Allied Health Professional Credentialing Instructions

If you are not employed by Children’s HealthSM, Children’s Medical Center, initial credentialing must be completed PRIOR to conducting the following activities at Children’s:

- Clinical Interaction with Children’s patients (history and physicals, participating in or obtaining consent for research, medication administration, phlebotomy, etc.)
- Collecting/reviewing Children’s PHI (protected health information) in paper format & electronic (including EPIC access). Please note that an Institutional Access Request (IAR) form does not need to be completed if you are a UT or Parkland employee and must be credentialed through the Children’s Centralized Verification Office (CVO).

Credentialing Instructions:

1. Complete the enclosed application for permission to provide services as an Allied Health Professional at Children’s HealthSM, Children’s Medical Center. Your supervising physician must also complete, sign and date the applicable section and the evaluation. You will also need to submit the following information:
   - Current Resume/CV – All dates must be listed in a month/year format
   - Position Description (enclosed)
   - Clinical Evaluation (enclosed)
   - Immunization Documentation – (Instructions enclosed)
   - Completion of ALL assigned CHEX training. (Instructions enclosed)
   - Current copy of liability insurance certificate or proof of liability insurance (required coverage of at least $100,000/$300,000). Please note that your name must be listed on the document. If your name is not listed on your sponsor’s policy, please contact your insurer to create an addendum to the policy noting your name. Alternatively, you may provide a letter from your employer verifying liability coverage through your employment.
   - Clear copy of a government issued photo ID and Professional Headshot Photo – Please Scan
   - If applicable to your role:
     - CEU’s obtained over the last two years (you submit copies of your CEU certificates or complete the enclosed CEU attestation
     - Copies of License, Certification, current BLS and/or PALS

2. Submit the application via email to CVO@childrens.com or via standard mail. You may also fax the application to (214) 456-1818. Please note your application will be processed sooner if it is sent via email or fax.

3. Complete and submit immunization documentation according to the instructions on the enclosed memo. You may contact the Children’s Occupational Health to schedule an appointment if you do not have all of the required documentation (make sure you keep a copy of immunization information for your records). Please note your application must be received by the CVO before you may contact Occupational Health to schedule an appointment.

4. Once all of the credentialing items have been received and processed, you will receive notification via email that your credentialing has been approved.

5. To obtain your ID badge, visit the Badge Office prior to, or on the beginning of your first day at Children’s.

6. Call the Children’s IS Helpdesk to obtain your username and password to obtain Children’s network and Epic access.

If you have any questions regarding this process, please contact the CVO at 214-456-1814.
Important Contact Information:

Central Verification Office:

Address: Central Verification Office
1935 Medical District Drive, Mail Code E3.08
Bright Building, 3rd Floor
Dallas, TX 75235
Email: CVO@childrens.com
Phone: 214-456-1814
Fax: 214-456-1818
Hours: Monday – Friday, 7:00 AM – 5:30 PM

Occupational Health (Dallas):

Address: Occupational Health and Wellness
1935 Medical District Drive, Mail Code BL.01
Building B, Lower Level, BL100
Dallas, TX 75235
Phone: 214-456-8678 (option 5) or 214-456-8343
Fax: 214-456-2665
Hours: Monday – Friday, 7:30 AM – 4:00 PM, closed daily from 11:45 AM – 1:00 PM

Occupational Health (Plano):

Address: Occupational Health and Wellness
7601 Preston Road, Mail Code P1.03-2
Ambulatory Care Pavilion, 1st Floor, P1130
Plano, TX 75024
Phone: 469-303-7300 or 34010
Fax: 469-303-4030
Hours: Monday –Friday, 7:30 AM – 4:30 PM, closed daily from 12:00 PM – 1:00 PM

Badge Office (Dallas):

Address: Badge Office
1935 Medical District Drive
Dallas, TX 75235

Main Hospital – lobby level in the New Employee Services Suite with Occupational Health and the HR Satellite Office just past the hallway that leads to the B1 Elevator and Continuity Clinic through the double glass doors. Office will be on right.

Phone: 214-456-1370
Hours: Monday, Wednesday and Friday 7:30 AM – 12:00PM, (closed for lunch from 12:00PM – 1:00PM) then re-open from 1:00PM – 4:30PM.
Tuesday and Thursday from 7:30AM – 12:00PM (closed for lunch from 12:00PM – 1:00PM) then re-open from 1:00PM – 3:00PM.

IS Help Desk Phone: 214-456-4636
1. NAME IN FULL: ____________________________________________________________
   (Last)            (First)          (Middle)        (Title)

2. [ ] MALE [ ] FEMALE

3. OTHER NAMES USED: ______________________________________________________
   (Maiden Name)     (Other Names Used)

4. OFFICE ADDRESS: _________________________________________________________
   (Street/Mail Code)    (City),  (State/Zip)      (Phone)  (Fax)

5. CREDENTIALING CONTACT: ________________________________________________
   (Name)    (Phone)   (Fax)

6. RESIDENCE ADDRESS ______________________________________________________
   (Street)                       (City),    (State/Zip)         (Phone)

7. PLACE OF BIRTH __________________________________________________________
   (City/State/Country)                                       (Citizenship)

8. DATE OF BIRTH ________________________________ (Month/Day/Year)

9. SOCIAL SECURITY NUMBER (for background check and identification purposes only): ________________________________

10. NAME(S) OF SPONSORING STAFF MEMBER(S):______________________________
    (Name)                        (Sponsor’s Specialty)
    ________________________________________________________________
    (Name)           (Sponsor’s Specialty)

11. PREFERRED METHOD OF CONTACT (Circle One):  EMAIL  REGULAR MAIL  FAX

12. PRIMARY CMC LOCATION (Circle One):
    Dallas Hospital  Plano Hospital
    ◆ Children’s Pavilion  ◆ Southlake Outpatient Clinics
    ◆ Southlake Surgery Center

13. EMAIL ADDRESS: _________________________________________________________

14. HAVE YOU PREVIOUSLY WORKED FOR CHILDREN’S MEDICAL CENTER OF DALLAS? [ ] YES  [ ] NO
    IF YES, WHEN AND WHAT POSITION?
    ________________________________________________________________

15. ARE YOU LICENSED OR CERTIFIED IN YOUR AREA OF PRACTICE? [ ] YES  [ ] NO
    (If yes, list Licensing Authority & License/Certification Numbers)
    License/Certificate #:
    ________________________________________________________________

16. DO YOU PERSONALLY OR DOES YOUR EMPLOYER CURRENTLY CARRY PROFESSIONAL LIABILITY INSURANCE WITH WHICH YOU ARE COVERED? [ ] YES  [ ] NO – ATTACH A COPY OF PROOF OF INSURANCE
17. ADDRESS HISTORY (for background check purposes only)

Please list the physical addresses where you have lived for the past seven years.

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   Years: Months:
   City: State: Zip Code:

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   Years: Months:
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   Apt: How Long:
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10. Street Address::
    Apt: How Long:
    Years: Months:
    City: State: Zip Code:

18. CLINICAL APPOINTMENTS / PRIVILEGES HELD AT OTHER HOSPITALS / HEALTH CARE FACILITIES: (PAST AND
PRESENT IF APPLICABLE – If more room is needed, list on a separate sheet of paper and attach.)

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19. DISCLOSURES - IF YOU ANSWER YES TO ANY OF THE FOLLOWING QUESTIONS, A THOROUGH EXPLANATION MUST BE SUBMITTED WITH YOUR APPLICATION.

A. Has your driver or professional license, registration and/or certification ever been restricted, suspended or revoked, or is it currently or previously been investigated or challenged or have you voluntarily/involuntarily relinquished such?  [ ] Yes  [ ] No

B. Have your privileges/employment at any organization ever been the subject of a disciplinary action or investigation, or voluntarily or involuntarily been suspended, reduced, revoked or not renewed, or have you voluntarily or involuntarily terminated your membership/employment?  [ ] Yes  [ ] No

C. Have you ever had any type of formal complaint filed against you related to behavioral or patient care issues?  [ ] Yes  [ ] No

D. Have you ever been named a defendant, cross defendant, or third party defendant in any professional malpractice litigation, or settled such a malpractice claim prior to being so named?  [ ] Yes  [ ] No

E. Are there any existing health problems which could affect your appointment as an Allied Health Professional or your ability to perform the privileges requested?  [ ] Yes  [ ] No

F. Have you previously or are you currently undergoing treatment for any type of alcohol or chemical abuse?  [ ] Yes  [ ] No

G. Have you been convicted, placed on probation, pled no contest, received deferred adjudication, or are you now under pending investigation on charges of criminal law violation or charges by a state or regulatory agency? Failure to disclose will result in denial of a request for permission to provide services.  [ ] Yes  [ ] No

Last Updated – 3/27/2015
H. Are you currently taking any medications that may affect either your clinical judgment or motor skills?  
[ ] Yes  [ ] No

I. Have you not reapplied/renewed a contractual relationship, staff appointment, clinical privileges or have you withdrawn your application or surrendered your privileges, employment, training program, contractual relationship or affiliation to avoid investigation or while under investigation by any healthcare entity or employment?  
[ ] Yes  [ ] No

20. PHOTOGRAPH REQUIREMENT - All applicants requesting permission to provide services at Children’s are required to submit a CLEAR, PROFESSIONAL color head shot photograph with their application to continue the credentialing process. This photo may be sent via email to your appropriate credentialing contact.

21. PLEASE ENSURE THIS SECTION IS COMPLETED BY YOUR SPONSORING MEDICAL/DENTAL STAFF MEMBER:

Is this applicant covered by your liability insurance carrier?  [ ] Yes [ ] No

I hereby verify that ____________________________________________________________

is in my employment in the capacity of _____________________________________________

I hereby verify that I will provide oversight of the above listed Allied Health Professional who will function within the guidelines of the privileges, protocols or scope of practice under my direction. I agree to assume responsibility for his/her actions in dealing with any patient(s) who is/are treated at Children’s Medical Center of Dallas. I also agree to notify the CVO of any changes in this arrangement.

THE SIGNATURE OF EACH SPONSORING STAFF MEMBER MUST BE OBTAINED. SHOULD YOU NEED AN ADDITIONAL SIGNATURE FORM, PLEASE CONTACT THE CVO.

__________________________________________________________  ______________________
SIGNATURE OF SPONSORING STAFF MEMBER                        DATE

__________________________________________________________  ______________________
SIGNATURE OF SPONSORING STAFF MEMBER                        DATE

(If more room is needed, please attach a separate sheet w/ Signature and printed name of additional sponsors)
22. EDUCATION

A. HIGH SCHOOL DIPLOMA OR EQUIVALENT?  [ ] YES  [ ] NO

B. COLLEGE, UNIVERSITY, VOCATIONAL, TECHNICAL, OR OTHER SCHOOLS ATTENDED

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(FROM) (TO)

23. COMPLETE WORK HISTORY FOLLOWING DEGREE OR CERTIFICATION  *(ALL TIME MUST BE ACCOUNTED FOR FROM DATE OF GRADUATION TO PRESENT. ATTACH ADDITIONAL SHEETS IF NECESSARY.)*

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**EMPLOYER:** ____________________________________________________________________________________

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| (FROM)            | (TO)                        |

**EMPLOYER:** ____________________________________________________________________________________

**ADDRESS:** ___________________________ **CITY:** ______________ **STATE:** _________ **ZIP:** ______________

**PHONE:** _____________________________ **FAX:** _____________________________

| DATES: ____________/____________ | REASON FOR LEAVING: ____________________________________________ |
| (FROM)            | (TO)                        |

**APPLICATION AGREEMENT**

By submitting this application, I specifically consent to the release of pertinent information from my present and past malpractice insurance carriers, and agree to fully assist in the compilation of such information. I further
APPLICATION AGREEMENT

By submitting this application, I specifically consent to the release of pertinent information from my present and past malpractice insurance carriers, and agree to fully assist in the compilation of such information. I further authorize the Board of Directors, the officers, employees and agents of Children’s Health Central Verification Office (CHCVO), Children’s Medical Center of Dallas, Children’s Southlake Surgery Center and Children’s Medical Center of Plano, Our Children’s House collectively referred to for purposes of this agreement as “Children’s” and the Medical and Dental Staff of Children’s and its committees to contact and consult with staffs and persons of other hospitals, health care facilities, and employers with which I have been associated, and to consult with any other persons or entities who may have information bearing on my competence, character, ethical qualifications, and health status (including without limitation, the National Practitioner Data Bank). I specifically consent to the release, inspection, and copying of all records and documents that may be material to an evaluation of my application.

I certify that all statements answered on this form or attached hereto are true and complete, to the best of my knowledge, and I understand that any falsification or misrepresentation of the information and data presented herein shall be cause for denial of my application and any permission to provide services at Children’s.

I further agree to abide by and be bound by the Bylaws, Rules and Regulations of the Medical and Dental Staff, as well as the Policies & Procedures of Children’s, should I be appointed as an Allied Health Professional.

It is understood, and agreed by all parties involved, that the physician employer of Applicant is completely and fully responsible for all actions and activities of the Applicant while providing services at Children’s as an Allied Health Professional.

In consideration of the above, I specifically release and hereby agree to INDEMNIFY, DEFEND, and HOLD HARMLESS from any and all claims, causes of action, damages, and liability all Trustees, officers, employees, agents, and representatives of Children’s and all members of Children’s Medical and Dental Staff who, acting in accordance with applicable laws, participate in the evaluation of my application. I further specifically release and hereby agree to INDEMNIFY, DEFEND, and HOLD HARMLESS from any and all claims, causes of action, damages, and liability any and all individuals and entities who provide information to Children’s and/or the Medical and Dental Staff concerning my application, my clinical practice or competence, when they provide such information in good faith, acting without malice (even if caused by the negligence, whether in whole or in part, active or passive, of any of such indemnified parties).

Photocopies of this agreement shall be as binding as the original.

__________________________     ______________________
Signature of Applicant          Date

______________________________
Name – Please Print
Applicant’s Consent and Authorization for Children’s to Obtain Consumer Reports

By signing below, I consent and authorize Children’s to procure a consumer report in connection with my permission to provide services on an annual basis.

I understand that the consumer report(s) that Children’s may obtain will be including but not limited to the following information:

- Records and information related to my criminal history or federal sanctions (including but not limited to convictions, deferred adjudication, probated sentences, warrants, and other types of charges).
- Medicare/Medicaid sanctions
- Social Security verification
- Employment records from previous employers
- Education verification
- Licensure/Certification verification
- Previous Addresses

If I am denied permission to provide services either wholly or partly, because of information contained in a consumer report, a disclosure will be made to me of the name and address of the consumer reporting agency making such report. I will also receive a copy of the report and a statement of my consumer rights.

_____________________________________                          __________________________
Applicant’s Signature                                                                 Date
Advanced Practice and Allied Health Practitioner Compact

This compact represents the practice agreements developed by Children’s HealthSM, Children's Medical Center for members of the Advanced Practice and Allied Health Practitioner Staff. By committing to hold Advanced Practice and Allied Health Practitioners accountable to these behaviors, we want to collectively create an environment that is patient-centered and ensure that we create an atmosphere that is in alignment with our mission To Make Life Better for Children.

Behavior
- Conduct actions in a professional and ethical manner at all times towards patients, families, employees, staff, etc.
- Communicate respectfully and with patients, families and members of the healthcare team
- Be respectful of the rights, privacy and cultural diversity of patients, families and others
- Address disagreements about patient care or other issues that impact the working environment promptly, directly and privately
- Retaliation of any kind will not be tolerated

Patient Centered Care
- Pledge to provide continuous care for my patients
- Provide patient care that is compassionate and within the scope of my privileges, education and training

Safety
- Participate in quality measures identified to improve patient safety
- Participate in the organization’s efforts to improve safety from a systems perspective by identifying and reporting potential performance improvement initiatives
- Participate in the hospital’s performance improvement activities
- Understand and participate (as applicable) in all hospital safety drills and codes

Professional Practice
- Maintain complete and accurate patient medical records and keep all such information confidential
- Agree to notify the hospital within 10 days of any significant changes to my information or practice (changes in physical or mental health that could affect my ability to practice, action taken at another hospital, commencement of a formal investigation by any authority, filing of any charges by any law enforcement agency, etc.). Notification should be made in writing to Medical Staff Services (Fax: 214-456-1814 or via email CVO@childrens.com).

I have reviewed the Advanced Practice and Allied Health Practitioner compact and agree to adhere to and abide by all expectations of the compact as well as the expectations set forth by all hospital policies and procedures and the Children’s Code of Ethical Conduct.

The following documents are available for your review on ChildNet (http://cmc-childnet/childnet/departments/home/index.asp). ChildNet is available via Internet Explorer.
- Code of Ethical Conduct
- Administrative Policy 1.25 - Non-Retaliation/Protection of Whistle Blowers
- Human Resources Policy 3.06 – Harassment

____________________________________       __________________
Signature             Date
CHILDREN'S MEDICAL CENTER

MEMORANDUM

TO: Medical/Dental Staff Services

FROM: Carolyn Amrich, RN, COHN
Manager, Occupational Health and Wellness

DATE: May 29, 2012

RE: IMMUNIZATION RECORDS

__________________________________________________________________________

Children’s HealthSM, Children’s Medical Center requires that all Medical/Dental staff have the following immunizations “prior to beginning work”:

1. Tdap (tetanus, diphtheria and pertussis)
2. The full series of Hepatitis B vaccine and/or immunity to Hepatitis B.
3. Current TB test within the past 30 days. If you have not had a TB test within the past twelve months, and one within 30 days we will do a Quantiferon TB blood test. If you have had a positive TST, we will need documentation (date and mm of induration) and record of a negative chest x-ray within the past year.
4. One (1) dose of Rubella vaccine or a positive titer
5. Documentation of positive titer for Varicella or proof of two doses of Varivax vaccine

In addition, Children’s requires the following if you were born after January 1, 1957:

1. Two (2) doses of Rubeola and Mumps vaccine, two (2) MMR’s or positive titers

You must provide documentation of all of the above to Occupational Health Services prior to your start date. FAILURE TO PROVIDE DOCUMENTATION WILL RESULT IN REVACCINATION.

Please provide copies of any titers that you have had done, such as Hepatitis B (post vaccine), varicella, measles, mumps, and/or rubella. If you have not had these done we will do them at the time of your Occupational Health appointment.

These immunizations are not negotiable. If you have any contraindications/allergies to immunization(s), a letter from a physician, other than yourself, must be provided.

If you have any questions, please call us at (214) 456-8948. Thank you for your cooperation and we look forward to meeting you.
CME/CEU ATTESTATION

Applicant: ________________________________________________________________

Department/Section: _______________________________________________________

I attest that within the last two years, I have completed ______ hours of Continuing Medical Education Credits/Continuing Education Units, of which hours ______% pertained to the specialty in which I currently practice and hold privileges at Children's Medical Center.

I will be able to provide documentation of the above information to Children’s Medical Center upon request from either Medical Staff Services, the Department Director, Chief Nursing Officer, Chief of Service of my clinical department, the Credentials Committee, the Medical Executive Committee or the Board of Directors.

_________________________________________  ____________________________
Signed                                      Date

Please note that a random 5% audit will be performed on an annual basis. Any applicant who is randomly selected as part of the 5% audit will be notified in writing and will be required to provide appropriate documentation within a reasonable amount of time.
Allied Health Professional Alternate Provider Attestation Form

Applicant Name: ________________________________

I hereby verify that I will provide oversight for the above listed Allied Health Professional who will function within the guidelines of the privileges, protocols or scope of practice under my direction. I agree to assume responsibility for his/her actions in dealing with any patient(s) who is/are treated at Children's Medical Center of Dallas. I also agree to notify Medical Staff Services at 214-456-1814 of any changes in this arrangement (cancellation, termination, extension, etc.).

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Advanced Practice and Allied Health Practitioner Compact

Name: __________________________________ Department: __________________________________

This compact represents the practice agreements developed by Children’s HealthSM, Children's Medical Center for members of the Advanced Practice and Allied Health Practitioner Staff. By committing to hold Advanced Practice and Allied Health Practitioners accountable to these behaviors, we want to collectively create an environment that is patient-centered and ensure that we create an atmosphere that is in alignment with our mission To Make Life Better for Children.

Behavior
- Conduct actions in a professional and ethical manner at all times towards patients, families, employees, staff, etc.
- Communicate respectfully and with patients, families and members of the healthcare team
- Be respectful of the rights, privacy and cultural diversity of patients, families and others
- Address disagreements about patient care or other issues that impact the working environment promptly, directly and privately
- Retaliation of any kind will not be tolerated

Patient Centered Care
- Pledge to provide continuous care for my patients
- Provide patient care that is compassionate and within the scope of my privileges, education and training

Safety
- Participate in quality measures identified to improve patient safety
- Participate in the organization’s efforts to improve safety from a systems perspective by identifying and reporting potential performance improvement initiatives
- Participate in the hospital’s performance improvement activities
- Understand and participate (as applicable) in all hospital safety drills and codes

Professional Practice
- Maintain complete and accurate patient medical records and keep all such information confidential
- Agree to notify the hospital within 10 days of any significant changes to my information or practice (changes in physical or mental health that could affect my ability to practice, action taken at another hospital, commencement of a formal investigation by any authority, filing of any charges by any law enforcement agency, etc.). Notification should be made in writing to Medical Staff Services (Fax: 214-456-1814 or via email CVO@childrens.com).

I have reviewed the Advanced Practice and Allied Health Practitioner compact and agree to adhere to and abide by all expectations of the compact as well as the expectations set forth by all hospital policies and procedures and the Children’s Code of Ethical Conduct.

The following documents are available for your review on ChildNet (http://cmc-childnet/childnet/departments/home/index.asp). ChildNet is available via Internet Explorer.

- Code of Ethical Conduct
- Administrative Policy 1.25 - Non-Retaliation/Protection of Whistle Blowers
- Human Resources Policy 3.06 – Harassment

__________________________________________ __________________________
Signature Date

Last Updated – 3/27/2015