- If admission to a specialty education program is based on verification of education and experience to date, the hospital does not need to verify education again.
- The process used by the government agency is documented by the hospital.
- The hospital must perform its own verification if the hospital does not have direct knowledge of the process used by the agency to verify education or has never had an opportunity to verify that the agency carries out the process as described.

Exception for SQE.05.01, ME 1, for initial surveys only. At the time of the initial JCI accreditation survey, hospitals are required to have completed primary source verification for new medical staff members who joined the medical staff within the twelve (12) months leading up to the initial survey. During the twelve (12) months following the initial survey, hospitals are required to complete primary source verification for all other medical staff members. This process is accomplished over the 12-month postsurvey period according to a plan that places priority on the verification of the credentials of active medical staff providing high-risk services.

Note: This exception refers only to the verification of credentials. All medical staff members must have their credentials collected and reviewed, and their privileges granted. A "phasing in" of this process is not acceptable.

Measurable Elements of SQE.05.01

1. Education, licensure/registration, and other credentials required by laws and regulations or issued by recognized education or professional entities as the basis for clinical privileges are verified from the original source that issued the credential.
2. Additional credentials required by hospital policy are verified from the source that issued the credential when required by hospital policy.
3. When third-party verification is used, the hospital verifies that the third party (for example, a government agency) implements the verification process as described in hospital policy and/or laws and regulations and that the process meets the following expectations:
   - The hospital verifies that the third party implements the verification process as described in hospital policy or regulations and that the process meets the expectations described in these standards.
   - The affiliated hospital that has already conducted primary source verification of the medical staff applicant is acceptable if the affiliated hospital has current Joint Commission International (JCI) accreditation with "full compliance" on its verification process found in SQE.05.01, MEs 1 and 2.
   - The hospital that bases its decisions in part on information from a designated, official, governmental, or nongovernmental agency must evaluate the agency providing the information initially and then periodically thereafter to ensure that JCI standards continue to be met.

Standard SQE.05.02

There is a uniform decision process for the initial appointment of medical staff members and others permitted to practice independently.

Intent of SQE.05.02

Established processes and select criteria ensure validation in the granting of appointments for medical staff.

Appointment is the process of reviewing an initial applicant's credentials to decide if the individual is qualified to provide patient care services that the hospital's patients need, and the hospital can support with qualified staff and technical capabilities. For initial applicants, the information reviewed is primarily from outside sources. Hospital policy identifies the individuals or mechanism accountable for this review, any criteria used to make decisions, and how decisions will be documented. Hospital policy identifies the process of appointment of medical staff for emergency needs or a temporary period. Emergency or temporary appointments and identification of privileges are not made until, at minimum, licensure has been verified.

Medical staff membership may not be granted if the hospital does not have the appropriate resources (that is, special medical equipment or staff) to support the professional practice of the individual. For example, a nephrologist seeking to provide dialysis services at the hospital may not be granted medical staff membership if the hospital does not provide such services.

Finally, when an applicant's licensure/registration has been verified from the issuing source, but other documents—such as education and training—have yet to be verified, the individual may be granted medical staff membership, and privileges may be identified for the applicant for a period not to exceed 90 days. Under such circumstances, these individuals may not practice independently and require supervision until all credentials have been verified. Supervision is clearly defined in hospital policy as to level and conditions and is not to exceed 90 days.

Measurable Elements of SQE.05.02

1. Medical staff appointments are made consistent with hospital policy and are consistent with the hospital's patient population, mission, and the care, treatment, and services provided.
2. Appointments are not made until at least licensure/registration has been verified from the primary source, and the medical staff member then provides patient care services under supervision until all credentials required by laws and regulations have been verified from the original source, up to a maximum of 90 days.
3. Ⓓ The method of supervision, frequency of supervision, and accountable supervisors are documented in the credential record of the individual.

Medical Staff Appointment and Privileges

Standard SQE.06.00

The hospital has a standardized, objective, evidence-based process to grant or deny privileges for medical staff members and others permitted to practice independently.

Intent of SQE.06.00

Privileging is the validation of a medical staff member's current clinical competence by the health care organization for the determination of what scope of clinical services the medical staff member will be authorized to perform. Privileging is a critical process that protects the safety of patients and advances the quality of the hospital's clinical services. The hospital establishes a uniform process to manage the applications for the granting, renewal, or revision of medical staff clinical privileges to ensure that the expectations for the appointment of medical staff membership are consistently followed. Considerations for clinical privilege delineation at initial appointment include the following:

Decisions regarding a medical staff member's clinical competence and clinical privileges are based primarily on information and documentation received from sources outside the hospital. The sources may include the following:

- Specialty education programs
- Letters of recommendation from previous medical staff appointments and/or close colleagues
- Any quality data that may be released to the hospital

Sources of information, other than those from educational institutions such as medical specialty programs, are not verified from the source unless required by hospital policy. These sources are used to identify the areas of presumed competence. Ongoing professional practice evaluation validates the areas of presumed competence.

There is no one best way to delineate which clinical activities the new medical staff member is privileged to perform. Specialty training programs may identify and list the general competencies of that specialty in areas of