a Disaster', a Medical Staff Policy). **Note that this policy requires approval by both administration and the Medical Executive Committees.**

Purpose:

- To allow practitioners credentialed at a Providence Health Care (PHC) hospital to provide emergency care at any of the four PHC hospitals during an emergency situation.
- To provide a process to grant qualified physicians and volunteers temporary privileges to provide care to patients during an emergency or disaster situation. The hospital President or his/her designee may grant temporary privileges to a qualified individual if the emergency management plan has been activated and PHFH or PSHMC are unable to meet immediate patient care needs.

Implementation:

1. The volunteer must present a current license to practice, government-issued photo identification such as a valid drivers license, and the name of the hospital(s) where the individual is currently affiliated or has recently practiced. These documents are to be presented to the hospital President/designee. Copies will be made of the license and photo ID and retained by the hospital. (Note that if the practitioner is credentialed at a PHC hospital and in good standing, this may be verified through the Medical Staff Office database and steps 1-3 will not be required.)
2. Status of a **Washington** State license will be verified by calling the Washington State Department of Health at 1-360-236-4788 or accessing the web site at https://fortress.wa.gov/doh/hpqa1/Application/Credential_Search/profile.asp This will be done within 72 hours from the time the practitioner presents to the organization. If this is not possible due to extraordinary circumstances, it will be done as soon as possible. (If these extraordinary circumstances exist, the Medical Center's designee will document the reason

that primary source documents could not be obtained, as well as evidence that the practitioner is continuing to provide adequate care, treatment, and services during the disaster situation.) Status of an **Idaho** physician license will be verified by calling the Idaho State Board of Medicine at 208-327-7000 or accessing the website at http://www.accessidaho.org/public/bomed/license/search.html. If a physician is licensed in a state other than Washington or Idaho, that state contact may be found on www.fsmb.org.

3. Whenever practicable, the hospital(s) where the individual is currently affiliated or has recently practiced will be contacted to verify that the individual is or has been a member in good standing.
4. The practitioner granted emergency privileges will be paired with and supervised by a currently credentialed medical staff member or hospital employee.
5. All individuals granted emergency privileges will be issued a temporary ID badge through Security. These badges will be clearly marked as 'Temporary Staff' and will be returned to hospital security when the services of these individuals are no longer needed**.**
6. If the disaster situation continues, the hospital President or his designee will make a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours from the time the volunteer practitioner presents to the organization regarding the continuation of the disaster privileges initially granted. Emergency/disaster privileges may also be rescinded as determined by any member of the hospitals' administrative team or Medical Executive Committee member without any stated cause.
7. All emergency privileges terminate immediately at the conclusion of the emergency or disaster situation which gave rise to the need for this policy to be implemented. Termination of those emergency/disaster privileges, regardless of the reason, shall not entitle any individual to the fair hearing rights defined in the Medical Staff Bylaws or other grievance procedure of the respective hospital.
8. All hospital property assigned to the volunteer will be returned to the manager or designee of the department to which s/he has been assigned.

Rationale: Accreditation standards require a hospital to have a credentialing policy in the event of a disaster in order to meet the anticipated needs of a community.

PROVIDENCE HEALTH CARE
EMERGENCY /DISASTER PRIVILEGES FORM

Badge ID: _____

DATE OF DISASTER: _____
HOSPITAL: _____

❒ **DMAT** ❒ **MRC** ❒ **ESAR-VHP**

Name _____ License: _____

Address: _____

Telephone:_____ Date of Birth: _____SSN: _____

Professional School:_____ Graduation Date: _____

License (State & Number:) _____

I attest that the information submitted by me in this application is correct and complete:

I hereby volunteer my professional services to the above listed PHC hospital during this emergency/disaster. I agree to abide by the hospital's Policies and Procedures, Incident Commander or any other hospital or Medical Staff leader.

I also acknowledge that my emergency/disaster privileges at the PHC hospital shall immediately terminate once the emergency/disaster has ended, as notified by the hospital.

I authorize the PHC hospital to consult with any individual(s) or organization(s) who may have information bearing on my professional qualification, competency, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter bearing on my professional qualifications and competency to carry out the emergency/disaster privileges I am requesting. I authorize all individuals and organizations who are requested to provide such information to the PHC hospital or its representative.

I release from any liability all representatives of the PHC hospital and its Medical Staff for their acts performed in good faith and without malice in connection with their evaluation of me and my credentials. I release from any liability all individuals and organizations who provide information to the PHC hospital in good faith and without malice concerning my competency, ethics, character and other qualifications including otherwise privileged or confidential information.

I agree that a photocopy or facsimile of this document with my signature may be accepted by any entity from which such information is sought, with the same authority as the original and I specifically waive written notice from any such entities or individuals who may provide information based upon this authorized request.

I certify that as of this date, I have no physical, medical or mental condition that would impair rendering care to the patients or meeting medical staff responsibilities. I further attest to having no impairment due to chemical dependency/substance abuse.

Signature of Volunteer Staff_____ Date _____

IDENTIFICATIONS: (Photocopy identification/license when possible; otherwise initial as visually inspected)

❒ Valid government-issued photo identification issued by a state or federal agency (Visually inspected by _____)

❒ Driver's License ❒ Passport ❒ Other government issued picture ID (Specify : _____)

(DMAT, MRC, ESAR-VHP Photo identification fills this requirement)

And ONE of the following

❒ 1. Current picture hospital identification card clearly identifying professional designation

❒ 2. Current Professional License/Certificate

❒ 3. Primary source verification of a license/State: _____
See below for verification

❒ 4. Disaster Medical Assistance Team (DMAT)

❒ 5. Medical Reserve Corps (MRC)

❒ 6. Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)

❒ 7. Other federal, state or municipal entity Specify: _____

❒ 8. Identification by current Hospital or Medical Staff member(s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during an emergency/disaster (Staff member: _____)

APPROVAL: Human Resources Manager, Administrator (or designee) Signature:_____Date _____

ID Badge No. _____	