

THE LIGHTHOUSE

Volume 4, Issue 1



January/February 2004

The official publication of the Maine Association Medical Staff Services, published by and for the MeAMSS membership

UPCOMING EDUCATIONAL MEETINGS IN 2004

Invite another colleague from your organization!

March 19

St. Joseph Hospital in Bangor

May 13 and 14

Biennial Conference
Grand Summit Hotel and Conference Center
Sunday River, Maine

September 10

Central Maine Orthopedics
Auburn, Maine

November 5

Central Maine Medical Center
Lewiston, Maine

REMINDER

Registration fees at regular educational sessions have increased by \$5:

Member fees- \$20

Non-member - \$30

President's Message

INVEST IN YOURSELF

Now that the holidays are over and we are settling back into our routines, I wanted to talk to you about investing in yourselves. There were about 25 attendees at our recent December educational meeting. So often I hear, "I can't take a day out of the office," or "I just don't have the time," or "There's nothing on the agenda that interests me or pertains to my job." My fellow members, if we don't take the time to invest in ourselves by advancing our education and/or skills, we run the risk of never growing, remaining stagnant, and possibly being seen as something less than what we are or could be.

Think about the amount of energy, time and effort you have invested in raising your children, keeping a successful marriage, or even purchasing stocks and bonds. Each of these takes work and effort on our part to grow, mature, and show the fruits of our labor. The same should be true for our individual careers. We shouldn't be content to stay where we are educationally or professionally.

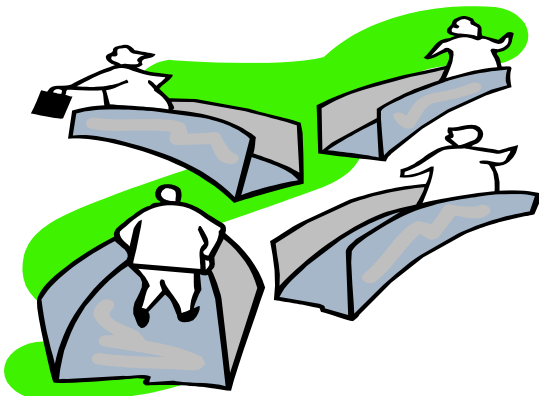
With that said, doesn't this sound like a good New Year's resolution? Begin to seek ways to invest in yourself. There is no time like the present to take advantage of workplace support in regards to continuing education. You simply cannot afford NOT to continue your education and professional development no matter what your age or job title. If I had taken advantage of the tuition reimbursement throughout my career, I could have had two degrees by now at no charge. Instead, I have just recently enrolled in college, on top of a full-time job, serving on the MeAMSS board, and other personal commitments. It will take me about 10 years, but the self satisfaction will be worth it.

Finally, as we gear up for 2004, I encourage you to attend each MeAMSS offering as

well as the NAMSS annual meeting. Our education chair is working on a great annual conference scheduled for May, in addition to our regular quarterly offerings which begin in March. I was surprised to find that, even though I thought the December schedule didn't have much for me, I learned a significant amount of information regarding J-1 Visas. Maybe I won't use it right now, but what if one day I am in a situation where someone asks the question? I believe the endeavor to further my education while still maintaining my office will give me the tools and information necessary to answer the question. Continuing your education in order to stay abreast of changes in our field will enable you to easily sail through any regulatory surveys, while expanding your individual professional growth. I also believe most employers will support these endeavors to the extent possible once they become aware that your professional growth is an asset to their organization.

I wish each of you a Happy New Year and look forward to seeing you in 2004.

Kim Pelletier, CPMSM
President, MeAMSS



Expanding Horizons

ADVERTISEMENT FEES

\$25 PER ISSUE OF THE LIGHTHOUSE WITH CONCURRENT WEBSITE POSTING OR \$125 PER YEAR (6 ISSUES) AND CONCURRENT WEBSITE POSTING

MeAMSS Website

Interesting changes have been made to the site. Be sure to check it out!

www.meamss.org.

Please send your feedback to Allison Meyer, CPCS, at allisonm@martinspoint.org

E-mail Etiquette

By

Cheryl Schilke, RN, CPMSM

Most of us use e-mail every day. It is a handy way to ask questions that don't require an immediate answer and to share information. It is easy. It is fast. It gives the illusion it is private. But e-mail isn't private. A casual e-mail dashed off without much thought may be just as quickly forwarded to others without your knowledge or consent. Your employer has the right to monitor all e-mail exchanges from your workstation. E-mail also lingers on in your deleted files or on the hard drive or server long after you thought it was deleted. To be safe, always follow the rules of e-mail etiquette.

- E-mail sent from your workstation or business address represents your business. The recipient will make judgments about your professionalism and your employer from your e-mail. Take as much care with business e-mail as you would with a formal letter on your company letterhead. Be sure to check your e-mail for grammar and spelling before sending it.
- Some companies, in particular large corporations, prohibit personal e-mails sent to office addresses. Check with your friends before you forward those lovely self-esteem messages that constantly circle the internet.
- Indicate that the message has been received. If the sender has gone to the trouble of sending you e-mail, then to respond is mere courtesy.

- Refer to the receiver by name/nickname in the body of the message when sending attachments. This is because most bogus emails have no personal greetings. Be very suspicious of any email with an attachment that doesn't have a personal reference to you in the message body.
- Include a copy of the original email in your reply. This is particularly important if the sender has asked a question since your response may not be immediate.
- Use the subject line appropriately. As well as helping the recipient to quickly assess the importance and relevance of the email to them, it will also make it easier for them when searching for a specific email in their mail folders.
- Use the same standards of courtesy that you would when talking to a person face-to-face. Avoid excessive bluntness (which will usually be interpreted as coldness or anger), sarcasm or annoyance.
- If you have an emotional response to e-mail you receive, wait 24 hours before responding. Compose a reply without sending it (or write nothing), wait 24 hours, then go back to reread the other person's message.
- Make an effort to keep e-mail addresses confidential. This can be done by deleting addresses on emails forwarded to others.
- Humor does not work well in e-mail. Without the cues of tone of voice or body language, the recipient may take your words literally and at best, fail to see the humor and at worst, be offended.
- Remember, anyone may see your e-mail.

NOTE

Over the coming year we shall be displaying different lighthouses in the newsletter. We welcome your feedback regarding the newsletter's new look. Let us know which lighthouse you prefer.

Mary Dufort, BSN, MEd. of DHS was asked when the proposed revisions to the Medical Staff Chapter of the Regulations would be finalized. Below is the response received:

“The regulations are currently in the review process and once this is completed, they will begin the APA process at which time the proposed new language will be sent to all interested parties and posted on the State Web page with the dates (www.maine.gov). I think that it is safe to say that this will probably take about 3 months to complete the process.”

My Role in Patient Safety

By Lois Macias
Vice President, Ancillary Services
Maine Coast Memorial Hospital

Anyone who picks up a newspaper, listens to TV and radio, or has ANY contact with the outside world, is aware of the national attention toward the reduction of medical errors. Those of us who work in healthcare may feel somewhat uneasy about this negative attention; however, it certainly becomes easier to make our point when everyone's listening.

As healthcare workers, we play a dual role in making a point about patient safety. First, whenever we or our loved ones need healthcare, we can be model patients who are empowered to play a major role in our own health. If you're anything like me, I suddenly lose my ability to think when faced with a white coat whose wearer's name is followed by "MD" who wants to talk about my health. I've been around hospitals my entire life (my dad was a hospital administrator) and I've only worked in healthcare, but suddenly I feel I'm being disrespectful if I question what a provider is telling me. Heaven forbid if I should want more information, but my provider hasn't asked, "Do you want more information?" As a model patient, I should feel obligated to ask questions until I have no more (it isn't

disrespectful), tell my provider even “unimportant” things, like I’m taking an herbal supplement, and question when something doesn’t “feel” right. As one physician was recently quoted in the December 15 issue of *Newsweek*, “I’m only a human being”. Good healthcare providers truly appreciate engaged and actively participating patients.

Our second role in ensuring patient safety is to be aware of what’s being reported in our industry on this topic. Much research is being done on any number of patient safety topics and the national call for data is a little deafening. The sharing of that research and the local analysis of that collected data will help us in our own organizations. For example, what is your organization doing toward meeting the Joint Commission’s National Patient Safety Goals for 2004? Whether or not your organization is JCAHO accredited, these goals are backed by national research and experience and should be used as a benchmark. The September, 2003 issue of Joint Commission’s *Perspectives on Patient Safety*, which describes the 2004 goals and how to meet them, is available free on their website, www.jcaho.org. Another document recently posted on that website is the “*Universal Protocol to Prevent Wrong Site Surgery*”. Other worthwhile sites are www.ecri.org and www.qualityforum.org.

Finally, let’s try to resist the urge to “blame” Joint Commission when a controversial, new patient safety policy or practice is presented for discussion and approval. It is easier to say, “Because JCAHO requires it”, but that doesn’t inspire the real support that presenting a convincing argument, including the data and the rationale, would stimulate.

As I write this, I’m thinking about my audience and I realize I’m preaching to the choir. Your role in patient safety in the area of credentialing, as just one example, cannot be overstated. Keep up the good work!

MEDICAL STAFF QUALITY

Achieving effective peer review

Joyce A. Allen, CPMSM
Sr. Manager, Medical Staff Services
The Aroostook Medical Center (TAMC)
Presque Isle, ME

In October, 2003 the VPMA, Medical Staff President, Chair of Medical Quality Review Committee and I attended the *Medical Staff Quality* program presented by The Greeley Company. The following is an overview of the key tools derived from the program.

Committee vs. Clinical Department Peer Review Process

The program reinforced the benefits of developing a medical staff committee that is responsible for peer review. It is important that the committee be established to report to the Medical Executive Committee (MEC) and that it have recommendation authority only. The medical quality review committee (MQRC) should be presented to the medical staff as the body responsible for gathering information through an objective, consistent method; with a collegial, educational, non-punitive approach. Keeping the medical staff informed of the MQRC process and providing regular summary reports is important to ensure the MQRC is seen in a positive light by the medical staff.

A medical quality review committee should be comprised of representatives from each of the clinical departments, appointed to serve for (staggered) terms between 2 – 5 years. This provides the longevity necessary for the members to gain experience in the peer review process.

As with any new method, there are growing pains, and the process may be tweaked to best fit the climate and customs of an individual hospital/medical staff. At TAMC, for example, we initially felt it was important for the clinical department chairs to serve on the MQRC. After some

consideration, we abandoned that approach for a couple of reasons:

- (1) it would create additional workload and meeting requirements on our volunteer department chairs; and
- (2) we felt there was a potential for conflict of interest if a case review was appealed since the department chairs serve on the MSEC.

Peer Review Indicators

Greeley suggests three types of indicators, as follows:

Type I Indicators – Rules. Establish indicators for which compliance is expected when privileges are granted. Rule Monitoring Reports should be provided to the physician with copies filed in the peer review file. No further action is necessary for rare or isolated deviation from compliance, since this usually represents a minor problem. However, if a pattern of events or a potentially serious isolated event is identified, a report from MQRC to the MEC should be made, as the MEC is responsible for determining future action.

Examples of Rules include: blood use, timely completion of H&P's, and compliance with restraint orders. It is important to provide the data in a blinded manner, so each physician can compare his/her performance with peers.

Type II Indicators – Significant events necessitating case review. A significant event that requires analysis by the MQRC to determine cause, effect and severity. The MQRC should develop, and have MEC approve, the Type II indicators. Also, consider adopting a policy that allows anyone in the hospital to refer a case for review by MQRC, in accordance with written guidelines for submitting a case. (A sample of the TAMC guideline and referral form is attached to this newsletter).

The review process of Type II cases has been revised by our MQRC during the past

4-5 years of its existence. Initially, the cases for review were divided between the members of the committee. Each member reviewed a case to determine the care rendered and whether the case required full committee discussion/review. When committee discussion was warranted, reviewing member presented the case identifying the questions or deviations.

The review method was changed to ensure a comprehensive and unbiased review. Currently the VPMA reviews all Type II cases, identifies those to be referred for committee discussion, and provides a summary of each case. Each member of the MQRC then reviews the cases prior to the meeting and makes preliminary assessments on **Outcome, Documentation, Issues, and Overall Care**

The committee then discusses and determines the questions, if any, to be posed to the physician(s) involved. Each physician receives a letter from the MQRC containing the questions posed and each physician is asked to respond in writing or, preferably, to attend the next meeting. (Hand-delivery of these letters by the MQRC Chair or VPMA, with affirmation of the collegial, educational, fact-finding process is highly recommended).

Following the physician's response, the MQRC makes final determinations regarding:

Outcome

- 1) No adverse outcome,
- 2) Minor adverse outcome,
- 3) Major adverse outcome,
- 4) Catastrophic adverse outcome.

Documentation (indicate all that apply)

- 1) No issue with documentation,
- 2) Documentation does not substantiate clinical course and treatment,

- 3) Documentation not timely to communicate with other caregivers,
- 4) Documentation illegible,
- 5) Other: (specify).

Problem Identification (indicate all that apply)

- 1) No issue with physician care,
- 2) Issue in physician diagnosis,
- 3) Issue in physician judgment,
- 4) Issue in physician technique/skills,
- 5) Issue with physician policy compliance,
- 6) Issue with physician supervision,
- 7) Potential system or process problem,
- 8) Potential issue with nursing care.

Overall Physician Care

- 1) Physician care appropriate,
- 2) Physician care controversial,
- 3) Physician care inappropriate.

The final determinations are provided to the physician. An appeal process must be offered whenever a physician's care is determined to be other than care appropriate.

All peer review documentation is maintained in the confidential peer review files. Issues identified by the MQRC that are outside its purview, i.e. nursing issues, are referred to the appropriate entity for further handling.

Type III Indicators – Rates. A record should be generated and maintained for statistical analysis, with a target range established for each rate indicator. The rate indicator may be based on best practice from benchmark data, statistical variation from the average or internal targets. The rates should be broken down by service, department, or individual physician. Feedback should be provided to physicians on a regular and timely basis. Only if a physician falls outside the target range is there a need for the MQRC to conduct a

more focused review and forward on to the MEC with an appropriate recommendation. Rate data does not require that any records be evaluated and, according to Greeley, it is not necessary to place rate scorecards in the peer review files.

Examples of Rate Indicators are:

- 1) Pneumonia Average Length of Stay,
- 2) CHF Readmission Rate < 31 Days,
- 3) C-Section Rate,
- 4) VBAC Rate,
- 5) Severity Adjusted Medicare Average Length of Stay,
- 7) Inpatient Satisfaction (with physicians).

Greeley suggests a Medical Staff Indicator Scorecard using the following rating key:

- G** = Good Performance; mean acceptable, data in control;
- Y** = Performance Concerns, mean acceptable, data not in control;
- R** = Poor Performance, mean unacceptable.

Establishing the targets for Type III indicators is a challenge both for the peer review process, as well as for the credentialing and privileging process. This may be another opportunity for MeAMSS members to assist each other by sharing target ranges that individual hospitals have established. I encourage anyone with benchmark data they are willing to share with MeAMSS members to email me and I will be happy to report the information in a future article.

Quarterly summary reports should be submitted from MQRC to MEC, the clinical departments and the Board of Directors.

It is also important for the MQRC to congratulate peers on positive performance. Best rules of thumb: *“It’s the behavior, not the person”* and *“Praise in public, chastise in private”*.

THE EVOLUTION OF CREDENTIALING

Part III

Claudia J. Edwards, CPMSM

This is a series highlighting cases that have had significant impact in the healthcare setting.

Elam v. College Park Hospital (1982) - Appeal

The hospital initially won a summary judgment in Superior Court of San Diego County, but the appellate court reversed this decision and remanded the case back to the lower court for factual inquiries to determine whether the hospital was “guilty of negligent credentialing” and thus guilty of corporate negligence.

Case history: Ms. Elam underwent surgery to correct bilateral bunions and bilateral hammer toes. She was jointly admitted to the hospital by Drs. Schur and Markarian (a medical doctor), as the hospital had a co-admission policy requiring a physician to assume responsibility for the overall medical care and to evaluate the patient’s history and physical to ensure that surgery was not contraindicated. Drs. Schur and Cahn performed the surgery.

Sophia Elam filed a complaint against Drs. Martin J. Schur, Merrill F. Cahn and Samuel Markarian for malpractice and College Park Hospital for corporate negligence. She alleged that all defendants provided negligent care in the surgery and in the post medical management of her care. She alleged that the hospital was negligent in not ensuring the competence of practitioners treating patients within its walls. Ms. Elam won her suit against Dr. Schur where at trial his medical care was found to be substandard (I was not able to determine from the sources reviewed whether the other

physicians settled or were dropped from the suit). Because of a prior case law, College Park Hospital was granted summary judgment and dismissed from the suit. Ms. Elam appealed.

At issue in this case was the failure of the hospital to take action against Dr. Schur even though the facility was aware of prior professional liability actions against him. The plaintiff’s attorney had brought three other malpractice actions against Dr. Schur. The hospital learned of at least one of these actions four and one-half months prior to Ms. Elam’s surgery.

The hospital defended its role by stating that Dr. Schur was always an independent contractor and was never an employee or agent. He performed his own services and directly billed Ms. Elam for services. Additionally, the hospital noted that Ms. Elam had personally selected Dr. Schur to evaluate her condition and perform surgery.

In June 1974, Dr. Schur applied to the College Park Hospital medical staff. The staff at College Park verified his podiatric degree, podiatric license and his privileges at two other San Diego hospitals. The College Park governing body granted him privileges on April 25, 1975.

On three separate occasions (June 17, 1974, October 22, 1974 and June 17, 1976) plaintiff’s attorney had brought malpractice actions against Dr. Schur. Each case involved Dr. Schur seeing a patient less than one week prior to performing extensive surgery (and billing for procedures not performed in at least one of these cases). College Park Hospital admitted it learned of the 1976 case about four and one-half months prior to Dr. Schur operating on Ms. Elam.

It is important to know that the “essential elements of negligence include:

1. **a defendant’s legal duty to use due care; (*emphasis added*)**
2. a breach of that duty; and

3. the breach as the proximate or legal cause of the resulting injury.

“The hospital argued it did not owe its patients a legal duty to exercise reasonable care in selecting, reviewing and periodically evaluating the competency of the physicians and podiatrists it permits to treat patients within its facilities.” Numerous cases supporting and countering this position were cited. The court cited Sections 32128n11 and Business and Professions Code Section 2282n12 and stated that by implication hospitals have a duty of care. Regarding the staff selection, the court found that the hospital had procedures for appointment and reappointment in accordance with JCAH standards. This implied that hospitals have a duty to perform periodic review of competency before reappointment. The hospital’s duty was also implied because:

1. It required renewal of staff privileges at least every two years;
2. Hospital bylaws, rules and regulations contained provisions for accurate and complete medical records including history and physical; and
3. There was a mechanism to perform periodic review of professional ethics and quality of medical care.

SUMMARY

The appellate court found that the lower court erred in granting the Motion for Summary Judgment. This decision was based on “the public’s perception of the modern hospital as a multi-faceted, health-care facility, responsible for the quality of medical care and treatment rendered.” The hospital was found to have a duty to carefully credential its medical staff as it assumes “the role of a comprehensive health center, ultimately responsible for arranging and coordinating total health care”. California law requires the hospital to exercise oversight responsibility in the medical staff’s discharge of its responsibilities in conducting proper peer review. “As a general principle, a hospital’s failure to insure the competence of its

medical staff through careful selection and review creates an unreasonable risk of harm to its patients.” The court stated the hospital is liable for malpractice by independent members of the medical staff even when the patient selects the physician.

The hospital’s Medical Care Evaluation Committee was responsible for monitoring, evaluating and improving the quality of care in the hospital. This committee regularly evaluated the medical records of its medical staff members and never reported to the hospital’s administrator that it had reason to consider Dr. Schur incompetent or unqualified. The Court emphasized it was the governing body’s responsibility to provide oversight of medical care rendered within the facility.

This case is important because it is the first time that a case of corporate responsibility was applied against a hospital for the care rendered by an independent practitioner who exercised privileges at the hospital.

Sources:

Excerpts were taken from the following:

Medical and Public Health Law Site: *Classic Hospital Liability for Medical Staff Member Liability – Darling v. Charleston Community Memorial Hospital*, 33 Ill.2d 326, 211 N.E. 2d 253, 14 A.L.R.3d 860 (Ill. Sep 29, 1965)

HcPro’s Credentialinfo.com, *Legal Issues in Credentialing and Privileging*
amda.com (American Medical Directors Association website), article: *Credentialing & Privileging: One Size Doesn’t Fit all*
Consumer & Media Resources, ATLA Press Room

HR 208 Quality Management

Medical and Public Health Law Site

Court of Appeals of California, Fourth Appellate District, Division One, 132 Cal. APP. 3d 332; 183 Cal. Rptr. 156, May 27, 1982.)

OSTEOPATHIC LICENSURE

The following was submitted by Susan Strout, Board of Osteopathic Licensure:

Beginning with licenses expiring after December 31, 2003, regardless of the date of initial licensure or last license renewal,

1. the license of every physician born in an even-numbered year expires at midnight in 2004 on the last day of the month of the physician birth; and
2. the license of every physician born in an odd-numbered year expires at midnight in 2005 on the last day of the month of the physician birth.

SCHEDULE FOR RENEWAL

Upon expiration of the license as stated in Section 2, a physician must file a timely and sufficient application with the Board to renew the license issued pursuant to 32 M.R.S.A. § 2581 every two years by the last day of the month of birth of the physician seeking license renewal, on forms prescribed and supplied by the Board.

Example A:

Physician A's birth date is February 29, 1966. After December 31, 2003, Physician A must submit a signed and completed application, on forms prescribed and supplied by the Board by midnight on February 29, 2004 and must be renewed again by February 28, 2006 and each and every even numbered year thereafter by the last day of Physician A's birth month.

Example B:

Physician B's birth date is July 5, 1957. After December 31, 2003, Physician B must submit a signed and completed application, on forms prescribed and supplied by the Board, by midnight on July 31, 2005 and must be renewed again by July 31, 2007 and

every odd numbered year thereafter by the last day of Physician B's birth month.

Physicians born January through June automatically will be renewed through June and then subsequently converted to renew on the biennial of their birth date.

REMINDER FROM NAMSS

Beginning on **January 1, 2004**, everyone who has earned and is using the CMSC (Certified Medical Staff Coordinator) credential should begin using the new designation of CPMSM (Certified Professional Medical Services Management). For more information on this name change, read the website article "[New Name for Changing Times.](#)" ([Click here to read the article now.](#))

Illustration by Dave Harbaugh



From the hcPro 2004 Calendar

Network Questions From Mary Gifford, CPMSM

1. [Do any members have a structured category for allied health identifying independent vs. dependent practitioners?](#)

One response received from Mayo Regional Hospital.

2. Would appreciate learning definitions of medical staff categories, particularly consulting medical staff.

Seven responses received – Acadia Hospital, Inland Hospital, Maine Coast Memorial Hospital, MaineGeneral Medical Center, Mayo Regional Hospital, Miles Healthcare, and Mercy Hospital.

3. Do you provide compensation to your medical staff?

Three responses:

TAMC - \$5,000 annual stipend to the Medical Staff President paid by administration. Members of the Quality Review Committee receive \$100 per meeting, each provided they attend the meeting and have done their chart reviews.

MCMH - \$1,000 per month to the Medical Staff President paid by administration.

Parkview - \$5,000 annual stipend to the Medical Staff President which is matched by hospital administration.

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QUIZ QUESTIONS

(from msspnext.com)

A. Which of the following actions is NOT reportable to the National Practitioner Data Bank?

1. Suspension of physician's privileges for 60 days.
2. Surrender of clinical privileges during a formal investigation.
3. Denial of a medical license application by a State Licensing Board.
4. Malpractice payments of less than \$5,000.

B. A hospital that does not query the Data Bank as required by HCQIA is

1. Reported in the Federal Register.
2. Legally liable for any information reported.
3. Subject to a civil monetary penalty of \$11,000 for each occurrence.
4. Subject to loss of NPDB query access.

C. HCQIA protections apply to:

1. Peer review of MD's, DO's and Dentists.
2. Peer review of MD's, DO's, Dentists and Podiatrists.
3. Peer review of MD's, DO's, Dentists, Podiatrists, and Independent Allied Health Professionals.
4. Peer review of any and all individuals providing direct patient care.

D. Individuals providing information to professional review bodies regarding competence and or conduct of a physician are protected from liability EXCEPT

1. When the information provided is false.
2. When the individual is in competition with the practitioner.
3. When the individual providing the information is related by marriage to the practitioner.
4. When the information provided is false and the person providing the information knew it was false.

Answers: A3, B2, C1, D4

**MEDICAL QUALITY REVIEW COMMITTEE
REQUEST FOR REVIEW**

Patient Name _____

Medical Record #

Date of Occurrence:

Place of Occurrence (ER, Inpatient, etc.):

Please list providers involved in care (if appropriate).

Describe below your reason and concerns for having this chart reviewed.

Name: (Please Print)

(Please sign your name and phone extension)

This form will be kept confidential. However, in order to conduct a thorough review, it is sometimes necessary to obtain additional information; therefore, without your signature, the review cannot be conducted.

Forward completed form to Medical Staff Services office.

:PCB407