

Community Hospitals and Wellness Centers  
CHWC Montpelier Hospital (CAH)  
CHWC Bryan Hospital  
CHWC Archbold Hospital

## MEDICAL STAFF SERVICES POLICY & PROCEDURE

SUBJ: DISASTER CREDENTIALING POLICY

DATE ISSUED: 05/09

REVISED:

REVIEWED: 10/11, 10/13, 10/15, 7/18

POLICY NUMBER: MD0002

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cc: EOP Plan

### I. DEFINITION

An emergency/disaster is defined as any time in which the Emergency/Disaster Operations Plan has been activated and the organization is unable to handle immediate patient needs.

### II. POLICY

Practitioners who do not possess medical staff privileges at Community Hospitals and Wellness Centers may practice at this hospital during an “emergency” or “disaster” (defined as any officially declared emergency or disaster, whether it is local, state or national). If the Hospital’s Emergency/Disaster Operations Plan has been activated, the Chief Executive Officer, Chief of Staff, Medical Director, or his or her designee(s) has the option to grant temporary disaster privileges, for the duration of the emergency/disaster, to any individual who meets the criteria as stated.

### III. PROCEDURE

- A. All hospital staff should be alerted to direct the practitioner(s) to the person or persons, designated in the Medical Staff Bylaws or hospital disaster policies to process disaster privileges.
- B. The individual credentialed during the declared emergency/disaster must complete the Emergency/Disaster Privilege Form and must sign the statement attesting that the information given to the hospital is accurate.
- C. The practitioner shall present a valid government-issued photo identification issued by a state or federal agency (e.g., driver’s license or passport) and at least one of the following:
  1. A current picture hospital ID card that clearly identifies professional designation
  2. A current license to practice
  3. Primary source verification of the license
  4. Identification indicating that the individual is a member of Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP other recognized state, or federal organization or group

5. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)
  6. Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster
- D. The "Privileges Granted in the Event of a Declared Emergency Disaster" form shall be forwarded as soon as possible to the Medical Staff Office to immediately verify as much of the information as possible, including verification of licensure, hospital affiliation(s), the National Practitioner Data Bank (NPDB) and the Office of the Inspector General (OIG excluded provider databank) (**Note:** results of the NPDB and the OIG are not required prior to granting these privileges). Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization.
- E. The practitioner will be under the direction and supervision of a member of the medical staff of Community Hospitals and Wellness Centers. This pairing should be recorded along with the licensing information. The Medical Staff Office shall retain a permanent record of this information.

#### **IV. IDENTIFICATION**

- A. The practitioner will be given a temporary identification badge that will identify him/her as a volunteer physician.
- B. A list of practitioners who have been granted emergency/disaster privileges will be sent to: Administration, Director of Nurses and the Admitting/Triage area.

#### **V. TERMINATION OF PRIVILEGES**

The following circumstances will immediately terminate the emergency/disaster privileges:

- A. A practitioner's temporary privileges granted in the event of an emergency or declared disaster are intended for the duration of the emergency/disaster and shall be immediately terminated once the disaster/emergency has been resolved.
- B. In the event that information received through the verification process indicates any adverse information or suggests that the person is not capable of rendering services in an emergency.

Termination of these emergency/disaster privileges, regardless of cause, does not entitle the practitioner rights to a hearing or review.

Approval: Credentials/Bylaws Committee: 07/18

Medical Staff: 08/18

Board of Directors: 08/18

### **TEMPORARY PRIVILEGES GRANTED IN THE EVENT OF A DECLARED EMERGENCY OR DISASTER**

DATE OF DISASTER: \_\_\_\_\_

**Information to be taken from practitioner, medical/drivers license and any other identification presented:**

Practitioner Name/Degree: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Medical License #: \_\_\_\_\_ Issuing State: \_\_\_\_\_

Hospital(s) where practitioner holds staff membership and privileges:

\_\_\_\_\_

I hereby volunteer my medical services to Community Hospitals and Wellness Centers during this emergency and agree to practice, as directed and under the supervision of a member of the medical staff. I also acknowledge that these privileges shall immediately terminate once the emergency/disaster has ended, or as notified by the hospital. I certify that the above information is true and correct to the best of my knowledge, information and belief.

\_\_\_\_\_  
Signature of Practitioner

\_\_\_\_\_  
Date



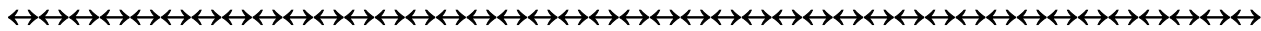
**The following information was provided by the practitioner and was reviewed and verified:**

- License copied/verified
- Photo ID verified (visual)
- Hospital affiliations verified
- Individual member of a Disaster Medical Assistance Team (DMAT)
- Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority granted by a federal, state or municipal entity
- Presentation by current hospital medical staff member with personal knowledge regarding the practitioner's identity (Staff member: \_\_\_\_\_)

Under supervision of: \_\_\_\_\_

Verifications completed by: \_\_\_\_\_

Date: \_\_\_\_\_



**APPROVAL:** \_\_\_\_\_

Chief Executive Office (or designee)

\_\_\_\_\_  
Date

**OR:**

\_\_\_\_\_  
Chief of Staff and or Credential's Chair (or designee)

\_\_\_\_\_  
Date