

TO: Applicant

FROM: Janet Galaway Graham, CPMSM, CPCS  
Director, Medical Staff Services

SUBJECT: INITIAL APPOINTMENT APPLICATION PACKET & DEADLINE FOR MEDICAL STAFF

You will be receiving your Request for Consideration (RFC) from the HCA Houston Credentialing Processing Center (CPC) within 10 days once you have completed the attached Request for New Application, Provider's Authorization for Delegate, and other MCA specific credentialing forms and returning them to Medical Center Arlington. The CPC packet will be an online link to the email address you provide for your delegate or to you if you choose no delegate. Please monitor your email's junk folder for the next few days to assure you receive the link. If you wish to receive a paper packet, please let us know. Both packets (CPC link/packet and this MCA packet) must be completed during this process.

Please note that **both packets should be returned within 45 days of receipt. If both packets are not received within 75 days of receipt, it will be assumed that you do not wish to apply for membership and privileges at MCA, and your initial request will be closed.** The appointment processing fee for all Medical Staff members is \$300. All checks must be made payable to "Medical Center Arlington". If you request expedited processing or temporary privileges, please note that there are additional fees as outlined in policy MDS134 "Application Fees" attached.

**\*\*Please note that, if you choose, you may submit the paper RFC packet (sent by the CPC) and the enclosed MCA packet to Medical Staff Services at Medical Center Arlington, and we will be happy to review and submit all of your information to the CPC for you.\*\***

We would greatly appreciate the prompt return of your packets since it generally takes 60-90 days to process your RFC. On behalf of the entire team, we look forward to working with you, and we pledge to give your appointment request the attention it deserves upon its return. If you have any questions or concerns, please feel free to contact me at [janet.graham@hcahealthcare.com](mailto:janet.graham@hcahealthcare.com) or 817-472-4926 or contact Stephanie Craddock, Medical Staff Coordinator, at [stephanie.craddock@hcahealthcare.com](mailto:stephanie.craddock@hcahealthcare.com) or 817-472-4852.

Attachments: Request for New Application Form  
Provider's Authorization for Delegate  
MCA Appointment Packet  
Current blank DOP(s)  
Return Envelope (if packet is mailed)

**MEDICAL STAFF SERVICES  
 REQUEST FOR NEW APPLICATION**

**Please complete and return your request to Medical Staff Services at 817-472-4767. The information will be forwarded to our Centralized Processing Center in Houston where you will receive an application within five business days.**

PERSON COMPLETING THIS FORM:	
PROVIDER NAME (AS LISTED ON TEXAS LICENSE):	
PROVIDER DEGREE	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPS <input type="checkbox"/> DDS
PROVIDER SPECIALTY:	
WILL PROVIDER REQUEST CONSCIOUS SEDATION PRIVILEGES (NON-ANESTHESIOLOGIST ONLY):	<input type="checkbox"/> Yes <input type="checkbox"/> No
PROVIDER SOCIAL SECURITY #:	
PROVIDER NPI#:	
PROVIDER DATE OF BIRTH:	
PROVIDER HOME ADDRESS	
PROVIDER HOME PHONE:	
PROVIDER PERSONAL EMAIL:	
PROVIDER ANTICIPATED START DATE:	
IS PROVIDER CURRENTLY COMPLETING TRAINING?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, anticipated date of completion: _____
DOES PROVIDER CURRENTLY HAVE A TEXAS LICENSE?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, date of application: _____
DOES PROVIDER CURRENTLY HAVE A DEA WITH TEXAS ADDRESS ON IT?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, date of application: _____
DOES PROVIDER CURRENTLY HAVE A DPS REGISTRATION WITH TEXAS ADDRESS ON IT?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, date of application: _____
DOES PROVIDER CURRENTLY HAVE INSURANCE FOR THIS PRACTICE AT MCA? IF NOT, ANTICIPATED START DATE FOR COVERAGE?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, date of application: _____
DO YOU WANT TO COMPLETE THE CPC ADDITIONAL PACKET ONLINE OR DO YOU WANT A PAPER PACKET?	<input type="checkbox"/> Online <input type="checkbox"/> Paper Packet (if paper, do not answer the remaining questions on this page)
CREDENTIALING DELEGATE NAME:	
CREDENTIALING DELEGATE EMAIL:	
CREDENTIALING DELEGATE PHONE:	
CREDENTIALING DELEGATE FAX:	
CREDENTIALING DELEGATE ADDRESS:	
DATE FORWARDED TO CPC: (MSS USE ONLY)	
SPECIFIC PRIVILEGE FORMS REQUESTED (MSS USE ONLY):	

## ***Announcing Online Credentialing!!!***

*We are pleased to announce a new credentialing process!! The new process will provide you the capability to submit your credentialing requests electronically for all HCA hospitals with the HCA Credentialing Online (HCO) tool.*

*The HCO tool will take the manual paperwork and data entry credentialing processes and transform them into an easy to use electronic process.*



### **HCO Benefits**

- Allow you to submit 1 credentialing request for all HCA hospitals
- Provide you with electronic access to create, modify, and submit your credentialing documents
- Electronic credentialing processes will ensure accuracy and completeness of your data being considered

### **HCO Features**

- Ability to establish a delegate to prepare the required forms and documentation for your approval
- Accessible to all providers having association to or seeking association to our facility
- Online attestation form completion

### **Learning about HCO and how to use it**

- You will receive an email notification when it is time for you or your delegate to complete your initial appointment or re-appointment packet which will provide you a link to job aids, instructions and training materials. If you would like to see this information before it is time for you to complete the forms you can do so by logging onto [www.hcacredentialingonline.com](http://www.hcacredentialingonline.com)

## ***Action Needed!***

To ensure you have capability to receive and submit information online through the HCA Credentialing Online system, please complete and return the attached form notifying us that you will provide credentialing information personally or through a delegate.

Please complete the attached authorization form and return in **14 days** to the fax number or mailing address indicated in Step 3. If you have any questions please contact our call center at **866-579-0803**

**HCA Credentialing Online - Provider's Authorization for Delegate**

**Step 1**

The contact information listed below has been pre-populated based on your information in our credentialing system. If changes are needed, please indicate below.

Provider Name:

Provider Phone:

Provider Email (required): \_\_\_\_\_

**NOTE: Provider email must be unique to the provider; it cannot be the same address as a delegate.**

**Step 2**

I do not want to select any delegates at this time. I will personally provide re-credentialing information. \_\_\_\_\_ *initial and skip to Step 3*

I understand that one delegate for all entities is preferred; however, I have different people handle my credentialing at different entities.

<input type="checkbox"/> I hereby authorize:	name:			
	email:			
	phone:	(    )	-	ext.

(hereinafter, individually referred to as "Delegate") to access the HCA Credentialing Online web portal to enter data and submit documents for the HCA Requests for Considerations (RFC) and HCA Reappointment Requests for Information (RRFCs) requests on my behalf. I understand that I will need to review the data and documents and attest to their accuracy before I submit them to HCA via the HCA Credentialing Online web portal.

I acknowledge that I have voluntarily provided the above information, and I have carefully read and understand this Authorization. I understand and agree that a facsimile or photocopy of this Authorization shall be as effective as the original.

\_\_\_\_\_  
PROVIDER SIGNATURE

\_\_\_\_\_  
NAME

\_\_\_\_\_  
SOCIAL SECURITY NUMBER or NPI

\_\_\_\_\_  
DATE (MM/DD/YYYY)

**Step 3**

Please complete, sign and date. The form may be returned via:

1. Scanned and e-mailed to email below
2. Faxed to the attention of the Intake Team at the fax below or
3. U.S. mail to the address below

**CHECK SHEET FOR APPOINTMENT – MEDICAL STAFF FOR:** \_\_\_\_\_  
Printed Name

All of the following items are required to be submitted to complete the RFC process. Please use this as your check sheet for the MCA specific packet and submit it with your application:

**Documents sent or requested in this RFC packet from Medical Center Arlington:**

- Check Sheet for Appointment – Medical Staff (Attachment MCA-1)
- Appointment Fee and any Expedited Processing or Temporary Privilege Fee, made payable to “Medical Center Arlington” (Attachment MCA-2)
- Membership Status Check Sheet (Attachment MCA-3)
- Reflex Testing Acknowledgement (Attachment MCA-5)
- Alternate Coverage Verification (Attachment MCA-6)
  - o You will need to give this directly to the medical staff member who has agreed to act as your Alternate Coverage and return with your application
- MRSA Active Surveillance Culture Authorization Form (Attachment MCA-7)
- Utilization of Hospitalist Physicians Form (Attachment MCA-8)
- Moderate Sedation Test (if requesting conscious sedation privileges) (Attachment MCA-9)
- Pediatric Sedation Test (if requesting pediatric sedation privileges) (Attachment MCA-10)
- Aim for Zero – Central Line Competency Assessment (if requesting central line insertion privileges) (Attachment MCA-11)
- Proof of Immunizations **\*NEW REQUIREMENT\*** If no specific documentation is available, applicant may go to MCA’s Employee Health Nurse in Human Resources (POB A, Third Floor) and have titers drawn at no charge w/current medical staff identification.) (See handout labeled Attachment MCA-12)
- ER On-Call Acknowledgement and Agreement (Attachment MCA-13)
- Affidavit of Identity (for Telemedicine Providers only, all others completed at orientation) (Attachment MCA-14)

**Documents sent or requested in the RFC packet from the Houston CPC:**

- Please refer to the Appointment Checklist provided by the CPC

I have received a CD or email containing the Medical Staff Bylaws, selected policies, the conscious sedation privilege form, Reflex Tests, Moderate “Conscious” Sedation Self-Study Guide, HIPAA Education, Safety Manual, Code of Conduct, and the “Physician Notice Regarding Medical Necessity and Compliance”.

By signing this form, I accept appointment to the Medical Staff of Medical Center Arlington, if extended to me, in the membership category with privileges described in such notification letter. I agree to abide by all Medical Staff and Hospital bylaws, policies, directives, and rules and regulations as are in force during the time I am appointed or reappointed to the medical staff, or exercise clinical privileges at Medical Center Arlington.

By signing this form, I attest that I have requested only those privileges for which by education, training and current experience and demonstrated performance that I am qualified to perform and that I wish to exercise at Medical Center Arlington. I have reviewed the delineation of privileges form and have marked the privileges/procedures to which I am limiting my practice. I attest that I meet the minimum criteria and agree to provide documentation as requested.

By signing this form, I attest that I have reviewed the entire contents of this Request for Consideration (appointment packet) and agree that it is current and complete. Notwithstanding anything contained herein to the contrary, I understand that any misrepresentation, misstatement, or omission contained in this application at the time of submission, whether intentional or not, is cause for automatic rejection of the application and may result in denial of appointment. Upon subsequent determination that incorrect information was provided, I understand that it may also be grounds for immediate termination.

\_\_\_\_\_  
Medical Staff Applicant's Signature Date

\_\_\_\_\_  
Printed Name

**APPOINTMENT FEE INVOICE - \_\_\_\_\_**  
 Printed Name

Qty	Description	Unit Price	Total
1	Appointment Application Fee	\$300.00	\$300.00
1	Plus, Expedited Processing Fee, if requested	\$500.00	\$500.00
1	Plus, Temporary Privileges Request Fee, if requested	\$200.00	\$200.00
	Please make check payable to: Medical Center Arlington		

If requesting temporary privileges, please explain the need for temporary privileges as it relates to fulfilling an important patient care need that cannot be otherwise met by the existing members of the Medical Staff or currently privileged APPs:

---



---



---



---



---



---



---



---

Requested Start Date: \_\_\_\_\_

\_\_\_\_\_  
 Signature of Designee/Applicant

\_\_\_\_\_  
 Printed Name

<b>MEDICAL CENTER OF ARLINGTON</b>	<b>POLICIES AND PROCEDURES</b>	PAGE 1 OF 4
	POLICY # MDS134	
TITLE: APPLICATION FEES		
REPLACES:	EFFECTIVE DATE: OCTOBER 2014	
FORMULATED BY: MEDICAL EXECUTIVE COMMITTEE	DATE REVIEWED: OCTOBER 2014	
APPROVED BY: MEDICAL EXECUTIVE COMMITTEE	DATE REVISED:	
MANUAL: <b>MEDICAL STAFF</b>	DATE RETIRED:	

**I. PURPOSE:**

The purpose of this policy is to outline the fee structure for initial and reappointment applications for Medical Staff and Advanced Practice Professionals.

**II. POLICY**

It is the policy at Medical Center of Arlington that all requests for initial processing (RFC – Request for Consideration) and for reappointment processing (RRFC – Recredentialing Request for Consideration) for membership and/or privileges will require an application fee.

The following table describes the applicable fees. These fees are required for the request to be considered complete, regardless of whether the requesting provider obtains membership and/or privileges:

Category:	Initial (RFC) Request Fee	Reappointment (RRFC) Request Fee
Active	\$300	\$300*
Courtesy	\$300	\$300*
Advanced Practice Professionals (Advanced Practice Registered Nurses and Physician Assistants)	\$300	\$300*
<b>Additional Fees:</b>	<b>Fee Due</b>	
Late Fee is due if the application is received 60 days or more after the date sent. If the application cannot be completed through normal processes, an Expedited Processing Fee also may be required.	\$250	
Expedited Processing	\$500	
Temporary Privileges	\$200 May be waived by the CMO, President of Medical Staff, or CEO.	
Temporary Privileges for Emergent Patient Care Need	\$200 May be waived by the CMO, President of Medical Staff, or CEO.	
Additional Privileges	\$200 May be waived by the CMO, President of Medical Staff, or CEO.	
Change in Membership Category	\$0	

\*Reappointment fee is waived and not required to be returned with the packet if the applicant:

- Meets criteria for Active Staff or APP Staff and returns complete application with 45 days of the date sent (includes all CPC documentation and all MCA specific documentation); or
- Requests Active Community Status with no privileges and returns a complete application within 45 days of the date sent (includes all CPC documentation and all MCA specific documentation); or;
- Documents monthly participation on the ED call roster for the past twelve months and returns a complete application within 45 days of the date sent (includes all CPC documentation and all MCA specific documentation).

All checks will be made payable to “Medical Center of Arlington” and deposited in a hospital account. Any inconsistencies in determining date sent and date received between Medical Staff Services records and the provider’s records will be determined by the Credentials Committee.

**Attachment MCA-3  
MEMBERSHIP STATUS CHECK SHEET - APPOINTMENT**

**ACTIVE**

The Active Medical Staff shall consist of Practitioners who admit and/or provide consultation for 12 or more patients in a one year period, an insufficient number of patients has been attended to allow for adequate determination of competence, the provisional one year period may be extended in increments up to one more year at the end of which time, if the Provisional Active Staff member has still not used the facility adequately, he shall be dropped from the staff without prejudice. Provisional Active staff members shall neither vote nor hold office in the Medical Staff organization.

**COURTESY**

The Courtesy Medical Staff shall consist of Practitioners who admit and/or provide consultation for 12 or less patients in a one year period, an insufficient number of patients has been attended to allow for adequate determination of competence, the provisional one year period may be extended in increments up to one more year at the end of which time, if the Provisional Courtesy Staff member has still not used the facility adequately, he shall be dropped from the staff without prejudice. Provisional Courtesy staff members shall neither vote nor hold office in the Medical Staff organization.

**By applying for appointment to the Medical Staff of MEDICAL CENTER OF ARLINGTON, I hereby:**

**Acknowledge that I, as an applicant for staff membership and privileges, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications for membership and clinical privileges and for resolving any doubts about such qualifications. Notwithstanding anything contained herein to the contrary, any misrepresentation, misstatement, or omission contained in this application at the time of submission, whether intentional or not, is cause for automatic rejection of the application and may result in denial of appointment. Upon subsequent determination that incorrect information was provided, it may also be grounds for immediate termination.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name**



**Attachment MCA-5  
REFLEX TESTING ACKNOWLEDGEMENT**

The purpose of this Reflex Testing acknowledgement is to ensure that our physicians understand when reflex tests will be performed and how they will be billed to Medicare. Medical Center of Arlington's laboratory will automatically perform reflex tests according to the criteria in the attached list when all three of the following conditions are met, unless your order specifically states that you do not want the reflex test performed: 1) an initial test has been performed as ordered; 2) the initial test result meets the criteria for the reflex test; and 3) the hospital's MEC has approved those tests and criteria. The hospital bills for medically necessary reflex tests according to the CPT code listed on the attachment. The Medicare fee schedule amount is listed with each CPT code.

By signing this acknowledgement, you acknowledge that you have reviewed the attachment and agree that, whenever the initial test ordered meets the reflex criteria, the corresponding reflex test will be performed, reported and billed. If in the case of an individual patient, you consider the reflex test unnecessary, you must order the initial test without the reflex. With the exception of those tests required by law, you may order any test without the reflex option. We recommend that you utilize the hospital laboratory requisition in order to clearly indicate the tests that you want performed. This acknowledgement may be terminated at any time with written notice to the laboratory director.

Notification of any additions or modifications to reflex tests will be communicated via the Notification of Additions or Modifications for Reflex Testing form as they are approved by the Medical Executive Committee.

---

Signature

---

Date

---

Printed Name

**Attachment MCA-6  
ALTERNATE COVERAGE VERIFICATION**

**THIS FORM DOES NOT APPLY** because I am a primary care physician and the Hospitalists will admit and manage my inpatient practice when I am not available.

**TO:** \_\_\_\_\_  
*(Write in Alternate Coverage Physician/Group Representative and send to them for completion. Form should be returned to applicant and returned with appointment materials)*

**FROM:** Applicant  
Return Fax: \_\_\_\_\_

**DATE:**

**SUBJECT:** Alternate Coverage Verification for – \_\_\_\_\_  
Printed Name of Applicant

I have applied for membership and privileges at Medical Center Arlington and per our previous agreement/discussion, you and/or your group have agreed to serve as my Alternate Coverage at Medical Center Arlington. Please confirm by checking one of the options below, signing at the bottom, and returning the form to me at my fax number above:

1.  **YES**, I agree that I am/we are the Alternate Coverage designation for Applicant and Applicant has agreed to act as a covering physician for me or my group; or
2.  **YES**, I agree that I am/we are the Alternate Coverage designation for Applicant; however, Applicant will not act as a covering physician for me or my group; or
3.  **NO**, I do not agree that I am/we are the Alternate Coverage designation for Applicant.

Select one:

Individual Alternate Coverage                       Group Representative

\_\_\_\_\_  
Signature of Alternate Coverage Physician/Group Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Alternate Coverage Physician/Group Representative

\_\_\_\_\_  
Group Name

I, \_\_\_\_\_ (applicant name), agree with Option 1 or 2 as selected above:

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Applicant

**Attachment MCA-7  
METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)  
ACTIVE SURVEILLANCE CULTURE AUTHORIZATION FORM**

**Policy:** It is the policy of the Medical Center Arlington to perform active surveillance cultures (ASCS) on all patients known, at high risk for, or undergoing a high risk procedure for Methicillin Resistant Staph Aureus (MRSA) at the time of admission to the facility or at the time of the preoperative visit for surgical procedures. These patients include, but are not limited to the following groups:

- If a patient is admitted with a history of MRSA and the most recent MRSA culture is longer than three (3) months, a nasal swab will be obtained in the Pre Admit or nursing unit to rule out MRSA colonization.

**Other patient populations that will be screened are:**

- All admissions/transfers including ICU into the adult critical care units, and neonates admitted to NICU born outside of facility.
- Elective or urgent hip and knee surgeries; including joint replacement (total and partial joint as well as revision procedures) and fractured cases.
- Pre-op for surgical procedures with the exception of oral, endoscopic gastrointestinal procedures and Women’s Center Procedures
- Cardio-vascular and vascular surgeries that involve mediastinal operative approach.
- Patients undergoing open spinal procedures (both anterior and posterior approaches).

**Other high risk patients:**

- Patients admitted from any other facility (nursing home, assisted living)
- Prison/jail or rehab facility – does not include Doctor’s Offices).
- Oncology patients
- Dialysis patients
- Reported of visualized open or draining wounds

**Additional Options:**

- Does not meet screening criteria
- Patient refuses procedure / place on Contact isolation
- Re-screening bi-weekly

If the screen is positive, the patient will be placed on Contact Isolation. The Centers for Medicare and Medicaid Services (CMS) Conditions of Participation require that all Licensed Independent Practitioners sign an annual consent for any treatment regimen or standardized specifications for care of any patients having a specifically-defined care need such as the patient group listed above and based upon the latest and best scientific evidence.

I consent to the MRSA ASCS protocol as it applies to the patient population for which I am responsible.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

**Attachment MCA-8**

**UTILIZATION OF HOSPITALIST PHYSICIANS REQUEST FORM**

**THIS FORM DOES NOT APPLY** because I am an anesthesiologist with no pain medicine practice, an emergency medicine physician, a pediatrician, a pediatric subspecialist, or a pathologist.

The Hospitalist physician is available as a resource for those members of the medical staff who choose to use the service.

\_\_\_\_\_ **Yes, upon admission to the hospital, I request that my admitted patients be Managed by the hospitalist program.**

\_\_\_\_\_ **No, upon admission to the hospital, I request that my admitted patients are not to be managed by the hospitalist program.**

➤ I have read and agree to Policy MDS117 "Utilization of Hospitalist Program"

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

**REQUEST FOR MODERATE SEDATION PRIVILEGES FOR NON-ANESTHESIOLOGISTS**

**PLEASE NOTE:** Physicians requesting Moderate Sedation privileges must initial each of the following statements indicating that you have read and are able to fulfill the criteria listed:

- \_\_\_\_\_ 1. Only a physician is qualified to order and/or select the medication(s) to achieve moderate sedation.
- \_\_\_\_\_ 2. Be familiar with dosing guidelines, administration, adverse reactions, and interventions for adverse reactions and overdoses. (Completion of Medication Exam Required)(Review of Self-Study Guide and MCA’s Policy and Procedure)
- \_\_\_\_\_ 3. Know how to recognize airway obstruction and demonstrate knowledge of skills in airway management resuscitation. (Review of materials on airway management and attendance of airway management class is required or documentation of twelve (12) successful moderate sedation cases.)
- \_\_\_\_\_ 4. Assess total patient care requirements/parameters, including, but not limited to, respiratory rate, oxygen saturation, blood pressure, cardiac rate and level of consciousness.
- \_\_\_\_\_ 5. Have the knowledge and skills to intervene in the event of complications. Practitioners responsible for the treatment of patients 13 years of age or under and/or the administration of drugs for sedation must be trained in, and capable of providing pediatric basic life support. Training in pediatric advanced life support is encouraged.

\_\_\_\_\_  
 Physician’s Signature

\_\_\_\_\_  
 Date

**APPROVED**  
 (Initials)

**NOT APPROVED**  
 (Initials)

Anes  
 Chair

Serv  
 Chair

Anes  
 Chair

Serv  
 Chair

\_\_\_\_\_ Moderate Sedation (> age 13)

\_\_\_\_\_ Moderate Sedation (13yrs and under)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PHYSICIAN SIGNATURE:** \_\_\_\_\_

**SERV/SPECIALTY:** \_\_\_\_\_

New Applicant: \_\_\_\_\_  
 Reappointment/no change \_\_\_\_\_  
 Reappointment/new privilege \_\_\_\_\_

**Attachment MCA-9**

- Requesting Moderate Sedation  
 N/A - Not Requesting Moderate Sedation

**MODERATE SEDATION COMPETENCY**

Name: \_\_\_\_\_

Score \_\_\_\_\_

1. All of the following describe moderate sedation except:
  - a) Allows protective reflexes to be maintained
  - b) A medically controlled state of depressed consciousness or unconsciousness from which the patient is not easily aroused and is unable to respond purposefully to physical stimulation or verbal command
  - c) Retains the patient's ability to maintain a patent airway independently and continuously
  - d) Permits appropriate response to physical stimulation or verbal command
  - e) The drugs, doses and techniques are not intended to produce a loss of consciousness
  
2. Prior to administering sedation for any procedure, documentation should include:
  - a) H&P
  - b) Baseline vital signs
  - c) Age and weight
  - d) NPO status
  - e) Evidence of informed consent
  - f) Results of pregnancy test (if warranted)
  - g) All of the above
  
3. A 55-year old woman has a history of adult onset diabetes mellitus. She also has a history of hypertension. Both diseases are controlled by diet alone. She is scheduled for colonoscopy. The patient is an ASA Physical Status Classification of:
  - a) ASA I
  - b) ASA II
  - c) ASA III
  - d) ASA IV
  - e) ASA V
  
4. You need to remove a drain and close the wound with a stitch on a child on whom you performed an appendectomy. The child is very anxious and you feel it may be better to do it in the room with the parents present. You inform the nurse that Versed should be given to relax the child. You note that there is oxygen and suction on the wall. You saw an emergency resuscitation cart in the hallway when you came into the room. You can proceed with your procedure and be in compliance with the hospital's policy on moderate sedation.
  - a) True
  - b) False
  
5. The initial dose range for Naloxone (Narcan) in the adult is:
  - a) 0.1 - 0.2 mg IVP
  - b) 1.0 - 2.0 mg IVP
  - c) 0.1 - 0.2 mg IM
  - d) 0.5 - 1.0 mg IVP

**Attachment MCA-9**

6. Monitoring parameters include:
  - a) Heart rate, blood pressure, respirations
  - b) Heart rate, blood pressure and oxygen saturation
  - c) Heart rate and rhythm, blood pressure, respirations, oxygen saturation and level of consciousness
  - d) Heart rate and rhythm, blood pressure, respirations and oxygen saturation
  - e) Heart rate, blood pressure, respirations and oxygen saturation
7. During the procedure the vital signs should be taken and documented
  - a) Pre and post procedure
  - b) Every 5 minutes
  - c) Every 10 minutes
  - d) Every 15 minutes
  - e) As the physician feels is necessary
8. Which of the following drugs can be given by non-anesthesiology staff for moderate sedation:
  - a) Ketamine
  - b) Propofol
  - c) Morphine
  - d) Nitrous oxide
  - e) Etomidate
9. Patients who receive moderate sedation do not need to go to the PACU post-procedure if the physician feels the patient is "wide-awake".
  - a) True
  - b) False
10. The RN monitoring the patient receiving moderate sedation:
  - a) May be the charge nurse
  - b) May also circulate in the room and get equipment from the hallway
  - c) May not apply oxygen if needed
  - d) May not be engaged in any other activity during this period
  - e) Should do the preoperative history and physical prior to the procedure
11. IV Versed should always be administered:
  - a) In 5 mg increments
  - b) As a bolus dose with follow up doses as needed
  - c) Rapidly
  - d) At the same dose in patients with chronic renal or hepatic disease
  - e) Over 2 or more minutes
12. You are performing a colonoscopy on a patient and it is very difficult. You have the nurse position the patient on their stomach. The patient has been complaining of pain and you instruct the nurse to give more Versed. Within a few minutes the oxygen saturation begins to drop. You should immediately:
  - a) Turn up the oxygen
  - b) Arouse the patient
  - c) Check the patient's respirations
  - d) Quickly turn the patient over
  - e) All of the above

**Attachment MCA-9**

13. The above patient's oxygen saturation continues to drop. You should:
  - a) Quickly finish the procedure so you can get the patient to the PACU
  - b) Leave the room to find an anesthesiologist
  - c) Have the nurse give Naloxone
  - d) Support the patient's airway and if necessary give oxygen via Ambu bag and mask
  - e) Tell the nurse to resuscitate the patient
  
14. What information is needed in the history of a patient undergoing moderate sedation?
  - a) Allergies
  - b) Past experiences with anesthetic drugs
  - c) Last meal
  - d) Pregnancy or menstrual history
  - e) All of the above
  
15. Prior to discharge the nurse must have all of the following except:
  - a) Written instructions from the physician for the patient
  - b) Name and telephone number of responsible adult to accompany the patient
  - c) Number of ride arranged with public transportation and address where they are taking the patient
  - d) Complete documentation of entire procedure including the recovery period
  
16. All of the following are considered clear liquids except:
  - a) Black coffee or tea
  - b) Clear soup broth
  - c) Orange juice with pulp
  - d) Apple juice
  - e) Water
  
17. Your patient is a 52-year old man with a history of ASCVD who had a MI a few years ago. He underwent a carotid endarterectomy last year. He reports that he does get a little tired after walking one block and has to rest after one flight of stairs. His ASA Physical Status Classification is:
  - a) ASA I
  - b) ASA II
  - c) ASA III
  - d) ASA IV
  - e) ASA V
  
18. Moderate sedation, a medically controlled state of depressed consciousness allows protective reflexes to be maintained.
  - a) True
  - b) False
  
19. If you have privileges to perform any endoscopic procedure, you automatically have privileges to administer moderate sedation.
  - a) True
  - b) False
  
20. The most effective way to open the airway is the head-tilt jaw lift.
  - a) True
  - b) False



**Attachment MCA-9**

21. Which of the following is true regarding bag-valve devices?
- a) Consist of self-inflating bag
  - b) Consist of non-rebreathing valve
  - c) May be used with a mask, an endotracheal tube or other invasive airway device
  - d) All of the above
22. The most common cause of airway obstruction is the tongue.
- a) True
  - b) False

Signature \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
Printed Name

Must get 16 correct to pass

**Attachment MCA-10**

- Requesting Pediatric Moderate Sedation
- N/A - Not Requesting Moderate Sedation

**PEDIATRIC MODERATE SEDATION TEST FOR MONITORING & DRUG ADMINISTRATION**

Name \_\_\_\_\_

Score \_\_\_\_\_

**Directions:** Select the best answer for the following questions:

1. Monitoring parameters for the patient receiving Moderate Sedation include (see list below):

- a. 1 only
- b. 1 and 4
- c. 1, 3, 4
- d. All of the above
  - 1) Blood pressure
  - 2) Heart rate
  - 3) Oxygen saturation
  - 4) Level of consciousness
  - 5) Respiratory rate
  - 6) LOC

2. Objective of Moderate Sedation include all of the following except:

- a. Alteration of mood
- b. Amnesia
- c. Cooperation during procedure
- d. Decreased pain threshold
- e. Stable vital signs

3. Undesirable effects of Moderate Sedation include all EXCEPT:

- a. Agitation
- b. Slurred speech
- c. Respiratory depression
- d. Involuntary movement of eyes

4. Flumazenil (romazicon) reverses the effects of midazolam (versed).

- a. True
- b. False

5. Name the drug used for reversal of narcotic overdose: \_\_\_\_\_

6. The minimal standard of documenting vital signs during the Moderate Sedation procedure is:

- a. q5mins
- b. q15mins
- c. q30mins
- d. There is no minimal standard

**Attachment MCA-10**

- 7. A 15 month old is having an MRI and the pulse oximeter gradually decreases from 98% and 89%. The child is sedated. The most likely treatment is:
  - a. Intubation
  - b. Application of nasal oxygen and continued monitoring
  - c. No further intervention needed
  - d. Continue to monitor saturations and notify the physician later

Identify the appropriate antagonist for each of the following Moderate Sedation medications:

- 8. Meperidine \_\_\_\_\_ a. flumazenil (romazicon)
- 9. Morphine \_\_\_\_\_ b. narcan
- 10. Midazolam \_\_\_\_\_
- 11. Fentanyl \_\_\_\_\_
- 12. Diazepam \_\_\_\_\_

13. Documentation of a patient receiving Moderate Sedation should include:

- a. Medication name, dose, route and time of administration
- b. Presence of IV site and any IV fluids given
- c. Any undesirable effects of Moderate Sedation
- d. All of the above

14. The recommended initial pediatric dosage of versed is:

- a. 1-2.5 mg IV
- b. 5mg IV
- c. 1mg/kg IV
- d. 0.08-0.1 mg Kg IV

15. The recommended initial pediatric dosage of Fentanyl is:

- a. 200 mcg IV
- b. 100 mcg PO
- c. 2 mcg/Kg IV
- d. 5 mcg/Kg IV

16. A code cart, with age appropriate equipment, must be readily available when administering Moderate Sedation.

- a. True
- b. False

17. Patients must meet discharge/recovery criteria before they can be transferred to a lower level of care unless otherwise ordered by the physician.

- a. True
- b. False

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Must get 12 correct to pass**

**Attachment MCA-11**

- Requesting Central Line Insertion  
 N/A - Not Requesting Central Line Insertion



**CENTRAL LINE COMPETENCY ASSESSMENT**

Name \_\_\_\_\_

Score \_\_\_\_\_

1. The mortality rate associated with CLABSIs is 12% to 25%.
  - a. True
  - b. False
2. Infections related to the use of central line can increase
  - a. Morbidity
  - b. Mortality
  - c. Hospital length of stay
  - d. Costs
  - e. All of the above
3. An elective central insertion should have a time-out before insertion
  - a. True
  - b. False
4. All are evidenced-based preventive strategies except
  - a. Maximum barrier precautions
  - b. Hand hygiene
  - c. Femoral site insertion
  - d. Chlorhexidene/alcohol for site preparation
  - e. Daily review of line necessity
5. Two-dimensional ultrasound reducing failed placement and complications
  - a. True
  - b. False
6. Preferred site selection for a central line is as follows:
  - a. Subclavian>internal jugular>femoral
  - b. Internal jugular>subclavian>femoral
  - c. Subclavian>femoral>internal jugular
  - d. Femoral>subclavian>internal jugular

**Attachment MCA-11**

7. Ms. Jones has an unexplained fever and you suspect a blood stream infection. Upon inspection of her internal jugular central line insertion site, you do not see obvious erythema or purulence but the site may be tender. Which of the following is not correct?
  - a. Paint site and remove line and using sterile scissors cut a 5 cm segment and send to microbiology for culture and draw blood cultures from a venipuncture site
  - b. Draw 2 blood cultures from different venipuncture sites
  - c. Draw blood culture from both line and venipuncture site
  - d. Draw both blood cultures from the hub
  
8. If a catheter culture comes back positive (either catheter tip or blood culture drawn from line), but the venipuncture blood sample cultures are negative, evaluate the entire picture and reassess the patient before giving antibiotics.
  - a. True
  - b. False

Signature \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
Printed Name

**Must get 6 correct to pass**

**IMMUNIZATION STATUS**

Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Last Four of SS#: \_\_\_\_\_

Reason for Review:  Initial Appointment (compliance required as of 1/1/13)  
 Reappointment (compliance required 9/1/13)

- Please provide evidence of immunity (either vaccination record or serologic testing) for the mandatory vaccines & TB screening information listed below from your personal physician.
- If you do not have any records or a personal physician, you may go to the Employee Health Nurse (located within the Human Resources Department) at Medical Center Arlington to complete screening for these requirements.

*NOTE: Please note the Employee Health Nurse is available Monday through Friday from 8am to 4:30pm. If you require TB testing, you may NOT visit the Employee Health Nurse on Thursday due to timing of the PPD read.*

**ATTACH PROOF OF IMMUNIZATION/TITER, AS APPROPRIATE FOR:**

- Initial 2-step \*\*TB skin test, or record of \*\*TST within past 12 months plus #2 TST here, OR
- Chest x-ray for positive PPD reactors (or CxR report if done within past 6 months), OR
- Annual TB Skin Test, OR
- T-Spot titer
- AND**
- Influenza vaccination for current season
- Hepatitis B vaccination series (3 Hep B vaccinations)
- 2 MMR vaccinations or immune titer for Rubeola, Mumps, & Rubella
- 2 Varivax vaccinations or immune titer for Varicella (Chicken Pox)
- TDaP (Tetanus, Diphtheria, Pertussis) vaccination

If you choose to have the Employee Health Nurse provide these services, please call to make an appointment, if at all possible, and then report to:

**Medical Center of Arlington**  
**Human Resources / Employee Health Nurse**  
**3301 Matlock Rd., #301**  
**Arlington, TX 76015**  
**817-472-4847 Fax: 469-713-8146**  
[michael.shaw@hcahealthcare.com](mailto:michael.shaw@hcahealthcare.com)

**Monday - Friday 8:00am – 4:30 pm**

**Attachment MCA-13  
EMERGENCY ROOM ON-CALL**

**ER ON-CALL ACKNOWLEDGEMENT AND AGREEMENT**

For all initial appointment and reappointment applications for Medical Staff membership:

“I, \_\_\_\_\_, acknowledge that I will satisfy all Emergency Room on-call and other consultation requirements set forth as required by the Medical Executive Committee pursuant to Hospital policy.”

Only Active members of the staff will be required to take ER call but all physicians are to complete this form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name