

Thank you for your interest in medical staff membership at Texas Health Presbyterian Rockwall (PHR). Enclosed is an initial appointment application for Medical staff membership and Privileges.

****Applicants applying for medical staff membership and / or clinical privileges must meet board certification and eligibility requirements that are defined by each discipline within their respective departments and approved by the Medical Executive Committee and Governing Board. Board certification is required within five (5) years after application, with exception for practitioners with twenty-five years or greater in same specialty with evidence of ongoing education and competency in said specialty. ****

CHECKLIST OF REQUIRED DOCUMENTATION FOR MEDICAL STAFF APPLICANTS TO RETURN

1. Completed Texas Standard Credentialing Application (TSCA) Application

- The application can be downloaded from the Texas Department of Insurance site (<http://www.tdi.state.tx.us/company/hmoqual/crform.html>).
- The current version of the TSCA must be submitted (TDI Rev. 01/07)
- The release must be signed & dated within the past 12 months.
- For any affirmative responses in Section II 'Disclosure Questions', please provide a detailed explanation and appropriate supporting documentation.
- The names and full contact information for 3 peer references must be provided (pages 4-5 on TSCA). Please NOTE the requirements listed below for acceptable peer references.

References must from individuals other than family or affiliated by marriage who must have personal knowledge of the applicant's recent professional performance, ethical character, current competence, health status (subject to any necessary reasonable accommodation to the extent required by law), and the ability to work cooperatively with others. The peers do not have to be of the same specialty, but should hold the same or higher degree of study. The peers must have observation of the practitioner within the past 3 years.

2. Completed Hospital Addendum

- Pages 2-11 must be returned.
- Attach a recent photo attached to page 3 of the Hospital addendum (i.e. passport photo or Polaroid)
- Signed Compliance Training Acknowledgement

3. Completed Privileges Form

- Provide case logs and/or training evidence as necessary for requested advanced procedures. Please note that advanced procedures will NOT be considered if the appropriate documentation for training and current case logs is not provided.

4. Curriculum Vitae

5. Current Copies of the following documents:

- Texas State License
- DEA
- DPS
- Education (degree, internship / residency, fellowship)
- PPD Test Result (Copy of skin test read or chest x-ray; If skin test, must have been read within past 12 months)
- Board certification (if applicable)
- ACLS/PALS/NRP card (if applicable)
- Malpractice liability insurance face sheet (\$100,000 / \$300,000 minimum liability coverage)

6. Copy of TX Drivers License / TX I.D. or Military I.D.

7. \$250.00 Application Fee for Active or Courtesy Staff // \$150.00 Application Fee for Community Staff (non-refundable)

**Please return your completed application packet to—
Medical Staff Office
Texas Health Presbyterian Hospital Rockwall
3150 Horizon Road
Rockwall, TX 75032**

Questions? Please contact Medical Staff Services at (469) 698-1572 or Alice.Willis@phrtexas.com

DEPARTMENT & STATUS REQUESTED

DEPARTMENT (PLEASE ✓):

STATUS (PLEASE ✓):

MEDICINE

- Allergy & Immunology
- Cardiology
- Dermatology
- Family Practice
- Emergency Medicine
- Endocrinology
- Gastroenterology
- Hematology / Oncology
- Rheumatology

Active *

- Infectious Disease
- Internal Medicine
- Nephrology
- Neurology
- Pediatrics
- Pulmonary
- Psychiatry
- Physical Medicine and Rehab
- Radiology

Courtesy **

Community ***

SURGERY

- Anesthesiology
- Cardio / Thoracic
- General Surgery
- Neurosurgery
- Obstetrics / Gynecology
- Ophthalmology
- Oral & Maxillofacial Surgery
- Orthopaedic Surgery
- Vascular Surgery

Active *

- Otolaryngology
- Pain Management
- Pathology
- Plastics and Hand
- Podiatric Surgery
- Spine Surgery
- Urology

Courtesy**

Community ***

NOTES:

* **ACTIVE:** REQUIRED TO TAKE EMERGENCY DEPARTMENT CALL AS DEFINED BY THE DEPARTMENT and consists of practitioners who regularly admit, or personally provide services other than written consultation, to patients in the hospital (which shall mean no fewer than twenty-four(24) admissions or in-hospital contacts where services are personally provided per calendar year) and who are located (primary or satellite office and temporary or permanent residence) within a reasonable distance, but no greater travel time of sixty (60) minutes, to the hospital in order to provide continuous care to their patients.

** **COURTESY:** Consists of practitioners who are located (primary or satellite office and temporary or permanent residence) within a reasonable distance and / or travel time of sixty (60) minutes to the hospital to provide continuous care for their patients. Courtesy staff members shall be members of the active or associate staff of another hospital in which their regular participation in quality / performance management activities is documented and their performance is evaluated. Courtesy staff applicants and members shall provide satisfactory evidence to the Credentials Committee of such membership, participation, and evaluation. Courtesy staff members are not eligible to vote on medical staff or departmental matters, or hold medical staff office. They may serve as voting members of designated departmental and hospital committees in which they may participate, except for the Credentials Committee and Medical Executive Committee. They shall not be required to attend medical staff meetings. At times of shortage of hospital beds or other facilities as determined by the Chief Executive Officer the elective patient admissions of courtesy staff shall be subordinate to those of active staff members.

*** **COMMUNITY MEDICAL STAFF** --The Community Medical Staff category shall consist of practitioners from the community who are not active in the Hospital but who have been credentialed by the Hospital. These practitioners are still actively practicing in the community but do not require clinical privileges at the Hospital. These practitioners are not eligible to admit, discharge or attend patients in the hospital or to write any patient orders or make notes in the patient's medical record but may, with the consent of the patient, view the medical records and the care being provided for the patient by the attending/consulting physician of his or her patients. They are not eligible to vote on Medical Staff matters, hold Medical Staff or department office, nor serve on committees, unless they are requested to do so. They must discharge the basic responsibilities of all Medical Staff members, abide by all policies, Bylaws, Rules and Regulations including confidentiality provisions and uphold the ethical principles of their profession. They may attend general staff or department meetings, including open committee meetings and educational programs that may be offered to the Medical Staff membership.

(Attach recent wallet size photo)

HOSPITAL ADDENDUM TO THE TEXAS DEPARTMENT OF INSURANCE (TDI) STANDARDIZED CREDENTIALING APPLICATION

This form and any and all attachments thereto are privileged and confidential peer review communications prepared at the discretion of the Governing Board for medical peer review purposes under the authority granted to the Governing Board in the Medical Staff Bylaws and related documents and under the state and federal laws that make such communications confidential. The voluntary disclosure of this document or any information contained therein to any third party who is not a party to the committee proceedings, other than to counsel, is strictly prohibited.

SECTION ONE - PERSONAL INFORMATION

LAST NAME:	FIRST NAME:	SPECIALTY:
CELLULAR: _____ / _____ / _____	<u>PREFERRED METHOD OF CONTACT</u>	
PAGER: _____ / _____ / _____	<i>(please ✓)</i> <u>PRIMARY</u> <input type="checkbox"/> PAGER <input type="checkbox"/> CELL PHONE <input type="checkbox"/> OFFICE	<u>SECONDARY</u> <input type="checkbox"/> PAGER <input type="checkbox"/> CELL PHONE <input type="checkbox"/> OFFICE
	<u>TERTIARY</u> <input type="checkbox"/> PAGER <input type="checkbox"/> CELL PHONE <input type="checkbox"/> OFFICE	

HEALTH STATUS

(Please ✓ one answer to each question below. Indicate comments as necessary in comment section):

What is your recent health status? GOOD FAIR POOR

Do you have any mental and / or physical health problems that would affect your clinical judgment and / or motor skills? Yes No

Are you taking any medications that would affect your clinical judgment and / or motor skills? Yes No

Are you aware of any alcohol and / or drug dependency by the applicant? Yes No

Comments:

TUBERCULIN (PPD) TEST RESULTS:

PLEASE ATTACH A COPY OF THE TEST RESULT – (TO INCLUDE CXR IF APPLICABLE.)

Date of Last PPD Test (MM/DD/YYYY): MUST BE WITHIN THE LAST 12 MONTHS. ____/____/____

Results of Tuberculin (PPD) Test? Positive Negative If positive, was x-ray taken: Yes No

PHYSICIAN INITIALS: []

CONTINUING MEDICAL EDUCATION

1. Have you met the minimum continuing medical education requirements for renewal of your license in the past two years
 Yes No

2. Please list or attach a list of the CME credits attained relative to your specialty during the past two years.

PROGRAM TITLE	DATES ATTENDED	CREDIT HOURS/CATEGORY

PHYSICIAN INITIALS: []

APPLICATION ACKNOWLEDGEMENT

I acknowledge that the information given in or attached to this addendum is complete, accurate and fairly represents the current level of my training, experience, capability and competency to exercise the clinical privileges requested. I understand and agree that as a condition to making this application, any misrepresentation or misstatement in, or omission from, this application, whether intentional or not, shall be grounds to deny or discontinue processing and will not entitle applicant to a fair hearing.

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

PHYSICIAN APPLICANT NAME (PLEASE PRINT)

PHYSICIAN INITIALS

PHYSICIAN SIGNATURE

_____/_____/_____
DATE

PHYSICIAN BACKGROUND VERIFICATION AUTHORIZATION

As a provider of medical services, Presbyterian Hospital of Rockwall requests your permission to conduct an investigation on your background which may include procurement of information regarding your state licensure, medical education, residencies, malpractice history, criminal history, employment history and background. As part of its investigation, PHR may obtain consumer reports from consumer reporting agencies. Under the Fair Credit Reporting Act (FCRA), PHR is required to obtain your written authorization prior to procuring such consumer reports. Please indicate your consent by signing below.

Please note: Credit histories are not part of the background check performed on physicians. The term “consumer report” applies to any type of information collected and compiled by a third party, but in this case, does not and will not include credit histories.

I, _____, hereby authorize Presbyterian Hospital of Rockwall to conduct an investigation, as necessary, of my state licensure, medical education, residencies, malpractice history, criminal history, employment history and background, which may include, but may not be limited to, procuring consumer reports from consumer reporting agencies.

PHYSICIAN APPLICANT NAME (PLEASE PRINT)

PHYSICIAN SIGNATURE

_____/_____/_____
DATE

MEDICAL STAFF CALL COVERAGE AGREEMENT

I hereby agree to provide call coverage for the following practitioner when he / she is not available:

PRACTITIONER NAME: _____

SPECIALTY: _____ **STAFF CATEGORY:** _____

I further certify that I am a member of the Presbyterian Hospital of Rockwall medical staff, and that I hold the same privileges in the same specialty as the practitioner for whom I am providing coverage.

I understand that in agreeing to provide call coverage, I will be responsible for the practitioner's Emergency Department call when he / she is not available.

PHYSICIAN INITIALS: []

MEDICAL STAFF CALL COVERAGE ATTESTATION

I hereby attest that the practitioner(s) listed below will provide call coverage for me when I am not available.* I further attest that the practitioner(s) is a member of the Presbyterian Hospital of Rockwall medical staff and holds identical privileges in the same specialty:

NAME (PLEASE PRINT)	NAME (PLEASE PRINT)
SPECIALTY (PLEASE PRINT)	SPECIALTY (PLEASE PRINT)
NAME (PLEASE PRINT)	NAME (PLEASE PRINT)
SPECIALTY (PLEASE PRINT)	SPECIALTY (PLEASE PRINT)

* A minimum of one (1) practitioner's name must be listed.

 PHYSICIAN APPLICANT NAME (PLEASE PRINT)

 PHYSICIAN INITIALS

 PHYSICIAN SIGNATURE

_____/_____/_____
 DATE



CENTERS FOR MEDICARE / MEDICAID ATTESTATION

As a prerequisite for submission of claims to Medicare, Medicaid and Champus, all hospitals are required to have on file a current, signed acknowledgement statement from the attending physician indicating the physician has received the notice below:

“Notice to all Physicians: Medicare, Medicaid and Champus payments to hospitals are based in part on each patient’s principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal or state funds, may be subject to fine, imprisonment or civil penalty under applicable federal or state laws”

All PRESBYTERIAN HOSPITAL OF ROCKWALL physicians with privileges are required to acknowledge receipt of the above-noted statement by signing this form. Please return this form to Medical Staff Services.

Each physician must sign the acknowledgement statement using his or her legal signature.

Initials are not acceptable.

PHYSICIAN APPLICANT NAME (PLEASE PRINT)

PHYSICIAN SIGNATURE (AS SIGNED ON PHYSICIAN ORDERS)

_____/_____/_____
DATE

**POLICY: MANAGEMENT OF THE DISRUPTIVE PRACTITIONER
ACKNOWLEDGMENT**

I have received and read a copy of the policy regarding management of the disruptive practitioner and agree to abide by this policy at all times.

(Note: Presence of this signed statement in the Practitioner's Medical Staff credentials file is required prior to any favorable action by the Governing Body on the Practitioner's application or re-application.)

PHYSICIAN INITIALS: []

MEDICAL STAFF
BYLAW AND RULES & REGULATIONS ACKNOWLEDGMENT

I have received and read a copy of the Presbyterian Hospital of Rockwall Bylaw and Rules & Regulations and agree to abide by the Bylaws and Rules & Regulations at all times.

(Note: Presence of this signed statement in the Practitioner's Medical Staff credentials file is required prior to any action by the Governing Body on the Practitioner's application or re-application.)

PHYSICIAN INITIALS: []

ELECTRONIC PATIENT RECORD SYSTEM (EPRS)
CONFIDENTIALITY STATEMENT

By signing below I acknowledge and understand:

The information contained in the medical record imaging system is considered part of the medical record, is confidential and must not be discussed with anyone. Of necessity, I am exposed to privileged information daily and it is my duty to protect this information. Therefore, I will not discuss information contained in the system or the medical record with anyone except in the course of completion of work and I will not give anyone access to the security level assigned to me by the system administrator. This shall include other practitioners, employees of the hospital, or anyone outside the hospital. I understand that breach of this policy regarding confidentiality is grounds for immediate suspension of my privileges.

PHYSICIAN INITIALS: [] _____

ELECTRONIC SIGNATURE NOTIFICATION

This is to inform you of my intent to electronically authenticate transcribed interpretations of dictated reports, as well as any entries, written orders, or instructions through the use of a unique, confidential PIN number assigned specifically to me.

I am the only person to whom this code is assigned. Thus I am responsible for all entries that I record into the computer system. I will neither delegate my assigned code to any other person, nor allow any other person to use it for authentication of such transcribed reports or entries.

PHYSICIAN INITIALS: [] _____

UPIN/ NPI NUMBER

Please list your **UPIN & NPI NUMBER** below. Our hospital computer system requires these numbers to be on file.

PHYSICIAN INITIALS: [] **UPIN NUMBER:** **NPI NUMBER:** _____



HEALTH INFORMATION MANAGEMENT

The Texas Department of Health and Human Services requires the following:

“The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.”

To ensure compliance, Health Information Management must have your signature and initials on file.

Please print your name and provide your signature and initials below.

Thank you very much for your cooperation.

PHYSICIAN APPLICANT NAME (PLEASE PRINT)

PHYSICIAN INITIALS

PHYSICIAN SIGNATURE (AS SIGNED ON PHYSICIAN ORDERS)

_____/_____/_____
DATE



DEA CERTIFICATE

Presbyterian Hospital of Rockwall requires physician DEA numbers and signatures on record in the Pharmacy. This is in compliance with State and Federal regulations for dispensing controlled substance orders to inpatients, outpatients, and emergency room patients.

Please complete the information below and return with your application packet.

PRINTED NAME

PHYSICIAN APPLICANT NAME (AS SIGNED ON ORDERS)

**DEA REGISTRATION NUMBER
(NUMBER ON DEA REGISTRATION FORM)**

**EXPIRATION DATE OF DEA REGISTRATION
(AS LISTED ON REGISTRATION FORM)**

This form will be forwarded to the Pharmacy for their records.

MANAGEMENT OF THE DISRUPTIVE PRACTITIONER

I. POLICY

It is the policy of Presbyterian Hospital of Rockwall ("Hospital") that all individuals within its facility be treated courteously, respectfully, and with dignity. To that end, the hospital requires all individuals, employees, physicians and other independent practitioners to conduct themselves in a professional and cooperative manner in the hospital.

Hospital is committed to providing a work environment that is free of discrimination and unlawful harassment. Inappropriate actions, words, jokes, or comments based on an individual's sex, race, ethnicity, age, religion, sexual orientation or any other legally protected characteristic will not be tolerated. As an example, sexual harassment (both overt and subtle) is a form of misconduct that is demeaning to another person, undermines the integrity of the professional relationship, and is strictly prohibited.

It is the policy of the Medical Staff of the Hospital that no Medical Staff member or other independent practitioner with Medical Staff clinical privileges engages in disruptive behavior, discrimination or harassment. Failure to abide by this policy may be the basis for corrective action in accordance with the Medical Staff Bylaws or for appropriate administrative intervention and action.

II. DEFINITIONS

A. Discriminatory Behavior

Discriminatory Behavior is considered an act or omission that is based in prejudice or bias and which is detrimental to another individual. Discrimination by a Medical Staff member against any individual (e.g., against another Medical Staff member, hospital employee, patient or visitor) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, marital status, sex, gender or sexual orientation shall not be tolerated.

B. Disruptive Behavior

Disruptive Behavior is any inappropriate and / or abusive behavior that may disrupt hospital operations, create a hostile or dangerous work environment, or which may negatively impact patient care. Disruptive Behavior includes, but is not limited to:

1. Verbal abuse of any individual;
2. Verbal abuse which is directed toward a group at-large, but would reasonably be perceived by a member of that group to be offensive;
 - a. unjustifiable delay of the progress of any diagnostic or therapeutic procedures to inappropriately reprimand nurses or staff;

MANAGEMENT OF THE DISRUPTIVE PRACTITIONER (CONTINUED)

DEFINITIONS (continued)

- b. throwing, tossing, flinging, or slamming down any equipment, instruments, records, or any other materials;
- c. making bad faith, false accusations of unprofessional behavior against any individual;
- d. any behavior which is a violation of State and Federal laws and regulations, or hospital or Medical Staff policy, rules, and regulations;
- e. any other aberrant behavior which may reasonably appear to compromise quality of care, either directly or indirectly, because it may disrupt hospital operations; or which may interfere or be inconsistent with a reasonable and safe working environment.

C. Harassment

Harassment is repeated offensive conduct that is sufficiently severe and pervasive to create an abusive working environment. Harassment includes, but is not limited to, intimidation, ridicule, belittlement, mocking, or insult, such that a reasonable person would find it to be offensive, hostile, and abusive; and that the victim perceives it as such.

D. Sexual Harassment

Sexual Harassment is unwelcome verbal or physical conduct of a sexual nature, which may include verbal harassment (such as epithets, derogatory comments, or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement of work), or visual harassment (such as the display of derogatory cartoons, drawings, or posters).

Sexual Harassment may be a single incident, or may be multiple incidents; and may include unwelcome sexual advances, request for sexual favors, or any other verbal, visual, or physical conduct of a sexual nature when:

1. Submission to the conduct is made either explicitly or implicitly a term or condition of employment;
2. Submission to or rejection of such conduct is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or
3. Such conduct has the purpose or effect of unreasonably interfering with an employee's work performance; or creating an intimidating, hostile, or offensive work environment.

Examples of Sexual Harassment include, but are not limited to:

1. Unwelcome sexual flirtations, advances, or propositions;
2. Pressure or requests for sexual favors;
3. Making or threatening reprisals after a negative response to a sexual advance;
4. Unnecessary touching of an individual;
5. Visual conduct, such as leering, making sexual gestures, displaying of sexually suggestive objects or pictures, cartoons, or posters;

MANAGEMENT OF THE DISRUPTIVE PRACTITIONER (CONTINUED)

6. Verbal conduct, such as making or using derogatory comments, epithets, slurs, and jokes; and
7. Verbal abuse of a sexual nature such as graphic verbal commentaries about an individual's body, sexually degrading words used to describe an individual, suggestive or obscene letters, notes, or invitations.

E. Practitioner

Practitioner as used in this Policy shall include all Medical Staff members and all other individuals holding Medical Staff clinical privileges who are not Medical Staff members, including, but not limited to, Allied Health Practitioners.

F. Prohibited Behavior

Prohibited Behavior as used in this Policy shall include Discriminatory Behavior, Disruptive Behavior, Harassment, and Sexual Harassment.

III. ACKNOWLEDGMENT

All Practitioners will be given a copy of this Policy when they receive their Medical Staff initial application and reappointment application. At the time of each application and each re-application, each practitioner will be required to sign a written statement acknowledging that he or she has read and agrees to abide by this Policy at all times. Presence of this signed statement in the Practitioner's Medical Staff credentials file is required prior to any action by the Governing Body on the Practitioner's application or re-application.

IV. REPORTING PROCEDURE

Complaints alleging that a Practitioner has engaged in Prohibited Behavior should immediately be reported and documented as follows:

A. Prohibited Behavior Directed at an Employee or Volunteer

Any employee or volunteer who encounters an incident of Prohibited Behavior should promptly report the matter to his or her supervisor. If the supervisor is unavailable or the employee believes it would be inappropriate to contact the supervisor, the employee should immediately contact the Human Resources Department. Employees may raise concerns and make reports of Prohibited Behavior without fear of reprisal.

B. Prohibited Behavior Directed at a Patient or Visitor

If the alleged victim is a patient or visitor, then the complaint shall be referred to a member of the Hospital Administrative Team and Risk Management.

MANAGEMENT OF THE DISRUPTIVE PRACTITIONER (CONTINUED)

REPORTING PROCEDURE (continued)

C. Prohibited Behavior Directed at a Practitioner

If the alleged victim is a Practitioner, then the complaint shall be referred to the Chief of Staff, another Medical Staff officer, or a Medical Staff Department Chair.

D. Prohibited Behavior by an Employee or Volunteer

If the parties involved in the matter are employees or volunteers (including employed physicians) then the matter will be handled in accordance with Hospital policies.

E. Prohibited Behavior by a Practitioner

All complaints regarding a Practitioner engaging in Prohibited Behavior shall be referred to the Chief of Staff, another officer of the Medical Staff, or a Department Chair of the Medical Staff; and a member of the Administrative Team.

F. Documentation of Prohibited Behavior

Documentation of disruptive conduct is critical since it is ordinarily not one incident that justifies action, but rather a pattern of conduct. That documentation shall include:

1. The date and time of the prohibited behavior;
2. If the behavior affected or involved a patient in any way, the name and medical record number of the patient;
3. A description of the circumstances which precipitated the situation;
4. A factual description of the prohibited behavior, including witnesses;
5. The consequences, if any, of the prohibited behavior, as it relates to patient care, hospital operations or the work environment; and
6. A record of any action taken to remedy the situation including date, time, place, action, and name(s) of those intervening.

V. REVIEW AND RESOLUTION

A. Review of Complaints

Any and all complaints of Prohibited Behavior will be reviewed in a prompt, thorough, and confidential manner. The review may include interviews with all parties involved, including witnesses. Reports of Prohibited Behavior may be made without fear of reprisal.

B. Action Plan

An action plan for resolution of all Prohibited Behavior complaints and concerns will be created. This plan may include referral of the matter to a Medical Staff Officer, Department Chair, and the Medical Executive

MANAGEMENT OF THE DISRUPTIVE PRACTITIONER (CONTINUED)

Committee or Medical Staff Health and Well-Being Committee for further review or other action pursuant to the Medical Staff Bylaws. Administrative action and / or alternative resolutions may be considered. Nothing in this policy shall be deemed to limit any action plan that may be appropriate under the facts and circumstances which are the issue of review.

C. Acknowledgment of Complaint

An acknowledgment of the complaint will be sent to the concerned or complaining individual with assurance that the issues will be reviewed. If the complaining or concerned individual is an employee, the individual may be informed of an action plan for resolution of the problem. Confidential peer review information shall not be disclosed to the individual.

D. Corrective Action

If warranted, formal investigation and corrective action may be initiated. Such investigation and action shall follow the procedures set forth in the Medical Staff Bylaws. In the event of adverse action affecting the practitioner's privileges, the practitioner's rights to a hearing and appellate review shall be as set forth in the Medical Staff Bylaws.

E. Privileges and Immunities

The complaints, results and conclusions of all Medical Staff reviews and investigations of a practitioner for Prohibited Behavior is part of the ongoing Medical Staff peer review performance improvement process, is confidential, will be maintained in the practitioner's credential's file, and will be considered at the time of reappointment or more often, as indicated.

Legal counsel may be consulted at any point in the Prohibited Behavior complaint to review process and all applicable privileges shall adhere thereto.