# Credentialing and Privileging Processes

## What Are the Risk Exposures?

According to the *Risk Management Handbook for Healthcare Organizations*, "credentialing is the process by which healthcare organizations review an applicant physician's licensure, certifications, references, and other professional information pertaining to his or her qualifications and ability to provide healthcare services."[1] Privileging (or granting privileges) is the process by which a healthcare organization authorizes the specific scope and content of patient care services that may be rendered by a provider based upon an evaluation of that individual provider's credentials and performance.[2] In short, credentialing verifies that a practitioner is qualified, while privileging allows the qualified practitioner to provide services and care to patients.

It is important to note that a practitioner may be granted medical staff membership in order to have an opportunity to be involved in the governance of a facility, but without clinical privileges. Conversely, it is permissible for a practitioner to have clinical privileges without being a member of the medical staff.

In the 1965 landmark case of *Darling v. Charleston Community Memorial Hospital*, the Supreme Court of Illinois found that the hospital had a duty to ensure that high quality care was delivered at the facility and that the institution was responsible for the competency of its medical staff.[3] This opinion served to establish the doctrine of "hospital corporate liability," under which the tort theory of negligent credentialing is now advanced. Prior to 1965, there was no liability on the part of healthcare institutions for the negligent acts of physicians practicing within its walls; disputes between patients and their practitioners did not attach to the organization that appointed practitioners to its medical staff.[4]

In a case that illustrates the significant potential for financial loss exposure, *Frigo v. Silver Cross Hospital and Medical Center*, the plaintiff argued that the hospital had been negligent when granting surgical privileges to a podiatrist who performed a bunionectomy on her. The hospital was found liable for negligent credentialing, and the patient was awarded nearly $8 million.[5] In this case, the facility failed to follow its own credentialing protocols and granted privileges without appropriately confirming the physician's competency to perform a surgical procedure included in the privileges requested.[6] In addition to negligent credentialing, other potential sources of liability include discrimination, restraint of trade, inadequate supervision of advanced practice providers, wrongful disclosure of peer review activities, and economic credentialing.





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Case law, as well as state hospital licensing standards, Centers for Medicare & Medicaid Services (CMS), guidelines, and accreditation standards address the responsibility of credentialing and privileging. Hospital bylaws, rules and regulations, and policies and procedures establish operational mechanisms for credentialing, privileging, and reappointment processes. Credentialing processes and decisions will likely be questioned by plaintiff attorneys in malpractice cases, as well as by practitioners who have their staff membership or privileges denied, reduced, or terminated. The recommendations presented here are designed to positively impact the quality of healthcare delivery and to minimize the risk of successful challenges to credentialing and privileging decisions. Additionally, each organization or facility should consult with its counsel regarding the applicability of any state-specific requirements relative to credentialing and privileging.

## When is This a Risk Issue?

The credentialing and privileging processes include activities designed to collect, verify, and evaluate data relevant to a practitioner's performance. These processes (or these data) that will service as the foundation for objective, evidence-based decisions regarding appointment and reappointment to the medical staff, as well as the delineation of clinical privileges.

Credentialing is the first step in the process, and may lead to appointment to membership on the medical staff if so requested by the applicant. Granting privileges to provide treatment presents a greater risk to the organization than granting membership alone.[7] If hospital personnel know, or should know, that a provider may not be qualified to provide a service or perform a procedure, but the provider is nevertheless allowed to do either, the hospital is at risk for allegations of negligent credentialing if a patient is injured as a result.

### Lack of Structure and Criteria

An organization or facility should ensure a thorough and systematic credentialing and privileging process. Both the structure of the process and its criteria should be explicitly defined in policies and procedures.

### Regulatory and Accreditation Requirements

Both accreditation and regulatory requirements play a significant role in the credentialing process. These requirements must be satisfied to meet the standards set by The Joint Commission, National Integrated Accreditation for Healthcare Organizations (NIAHO), and/or the Healthcare Facilities Accreditation Program (HFAP).

CMS also has regulations that address the credentialing and privileging responsibilities of hospitals that receive federal funding.

## Roles and Responsibilities

Many people and committees play a role in a successful credentialing and privileging process. For instance, only the hospital's governing body has the authority to grant a practitioner privileges to provide care in the hospital.[8] It is important that the roles and responsibilities for all participants in the process are well-defined.

Accreditation standards from The Joint Commission, FHAP, NIAHO, and the CMS Conditions of Participation concur that it is the responsibility of a hospital's governing body to appoint individual practitioners to the medical staff upon recommendations from the medical staff executive committee. The standards also maintain that leaders must ensure that the competency of all staff members is assessed, maintained, demonstrated, and continually improved. The commitment of leadership to the competency assessment and credentialing and privileging process is crucial.

The governing body is not bound by the recommendations of the medical staff executive committee in making a decision. Whether adverse or not, the decision must adhere to the bylaws and not be arbitrary, discriminatory, or capricious.

## Medical Staff Bylaws

Medical staff bylaws are written documents that provide both rules for self-governance and an organizational structure to the medical staff. These bylaws serve a significant purpose, and medical leaders should ensure that medical staff know the purpose for bylaws, as well as the content, any relevant rules, policies and regulations, and how such bylaws are adopted and amended.[13] The most effective and efficient medical staff credentialing and privileging systems will have the basic steps clearly defined in the bylaws and the details of the process, which may change frequently, in the rules and regulations and policies/procedures/protocols.[14]

Accredited hospitals are required to have certain items in their bylaws. Some may only be required for hospitals, while some bylaw items may be required for hospitals and critical access hospitals (CAHs). Still others are specific to multi-hospital systems.

### *Multi-hospital Systems*

The Joint Commissions' standard for a multi-hospital system is as follows:

> When a multi-hospital system has a unified and integrated medical staff, the bylaws describe the process by which medical staff members at each separately accredited hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) are advised of their right to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their respective hospital.[15]

While the bylaws must address particular elements noted in The Joint Commission's standard, there are related details that may either be documented in the bylaws, in rules and regulations, or in policies.[16] The medical staff determines what is considered a detail that may be in a supplemental document, which supplemental documents are to contain the details, and whether adoption of the details that are located in supplemental documents may be delegated.[17]

## Initial Appointment

Initial appointment refers to the process whereby the applicant is selected as a member of the organized medical staff. To avoid unnecessary delays, time limits should be established for each step of the process. The Joint Commission requires that complete applications be acted upon within the time frame as specified in the medical staff bylaws.[23]

### *Prescreening*

Prescreening applications may allow determination of ineligibility prior to the application process, allowing the provider to be notified that he or she is not eligible for the appointment.[24]

### *Application and Primary Source Verification*

Organizations should use only approved and standardized forms to ensure that all relevant information is requested and obtained from the applicant.[25] They should additionally, ensure that all information in the support of the standards listed by the National Association of Medical Staff Services is primary-source verified within 180 days.[26]

## Staff Privileging

The decision to grant, deny, and/or renew a clinical privilege is an objective, evidence-based process that must be clearly defined.[33] The granting of clinical privileges depends on evidence of current clinical competence and the ability of the applicant to demonstrate that his/her professional education, training, and experience meet the criteria established by the organization. Additionally, the delineating of clinical privileges is becoming more complex with the advent of new technology, new procedures, and cross-training among specialties.

The purpose of medical staff privileging is to improve the quality and efficiency of patient care in the hospital. Physicians who are involved in granting, denying, or terminating hospital privileges have an ethical responsibility to be guided by concern for the welfare and best interests of patients.

For physician practitioners granted privileges only, the hospital's governing body, and its medical staff must exercise oversight, which may be accomplished via credentialing and competency review, of those other physician practitioners to whom it grants privileges, just as it would for those practitioners appointed to its medical staff.[34] For example, certain advanced practice and telemedicine providers may qualify for this status.

*New Clinical Privileges*

Only after the governing body has approved the new procedure or services, and the minimum criteria to apply or the privilege has been developed may a provider apply for the privilege. If the provider applies for the privilege between credentialing periods, the applicable credentialing information gathering and verification regarding the new privilege must take place (e.g., verification of training and experience for the new privilege).[35]

**Focused Professional Practice Evaluations**

According to The Joint Commission, organizations must monitor newly appointed physicians for whom the organization does not have evidence of current competence to perform the privileges that they have been granted.[47] The Joint Commission uses the term focused professional practice evaluation, or FPPE, to describe this monitoring process. The FPPE process may include chart review, monitoring clinical practice patterns, simulations, proctoring, external peer review, and discussions with staff members who work with the provider being evaluated.[48]

**Reappointments**

Equally as important as the initial appointment and clinical privilege-granting processes is the establishment of comprehensive processes for medical staff reappointment and reappraisal of privileges. The hospital, through its governing body and medical staff, has a duty to ensure the continuing competence of its medical staff members and to verify this through its medical staff reappointment and clinical privilege reappraisal process.

As with the initial appointment, information is collected on an application form and verified by the designated individual. Information that has not changed (e.g., where the applicant completed medical school) does not need to be requested or verified. Along with other items that need to be primary source-verified, the applicant's health status should also be verified. The department chairperson commonly provides this verification. However, if there are any concerns about the applicant's ability to safely perform the privileges requested, an evaluation by an external or internal source is appropriate.[50]

**Ongoing Professional Practice Evaluation**

The Joint Commission requires accredited organizations to continuously monitor and evaluate practitioner performance so that performance concerns may be identified and corrected as soon as possible.[58] The process is referred to as ongoing professional practice evaluation or OPPE. The results of an OPPE must be considered by the medical staff on an ongoing basis and by the medical staff and governing body when making recommendations and decisions to renew medical staff membership and privileges.[59]

The Joint Commission recommends, but does not require, using the six general areas of competency recognized by the American College of Graduate Medical Education (ACGME) and

the American Board of Medical Specialties (ABMS) to evaluate practitioners. The six competencies were adopted by The Joint Commission to encourage and facilitate and evidence-based physician evaluation process based on greater validity and objectivity.[60]

The facility should have written directives that clearly define the OPPE process and which data will be collected and considered.[61] In addition to the facility-wide directives for OPPEs, specialty-specific policies may include additional detail regarding the data collected and the methods of collection for that specialty/department.[62, 63]

Any performance concerns identified by the OPPE may lead to implementation of the FPPE process. In the FPPE process, the provider's performance regarding the area of concern would be evaluated for a limited time and appropriate corrective actions would be taken as needed.[64]

**Expedited Appointment and Reappointment Process**

An expedited governing body approval process may be used for appointment, reappointment, renewal, or modification of clinical privileges. The governing body may delegate the authority to render those decisions to a committee consisting of at least two governing body voting members.

Under certain circumstances, temporary privileges may be granted by an organization for a limited period of time.[72] Medical staff bylaws, rules and regulations, and/or policies should describe the mechanism for granting temporary clinical privileges in the organization. Emergency and disaster privileges may be granted based upon a needed response to a particular situation; however, a modified credentialing and privileging process still needs to be in place.

For information regarding the credentialing and privileging of telemedicine providers, please see the ***Telemedicine*** chapter in the Healthcare Facility Risk Management Manual on the Risk Management Policyholder Resources Portal.

**Non-physician Providers**

Each day, thousands of advanced practice providers and other professionals care for patients in the hospital setting, including physician assistants, nurse practitioners, midwives, dieticians, psychologists, clinical social workers, and speech therapists. An important distinction among these non-physician providers is whether they may practice independently or must always work under the supervision of a physician, dentist, or other licensed independent practitioner. Due to the higher acuity of patients in the hospital setting, some practitioners are required to provide their services under the sponsorship and collaborative agreement with a licensed independent practitioner.[82]

While some dependent providers may or may not be licensed by the state, they are not authorized by the hospital or the licensing agency to practice independently. Examples include physician assistants and surgical, radiology, or cardiology technicians. A third category includes those who are licensed by the state to practice independently but are limited by the hospital to practice under the supervision of a licensed independent practitioner. An example is a certified registered nurse anesthetist (CRNA) who works under the supervision of an anesthesiologist.

Non-physician providers may also be contracted staff members who are not employed by the hospital, but provide services within the hospital. Examples include agency staff members, therapists, and clinical dieticians. Some who provide such services within the hospital may be employed by a specific independent practitioner, such as a surgical tech who is employed by a surgeon or a physician assistant who is employed by a physician.

### Management of Credentialing Files

Proper maintenance of credentialing files is required for each individual requesting medical staff membership and privilege. How files are to be maintained should be outlined in an organization's policies and procedures. Files, no matter whether kept in paper or electronic form, must be protected for security and confidentiality reasons.

## How Can I Reduce Risk?

It is incumbent upon the risk management professional in a facility or organization to assess the credentialing and privileging practices and act as a valuable resource and educator with respect to best practices and the consequences associated with worse case scenarios. To protect the facility from a claim of negligent credentialing, the best defense is to design and maintain a sound credentialing process for both the initial appointment and any reappointment. The loss prevention and patient safety benefits of a thorough and exacting credentialing process far exceed the time and effort involved.

| Create Administrative Structure and Criteria for Credentialing and Privileging | |
|---|---|
| **Create structure and criteria** | • Understand that a comprehensive process begins with an administrative structure and criteria for granting membership and/or privileges.<br>• Clearly define the structure and criteria in written policies, procedures, and forms.<br>• Describe the organizations expectations for medical staff applicants in medical staff bylaws, rules, and regulations<br>• Consult with counsel regarding applicable law. |

## Create Administrative Structure and Criteria for Credentialing and Privileging

- Make clear the guidelines for processing applications and requests for privileges.
- Require medical staff services personnel to follow processes precisely, step-by-step.
- Have risk management professionals regularly review documents to ensure that they facilitate a bona fide and viable credentialing process which meet current legal, regulatory, and accreditation requirements.

## Meet Regulatory and Accreditation Requirements

**Meet requirements**

- Understand that hospitals must credential all licensed independent practitioners (LIPs), and other individuals who are permitted by law to provide healthcare services without direction or supervision.
- Be aware that all medical staff members are required by applicable standards to possess delineated clinical privileges that address the scope of patient care services the individual practitioner may independently provide in the hospital.
- Be aware that CMS and accreditation organizations require that medical staff members be appointed and reappointed to the medical staff and granted clinical privileges based on approval of the governing body.

## Understand the Roles and Responsibilities in the Credentialing/Privileging Process

**Understand roles and responsibilities**

- Be aware of what the governing body does, that it:
  - Determines whether to grant, deny, continue, revise, discontinue, limit, or revoke specified privileges, including medical staff membership, for a specific practitioner after considering the recommendation of the medical staff
  - Makes determinations consistent with established hospital medical staff criteria, as well as with state and federal laws and regulations

## Understand the Roles and Responsibilities in the Credentialing/Privileging Process

  - Is not bound by the recommendations of the medical staff executive committee in making a decision, but instead adheres to the bylaws and not be arbitrary, discriminatory, or capricious
  - Reflects any final action in the meeting minutes
- Understand that the role of the chief executive officer (CEO) is to ensure that the application and all of the documents reach the appropriate person(s) or groups at the appropriate time, as well as to notify the applicant, the department chair, and the medical staff executive committee of the governing body's final decision.
- Understand that the role of the medical staff executive committee is to make recommendations regarding medical staff membership directly to the governing body.[9]
- Be aware that a credentialing committee is not required, though for organizations that choose to have such a committee, it is generally responsible for:
  - Reviewing each completed application;
  - Addressing all concerns;
  - Making recommendations to the medical staff executive committee; and
  - Asking for additional information about the applicant or conduct an interview.
- Understand that the department chairperson:
  - Reviews the completed file;
  - Interviews the applicant;
  - May obtain additional information from outside sources;
  - Makes recommendations to the credentialing committee regarding membership and privileges;
  - Continues to surveil the professional performance of all department providers who have delineated clinical privileges;[10]

## Understand the Roles and Responsibilities in the Credentialing/Privileging Process

- Reporting findings to the credentials committee and medical staff executive committee on an ongoing basis and at time of reappointment.

- Be aware that the medical staff services office professional is responsible for processing and maintaining the credentialing files of all medical staff members, including:
  - Prescreening applicants;
  - Distributing applications;
  - Gathering and verifying data;
  - Preparing the file for review;
  - Updating files at reappointment;
  - Ensuring licensure and medical professional liability remain current; and
  - Monitoring access to files.[11, 12]

## Include Required Items in Medical Staff Bylaws

**Include these items**

- Follow The Joint Commission's list of items that must be included in the bylaws for accredited hospitals and critical access hospitals (CAHs), for hospitals only, and those required only for multi-hospital systems:
  - For hospitals and CAHs:
    - The structure of the medical staff;
    - Qualifications for appointment to the medical staff;
    - Process for privileging and re-privileging independent practitioners, which may include the process for privileging and re-privileging other practitioners;
    - A statement of the duties and privileges related to each category of the medical staff;
    - Requirements for completing and documenting medical histories and physical examinations - Medical history and physical examination are completed and documented by a physician or

## Include Required Items in Medical Staff Bylaws

other qualified licensed individual in accordance with state law and hospital policy; and

- Qualification, roles, and responsibilities of the department chair, as defined by the organized medical staff, if departments of the medical staff exist. Those should include the following:
  - Qualifications:
    - Certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process.
  - Roles and responsibilities:
    - Clinically-related activities of the department;
    - Administratively-related activities of the department, unless otherwise provided by the hospital;
    - Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;
    - Recommendations of criteria to the medical staff for clinical privileges that are relevant to the care provided in the department;
    - Recommendation of clinical privileges to each members of the department;
    - Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization;
    - Integration of the department or service into the primary functions of the organization;

## Include Required Items in Medical Staff Bylaws

- Coordination and integration of interdepartmental and intradepartmental services;
- Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;
- Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;
- Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;
- Continuous assessment and improvement of the quality of care, treatment, and services;
- Maintenance of quality control programs, as appropriate;
- Orientation and continuing education of all persons in the department or service; and
- Recommending space and other resources needed by the department or service.[18, 19]

- For hospitals only:
  - Indications for automatic suspension of a practitioner's medical staff membership or clinical privileges;
  - Indications for summary suspension of a practitioner's medical staff membership or clinical privileges;
  - Indications for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges;

## Include Required Items in Medical Staff Bylaws

- The process for automatic suspension of a practitioner's medical staff membership or clinical privileges;
- The process for summary suspensions of a practitioner's medical staff membership or clinical privileges;
- The process for recommending termination or suspension of medical staff membership and/or termination, suspension or reduction of clinical privileges;
- The fair hearing and appeal process (refer to The Joint Commission Standard MS.10.01.01) which at a minimum shall include:
  - The process for scheduling hearing and appeals, and
  - The process for conducting hearings and appeals.
- The composition of the fair hearing committee.[20]

- For multi-hospital systems, regardless the location of the instructions:
  - Responsibility for providing appointment/reappointment information (e.g., completed application forms, certifications, releases, peer recommendations) and complying with timelines established in the bylaws should reside with the applicant. An individual within the organization's medical staff office should be assigned the responsibility for coordinating this process and collecting, logging and maintaining such information in a file.[21]
  - Responsibility for verification of appointment/reappointment information from various licensure boards, professional liability carrier, references, etc., obtaining an AMA profile and querying the (National Practitioner Data Bank (NPDB) - This responsibility should be outlined in a policy and/or procedures and be addressed in the job description of the individual designated by

## Include Required Items in Medical Staff Bylaws

the organization to coordinate the credentialing process.

- A statement that appointment and reappointment to the medical staff and the granting, renewal, or revisions of clinical privileges are made for a period of not more than two years.[22]

## Follow Appropriate Steps for the Initial Appointment

**Follow these steps**

- Pre-screen the applicant.
  - This may involve using a pre-application form that solicits such information as address, education, training, licensure, board certification, amount of professional liability insurance, distance from home or office to the healthcare facility, and other membership requirements.
- Send application and verify content.
  - Send an organization-approved, standardized application form, privileging form, or whatever form is required.
  - Confirm that applicable standards/laws require an entity to make every effort to primary-source verify (i.e., obtain and verify a credential directly from the original issuing entity) all applicable elements.
    - Ensure applicants know they are responsible for contacting the primary source if the primary source is not responsive to material requests.
    - Understand that until it is verified at the primary source, the application remains incomplete.
    - Be aware that secondary sources (credential verification from another facility, copies of a credential verification, or confirmation from a source that verified the credential) may be used if a primary source no longer exists.
    - Understand that information from a credentials verification organization (CVO) may also be used and considered primary source verification if the CVO meets the following specific criteria:

## Follow Appropriate Steps for the Initial Appointment

- The CVO advises the user of the data and information it can provide.
- The CVO provides documentation on how its data collection, information development, and verification processes are performed.
- The user is provided sufficient and clear information on database functions, including limitations of information available (such as practitioners not included in the database), the time frame for responses to requests for information, and a summary of the quality control processes related to data integrity, security, transmission accuracy, and technical specifications.
- The user and CVO agree on the format for transmitting credentials information.
- Primary source data are easily discernible from data that are not from a primary source.
- For information transmitted by the agency that is date-sensitive (for example, licensure or board certification), the CVO provides the date the information was last updated from the primary source.
- The CVO certifies the accuracy of the information it obtains and transmits to the user.
- If additional primary source data are available but were not transmitted by the CVO, the CVO provides the user with information on how the data may be obtained.
- The CVO's quality control processes are available to the user, when necessary, to resolve concerns about transmission errors, inconsistencies, or other data issues that may be identified.
- The user and the CBO have entered into a formal agreement for communicating changes in credentialing information.[27]

## Follow Appropriate Steps for the Initial Appointment

- Consider using the National Association of Medical Staff Services (NAMSS) best practice standards regarding acceptable primary source verification to be used when credentialing an initial applicant.

1. ***Proof of Identity***
    a. Documents:
        i. Government-Issued photo identification.
        ii. National Provider Identification (NPI) number.
        iii. I-9 documentation listed as List A or List B or List C as defined on form.
        iv. VISA card or Employment Verification card.
    b. Primary source:
        i. Government-issued identification.
2. ***Education and Training***
    a. Documents:
        i. Complete list (domestic and foreign) of medical school, training programs, internship, residency, and fellowship enrollment and completion dates, as well as clinical degrees and other relevant experience in MM/YY format.
        ii. Completion status.
        iii. Explanation of any time gaps greater than 60 days.
        iv. Fifth Pathway certification, if applicable Educational Commission for Foreign Medical Graduates (ECFMG) validation.
    b. Primary Source
        i. May include but should not be limited to state regulation and applicable professional and training schools or residency training programs, National Student Clearinghouse, American Medical

Association (AMA) American Osteopathic Association (AOA), ECFMG, Federal State Medical Boards (FSMB), and state medical boards.

3. ***Military Service***
   a. Documents:
      i. DD214 if recently discharged (i.e., within the past 12 months).
      ii. If currently serving, a comprehensive list of military experience, including military branch and enlistment dates.
   b. Primary Source:
      i. DD214.
      ii. National Personnel Records Center (NPRC).
      iii. Verification from the applicable military branch.
      iv. Current duty station.
4. ***Professional Licensure***
   a. Documents:
      i. Complete list and/or all copies of all professional licensure including the issuing state, license type, license number, status, issue and expiration dates.
   b. Primary Source
      i. State licensing boards and FSMB.
5. ***Drug Enforcement Administration (DEA) Registration and State Department of Public Safety (DPS) and Controlled Dangerous Substances (CDS) Certifications***
   a. Documents:
      i. Complete list and/or copies of DEA, DPS, and/or CDS certificates including issuing

## Follow Appropriate Steps for the Initial Appointment

state, status, registration number, and issue and expiration dates.

b. Primary Source:

i. DEA, National Technical Information Service, state DPS, state CDS.

***6. Board Certification***

a. Documents:

i. Complete list and/or copies of all professional licensure including the issuing state, license type, license number, status, and issue and expiration dates.

b. Primary Source:

i. Directly from the board or display agent, such as American Board of Medical Specialties (ABMS), AMA, or AOA.

7. ***Affiliation and Work History***

a. Documents:

i. Chronological, comprehensive list of all facilities in which a practitioner has worked or held clinical privileges (e.g., academic appointment, hospitals, practice groups, surgery centers), including start date, date on staff, employment or staff status, verification of standing, and end date for at least the past five years for work history and five years for affiliation history – or as far back as necessary to resolve/address any conflicting information or suspicious indicators.

ii. Explanation of any gaps greater than 60 days.

b. Primary Source:

i. NAMSS PASS or verification from applicable facilities (NAMSS PASS is a secure, online database that provides quick, easy, and inexpensive access to the

## Follow Appropriate Steps for the Initial Appointment

affiliation history of practitioners and is the first and only universal resource for tracking practitioners' affiliation histories).

8. ***Criminal Disclosure Background***
    a. Documents
        i. Federal, state, and country databases.
    b. Primary Source:
        i. National, state, and county criminal databases (facility-approved government body vendor).
9. ***Sanctions Disclosure***
    a. Documents:
        i. Federal and state, if applicable.
    b. Primary Source:
        i. NPDB, Office of Inspector General (OIG), System for Award Management (SAM), FSMB.
10. ***Health Status***
    a. Documents:
        i. Verifying whether the applicant has or ever had any physical or mental condition that would affect his/her ability to practice.
    b. Primary Source:
        i. Applicant's attestation.
        ii. Practitioner's application.
        iii. Physical, if applicable.
11. ***National Practitioner Data Bank*** (***NPDB***)
    a. Documents:
        i. Database query.
    b. Primary Source:
        i. NPDB.

## Follow Appropriate Steps for the Initial Appointment

12. ***Malpractice Insurance***
    a. Documents:
        i. Comprehensive list of insurance carriers, including coverage dates and types.
        ii. List of open, pending, settled, closed, and dismissed cases.
        iii. Current certificate of insurance.
    b. Primary Source:
        i. Current and past malpractice carriers.
        ii. NPDB.
13. ***Professional and Peer References***
    a. Documents:
        i. Professional references noting current competence.
    b. Primary Source:
        i. Letter of form signed and dated from the professional reference.

- Obtain legally binding documents, along with the application, in which the applicant agrees to:
  - Attest to only requesting the privileges that he/she is competent to perform.
  - Adhere to established policies and regulations.
  - Authorize the organization to perform the credentialing and privileging verification process.
  - Release the organization and those who respond to verification queries from civil liability, provided that the processes are performed in good faith.[28]
- Pay attention to the following application issues closely:
  - Unexplained gaps in training or practice.

## Follow Appropriate Steps for the Initial Appointment

- Any inconsistencies between information on the application and information obtained from a source during the verification process.
- Loss of privileges or restriction at another organization.
- Short tenure at multiple organizations.
- Several lawsuits pending or settled.
- Previous history of alcohol or drug abuse.
- Active, past, or pending medical board action(s).
- Unanswered reference inquiries.
- Excessive professional liability claim history.
- Inadequate professional liability insurance coverage.[29, 30]

- Ensure department chairperson review.
  - The department chairperson reviews the completed file, interviews the applicant if appropriate, and obtains any needed additional information from outside sources.
  - The chairperson then makes a recommendation to the credentials committee regarding membership and privileges.
  - This recommendation may be made to the medical executive board if a credential committee is not in place.
- Ensure credentials committee review.
  - The credentials committee or its agent is responsible for reviewing each completed application.
  - The committee must address any concerns.
  - The committee then makes recommendations to the medical executive committee.
  - If additional information or an interview is needed, the committee may ask for this.
- Ensure medical staff executive committee review.

## Follow Appropriate Steps for the Initial Appointment

- The medical staff executive committee is to make recommendations directly to the governing body for each practitioner privileged.[31]

- Confirm governing body approval.
  - The governing body acts on the recommendation of the medical staff executive committee in granting/approving final decisions regarding appointment, reappointment, and the granting of privileges.
  - The governing body has final authority.[32]
  - The governing body is not bound by the recommendations of the medical staff executive committee in making a decision.
  - The decision must adhere to the bylaws, and cannot be arbitrary, discriminatory, or capricious.
  - The final decision should be reflected in meeting minutes.

## Establish Straightforward Policies and Procedures for Clinical Privileging

**Delineate clinical privileges**

- Understand that the medical staff bylaws provide for predefined professional criteria that are uniformly applied to all applicants for delineated clinical privileges.
- Recognize that each clinical department makes recommendations regarding professional criteria for clinical privileges that are hospital-specific and designed to ensure that patients will receive quality care.
- Consider utilization of one of the three basic models for delineating privileges:
  - Procedures and Conditions List – In this model, the delineated privileging form lists all the procedures that may be performed and conditions that may be treated within a specific department or specialty. The advantage of this method is that it is very specific about which privileges are requested and granted. The list may be very long and lack specific minimum eligibility criteria for each privilege. Also, applicants often simply select every item on the list without considering each privilege

## Establish Straightforward Policies and Procedures for Clinical Privileging

individually. Another challenge is keeping the list up to date with all the condition treated and procedures performed at the hospital.[36, 37]

- Practitioner Specialty Core Privileges – In this model, privileges for each specialty are grouped together and the applicant applies for all of the privileges in the group or "core." The core represents the procedures or conditions that the practitioner within the specialty or department should be competent to perform. A drawback of this system is that training programs are different, so everyone with the same specialty training may not have the competency to perform the same procedures and/or treat the same conditions. Also, this method may result in uncertainty regarding exactly which privileges are included in the core.[38, 39, 40]
- Combination of Core Privileges and Procedures List – In this model, the core privileges are determined for each specialty, along with a list of conditions that may be treated and/or procedures that may be performed.[41, 42] Minimum criteria are established for both the core privileges and each additionally listed privilege. The additional privileges are often referred to as "special" or "specific" privileges and include those procedures or treatments that require additional training, are high-risk and/or volume-sensitive, and/or may cross specialty lines.

**Establish policies and procedures**

- Distinguish between criteria for medical staff membership/appointment and the criteria for clinical privileges.
- Understand that criteria-based privileging assists organization in making objective decisions.
- Establish consistent methods to delineate clinical privileges collaboratively with medical staff department, the medical executive committee, and the governing body, as appropriate.
- Understand that the training and experience necessary to meet the established criteria need not be the same for all applicants for the same procedure, but need to be equivalent.

## Establish Straightforward Policies and Procedures for Clinical Privileging

**Use caution with new clinical privileges**

- Ensure that all practitioners performing the same privilege are held to the same standard of care.
- Take steps to ensure that providing the new service with meet community needs, the goals of the organizations, and the procedure may be performed safely.
- Ask the following questions before recommending a new service to the governing body:
  - Is this a procedure that the organization should offer to patients?
  - Are staffing resources available to support the procedure?
  - Will new equipment be needed?[43]
  - Will staff members require additional training to assist practitioners with the procedure?
  - Will practitioners require training prior to performing the procedure?
  - What amount of time will be required for training practitioners and what volume of procedures will constitute the requisite competency for privileges to be granted?[44]
  - Will the organization be reimbursed for the service?[45]
- Research current literature and collaborate with practitioners with clinical expertise in the specialty or new procedure being considered.
- Determine minimum training and experience that will be required for a practitioner to apply for a new privilege.
- Understand that only after the governing body has approved the new procedure or service and the minimum criteria to apply for the privilege have been developed may a provider apply for the privilege.
- Understand that if the provider applies for the privileges between credentialing periods, the applicable credentialing information gathering and verification regarding the new privilege must take place (e.g.,

## Establish Straightforward Policies and Procedures for Clinical Privileging

verification of training and experience for the new privilege).

- Be aware that the National Practitioner Data Bank (NPDB) must be queried whenever there is a request for additional privileges.[46]

## Monitor Providers with Focused Professional Practice Evaluations

**Use FPPE**

- Conduct FPPE on newly appointed providers.
- Understand that hospitals seeking accreditation from The Joint Commission are to utilize the monitoring process when there are questions or concerns regarding the performance of any provider with privilege.
- Limit review to privileges in question when the review is conducted on a provider not new to the organization.
- Ensure that the medical staff clearly defines the following:
  - Criteria for conducting FPPE;
  - Method for establishing a monitoring plan specific to as requested privilege;
  - Method for determining how long a provider will be monitored; and
  - Circumstances requiring external monitoring.[49]
- Ensure that professional evaluations are implemented consistently and documented completely and according to established criteria.
- Document the resolution of performance issues.

## Establish Comprehensive Processes for Medical Staff Reappointment

**Establish reappointment processes**

- Understand The Joint Commission requirements that reappointment to the medical staff and/or the granting of clinical privileges is to be performed at least every two years.[51]
- Send reappointment applications to providers up to six months in advance to allow enough time for the reappointment process.[52]

## Establish Comprehensive Processes for Medical Staff Reappointment

- Ensure that the reappointment application requests the following information:
  - Current licensure and past and pending challenges to licensure, including voluntary/involuntary relinquishment;[53]
  - DEA/state registration;
  - Past (two years) and pending malpractice history (including claims, suits, notices of intent, and settlements);
  - Professional liability coverage and policy limits;
  - Past (two years) and pending challenges to medical staff membership/privileges at other healthcare facilities, including voluntary/involuntary relinquishments;[54]
  - Healthcare-related employment history (generally two years), including terminations, challenges or decisions pending, and voluntary resignations and relinquishments;
  - Evidence of continuing medical education (CME), including but not limited to:[55]
    - Obtaining copies of program certificates
    - Obtaining a copy of the information submitted with a license renewal application when CMEs are required by the state
    - Obtaining an attestation statement from the licensed independent practitioner which attests to his/her attendance at CME programs that relate to their area of practice, with the stipulation that proof of attendance and program content will be submitted upon request
  - Office of Inspector General (OIG) sanctions (review of OIG exclusions list, NPDB, or AMA Physician Masterfile with Medicare/Medicaid sanctions);
  - NPDB query;[56]

## Establish Comprehensive Processes for Medical Staff Reappointment

- Specialty board status and/or recertification (if applicable); and
- The applicant's health status.[57]

- Collect information about new training, education, and experience if the applicant is requesting new privileges.
- Verify the following items with the primary source:
  - Current licenses;
  - DEA registration;
  - Malpractice liability coverage and claims history;
  - Specialty board status;
  - OIG sanctions; and
  - NPDB report.
- Organizations should consult with counsel regarding any applicable state-specific requirements that may affect their reappointment process.

## Conduct Ongoing Professional Practice Evaluations

**Conduct ongoing evaluations**

- Continuously monitor and evaluate practitioner performance.
- Document and store OPPE information in the medical staff office in the individual provider's confidential quality file.
- Consider using the six general areas of competency recognized by the American College of Graduate Medical Education (ACGME) and recommended by The Joint Commission to evaluate practitioners:
  - Patient care: appropriate, effective, and compassionate;
  - Medical/clinical knowledge: current and evolving biomedical, clinical and social sciences;
  - Practice-based learning and improvement: use of scientific evidence and methods to investigate, evaluate, and improve patient care practices;

## Conduct Ongoing Professional Practice Evaluations

- Interpersonal and communication skills: professional relationships with patients, family members, and other members of the healthcare team;
- Professionalism: sensitivity to diversity; responsibility towards patients, the professional, and society; professional development; ethical practice; and
- Systems-based practice: understanding of healthcare systems applied to improve and optimize healthcare.[65]

- Use the following to assist in implementation of the six areas of competencies:
  - Classify current physician performance data according to the competency categories by correlating the six areas of general competencies with each of the data elements.
  - Identify which general competencies are not currently evaluated or measured.
  - Ensure that the following quality data are consistently reviewed:
    - Use of medications and blood;
    - Procedures performed;
    - Medical assessment, treatment of patients, and coordination of care;
    - Clinical practice patterns and variation from established clinical practice;
    - Patient education;
    - Medical record completion;
    - Patient safety data;
    - Sentinel events;
    - Autopsies; and
    - Peer review results.
  - Include the following in the data collection:
    - Activity and utilization data;
    - Core measure data;
    - Hospital-acquired conditions data;

## Conduct Ongoing Professional Practice Evaluations

- Patient complaints and compliments; and
- Incident reports and occurrence screens.

- Eliminate the measure if collected data are no longer valuable.
- Consider data element that is currently collected and ask the following:
  - Is this required by regulatory or accreditation standards to collect the data?
  - If not, do the data identify opportunities for improvement?
  - Are the data needed to track progress on new patient safety initiatives?
  - Are the data needed to maintain process reliability through periodic quality audits?[66]

- Evaluate physicians not only for technical care, for also for:
  - Quality of service and observance of patient safety practices;
  - Observance and advancement of patient rights;
  - Citizenship and peer and coworker relationships; and
  - Appropriate use of facility resources.[67]
- Have each department or service determine which data will be collected on providers with privileges in that department.
- Collect data through periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, and discussions with other staff members involved in the care of the provider's patients.[68]

**Conduct peer review**

- Recognize that The Joint Commission calls for a peer recommendation for reappointment of membership and privileges.
- Ensure that the peer reference is provided by a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice.

## Conduct Ongoing Professional Practice Evaluations

- Address the following competencies through the peer recommendation:
  - Medical and clinical knowledge;
  - Technical and clinical skills;
  - Clinical judgment;
  - Interpersonal skills;
  - Communication skills; and
  - Professionalism.[69]
- Ensure that the department chairperson considers and reviews OPPE information prior to making peer recommendation to credentials committee.
- Make OPPE information available to the credentials committee, the medical executive committee, and the governing body during the reappointment process.

**Address performance concerns**

- Implement the FPPE process if performance concerns are identified in the OPPE process.
- Understand that it is no longer advisable or acceptable to review practitioner performance every two years just prior to reappointment, because this does not allow time for correction prior to making the reappointment decision.
- Be aware that OPPE outcomes should be reviewed by the medical staff on an ongoing basis, but for a period of no more than eight months.[70]
- Give provider the opportunity to review his or her own data and provide feedback on any discrepancies so that the data may be corrected, as indicated, before reviewing by the provider's chief.[71]

**Consider additional information**

- Consider the following in the reappointment decision-making process:
  - Results of aggregated peer review data/activities and volume since last date of appointment/reappointment;
  - Summary report of results of internal quality assurance monitoring;

## Conduct Ongoing Professional Practice Evaluations

- Summary report of external quality membership at other facilities with which the applicant is affiliated;
- Discharge of professional obligations/responsibilities of medical staff membership; and
- Utilization management data/information.

## Utilize Expedited Appointment and Reappointment Process if Appropriate

**Consider expedited process**

- Ensure that the medical staff develops criteria for the expedited privileging process.
- Be certain that it is explained that the applicant loses eligibility for an expedited process if the submitted application is incomplete or the final recommendation of the medical staff executive committee is adverse or has limitations.[73]
- Evaluate the following situations on a case by case basis, as they will usually result in ineligibility for the expedited process:
  - A current challenge or a previously successful challenge to licensure or registration;
  - An involuntary termination of medical staff membership at another hospital;
  - Involuntary limitation, reduction, denial or loss of clinical privileges; and
  - Hospital determination that the applicant has exhibited an unusual pattern or excessive number of professional liability actions resulting in a final judgment against the applicant.[74]

**Understand expedited process**

- Understand that the completed application may be reviewed by the department chairperson and credentials committee chairperson at the same time.
- Recognize that the organization's policies can also state that the credentials committee does not need to review the application if the department chairperson finds no problems.
- Understand that the next step is for the medical executive committee or designee of the committee to review the

## Utilize Expedited Appointment and Reappointment Process if Appropriate

application and forward its recommendation to the governing body.

- Ensure that the policy directs whether the application is then reviewed by the governing body or an authorized subcommittee of the governing body.[75, 76]

## Create Policies for Temporary, Emergency, Disaster and Telemedicine Privileges

**Create policies**

- Understand that temporary privileges may be granted for a limited period of time, in the following circumstances:
  - To fulfill an important patient care need for a time period specified in the bylaws (verification of current licensure and current competence required), and
  - When a new applicant is awaiting review and approval of the medical staff, upon verification of the following:[77]
    - Current licensure;
    - Relevant training and experience;
    - Current competence;
    - Ability to perform the privileges requested;
    - Other criteria required by the organized medical staff bylaws;
    - A query and evaluation of the National Practitioner Data Bank (NPDB) information;
    - A complete application;
    - No current or previously successful challenge to licensure of registration;
    - No subjection to involuntary termination of medical staff membership at another organization; and
    - No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.[78]
- Understand that all temporary privileges are granted by the CEO or authorized designee upon the recommendation of the medical staff president or authorized designee and are not to exceed 120 days.

## Create Policies for Temporary, Emergency, Disaster and Telemedicine Privileges

- Understand that medical staff bylaws may stipulate that any medical staff member with clinical privileges can be granted emergency privileges in order to provide any type of patient care, treatment, and services necessary as a life-saving measure or to prevent serious harm.
- Understand that the care, treatment, and services provided must still be within the scope of the individual's license.[79]
- Recognize that disaster privileges may be granted in response to a disaster situation, provided that:
  - The organization's emergencies operations plan has been activated, and
  - The organization is unable to meet the immediate care needs of patients.
- Ensure that a modified, streamlined credentialing and privileging process for eligible volunteer practitioners is in place.
- Be aware that The Joint Commission allows for hospitals to identify (in the medical staff bylaws) those individuals who have a responsibility for granting disaster privileges to licensed independent practitioners who volunteer.[80]
- Recognize that the disaster privileging process must address the following to ensure safe patient care and compliance with The Joint Commission's standards:
  - A mechanism for the medical staff to oversee the professional performance of individuals who have been granted disaster privileges (e.g., direct observation, mentoring, or medical record review);
  - A system for distinguishing volunteer practitioners from other practitioners (e.g., identification cards, wristbands, vests, hats, or badges);
  - A requirement that before a volunteer practitioner is considered eligible for disaster privileges, they present a valid government-issued photo identification (e.g., a driver's license or passport) and at least one of the following:

## Create Policies for Temporary, Emergency, Disaster and Telemedicine Privileges

- A current picture ID card from a healthcare organization that clearly identifies the person's professional designation (e.g., MD, DO);
- A current license to practice;
- Primary source verification of the license;
- Identification that indicated the individual is a member of the Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP), or another recognized state or federal organization or group;
- Identification that the individual has been granted authority to render patient care in disaster circumstances by governmental entity; and
- Verification of individual practitioner's identity by a current hospital or medical staff member with personal knowledge by that individual.[81]

  - Ensure that primary source verification of licensure begins as soon as the disaster is under control and is completed within 72 hours from the time the volunteer practitioner presents to the organization, if possible.
  - Ensure that a decision on the continuation of the disaster privileges is made by the organization.

- Please see the ***Telemedicine*** chapter for information regarding telemedicine credentialing and privileging.

## Develop Clear Practitioner Categories for Non-Physician Providers

**Develop clear practitioner categories**

- Develop clear practitioner categories, such as licensed independent practitioners and dependent practitioners.
- Understand these categories will determine whether the practitioner should follow the medical staff credentialing process or be managed by the human resources process.
- Understand that all licensed independent practitioners are credentialed and privileged by the organized medical staff.

## Develop Clear Practitioner Categories for Non-Physician Providers

- Be aware that a human resource process still needs to be equivalent to the medical staff process and use the same criteria.

**Conduct appropriate supervision**

- Ensure that the medical staff has a defined supervision process in place for program participants, such as residents and medical students, if the hospital has a professional graduate education program.
  - This is required by The Joint Commission.
  - Participants must be monitored by a licensed independent practitioner with the appropriate privileges.[83]
- Be certain that the roles and responsibilities of all participants in the graduate education program are delineated with written descriptions.
- Include a description of how the director of the program makes decisions about each student's progressive independence in patient care activities.[84]
- Be aware that teaching hospitals not accredited by The Joint Commission may choose to address the roles and limitations of residents though contracts or their credentialing process.[85]

## Manage Credentialing Files Appropriately

**Manage files**

- Maintain a separate credentialing file for each individual requesting medical staff membership and privileges.
- Outline how the file is to be organized and prepared for medical staff review within policies and procedures.
- Do not act upon an application until all of the information has been collected, verified, and assessed.
- Recognize that medical staff bylaws specify the reasonable period of time within which the complete applications must be acted upon.
- Segregate peer/professional review data and quality findings from information not covered by peer review

## Manage Credentialing Files Appropriately

protection (e.g., copies of licenses) into clearly marked section of the credentials file or in a separate file.

**Be secure**

- Be aware that credentialing files may be maintained in their original form, in scanned form, or other electronic storage media.
- Maintain credentialing files under lock and key in the medical staff services office.
- Ensure that authorized reviews of any credentialing file are still supervised by appropriate medical staff services office personnel.
- Keep records of requests made for and access granted to credentialing records.
- Protect electronically stored records with passwords and read/write controls.
- Limit access to files to the following persons to the extent necessary to perform official functions:
  - Designated office staff members processing credentialing information
  - Department head/service chief/division head
  - Medical staff officers
  - Medical staff committee members
  - Chief executive officer (CEO)
  - Members of the governing body or designated representative
  - Hospital surveyors (accreditation or regulatory agencies):
    - The review must be under the supervision of a hospital staff member
    - The original or copies may not be taken
    - The surveyor
  - Other persons, only as authorized by the medical executive committee, its designated representative, or the CEO[86]

## Manage Credentialing Files Appropriately

- Understand that a practitioner may review his/her own file, under the following conditions:
  - The request is approved by the CEO, department chair, president of the medical staff, or the credentials committee chairperson;
  - The review is accomplished in the presence of the medical staff coordinator, a member of the credentials committee, or an officer of the staff;
  - The physician understands that nothing may be removed from the credentialing file;
  - Nothing may be photocopied without permission of the CEO;
  - An explanation note or document may be added to the file; and
  - Confidential reference letters received during initial appointment or at reappointment may NOT be reviewed.

**Sample tools**

- ***Clinical Privileges Delineation Policy – SAMPLE***,
- ***Credentialing, Privileging and Peer Review Self-Evaluation – SAMPLE***,
- ***Department of Medicine Delineation of Privileges Form – SAMPLE***,
- ***Department of Obstetrics and Gynecology Delineation of Privileges Form – SAMPLE***,
- ***Expedited Appointment and Reappointment Process Policy – SAMPLE***,
- ***Focused Professional Practice Evaluation Checklist – SAMPLE***,
- ***Focused Professional Practice Evaluation Form – SAMPLE***,
- ***Focused Professional Practice Evaluation Policy – SAMPLE***,
- ***Medical Staff Appointment Checklist – SAMPLE***,
- ***Medical Staff Credentialing Files Policy – SAMPLE***,
- ***Medical Staff Credentialing and Initial Appointment Policy – SAMPLE***,
- ***MSC Reappointment and Renewal of Privileges Policy-SAMPLE***,

## Manage Credentialing Files Appropriately

- *Medical Staff Services Professional Policy – SAMPLE*,
- *New Appointee FPPE Completion Letter – SAMPLE*,
- *New Appointee FPPE Letter – SAMPLE*,
- *New Appointee FPPE Plan – General Surgery Form – SAMPLE*,
- *New Appointee FPPE Plan – OB-GYN Form – SAMPLE*,
- *New Appointee FPPE Status Letter – SAMPLE*,
- *New Privilege FPPE Conclusion Letter – SAMPLE*,
- *New Privilege FPPE Status Letter – SAMPLE*,
- *New Privileges for Credentialed Practitioners FPPE Worksheet – SAMPLE*,
- *New Privileges FPPE Letter – SAMPLE*,
- *New Privileges FPPE Request for Information Letter – SAMPLE*,
- *Notification of Reappointment and Renewal of Privileges Letter – SAMPLE*,
- *OPPE Indicators for Cardiothoracic Surgery – SAMPLE*,
- *OPPE Indicators for Gastroenterology – SAMPLE*,
- *Ongoing Professional Practice Evaluation Policy – SAMPLE*,
- *OPPE Report Card – OB-GYN Form – SAMPLE*,
- *OPPE - Surgery PA – SAMPLE*,
- *Professional Reference Questionnaire – SAMPLE*,
- *Querying the National Practitioner Data Bank – SAMPLE*,
- *Questionnaire Pertaining to Reappointment of Practitioner – SAMPLE*,
- *Reporting to the National Practitioner Data Bank Policy – SAMPLE*,
- *Requesting Additional Information Form – SAMPLE*,
- *Temporary Privileges Application Checklist – SAMPLE*,
- *Temporary Privileges Memorandum – SAMPLE*,
- *Temporary Privileges Policy – SAMPLE*,
- *Verification of Board Certification Form – SAMPLE*,
- *Verification of Insurance and Claims History Form – SAMPLE*,

## Manage Credentialing Files Appropriately

- ***Verification of Internship-Residency-Fellowship Form – SAMPLE***,
- ***Verification of Medical Staff Affiliation and Clinical References Form – SAMPLE***, and
- ***Verifying Credentialing Information Policy – SAMPLE*** are available in the Healthcare Facility Tool Chest on the Risk Management Policyholder Resources Portal.

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