EMORY HEALTHCARE

MEDICAL STAFF SERVICES
& SYSTEM CREDENTIALING

Dear Applicant,

Thank you for your interest in Emory Healthcare. We use a pre-application process to determine whether prospective applicants meet our basic criteria for Medical Staff membership.

We will review your pre-application and the accompanying documentation. If you meet our general membership criteria, we will provide you with an online application for membership to the Medical Staff.

Before returning the pre-application, please take a moment to review the checklist to make sure all of the information is complete and all the required documents have been attached to the application.

Sincerely,

The Medical Staff Services Office

EMORY
HEALTHCARE

Emory Decatur Hospital ♦ Emory Long-Term Acute Care ♦ Emory Hillandale Hospital

PRE-APPLICATION
FOR
MEDICAL STAFF MEMBERSHIP

PLEASE COMPLETE ALL SECTIONS OF THE APPLICATION FORM, PROVIDE COPY OF REQUESTED ITEMS, AND RETURN TO THE EMAIL ADDRESS LISTED BELOW:

Sheronda A. Davis
Sr. Medical Secretary, Medical Staff Services (1023B)
Emory Decatur Hospital
2701 North Decatur Road
Decatur, GA 30033
(P) 1-404-501-1724 (F) 1-404-501-5093
Sheronda.davis@emoryhealthcare.org

Emory Decatur Hospital ♦ Emory Long-Term Acute Care ♦ Emory Hillandale Hospital

MEDICAL STAFF SERVICES POLICY

Application Process and Fees

STATEMENT

The pre-application process is used to determine if an individual is eligible for medical staff membership and clinical privileges.

MEDICAL STAFF: *New Applicants*

The pre-application process includes a pre-application and a criminal background check. Results of the criminal background check will be reviewed on a case-by-case basis by the Chair, Credentials Committee. The following will be considered for individuals with misdemeanor or felony results:

1. The nature and seriousness of the crime;
2. How long ago the crime was committed;
3. The applicant's age when the crime was committed;
4. Evidence of rehabilitation;
5. Whether the applicant's licensure was reinstated in all pertinent jurisdictions;
6. The relationship of the crime to the applicant's ability to practice medicine safely and ethically.

It is the burden of the applicant to produce any information requested to resolve issues or concerns regarding the pre-application. Individuals, who meet the criteria in the Medical Staff Bylaws, and Department Rules and Regulations and pass review for the criminal background check, will receive an application for Medical Staff membership and clinical privileges.

The application fee is $500 for any Emory Healthcare Facility (Emory Decatur Hospital, Emory Long-Term Acute Care, Emory Hillandale Hospital); $625 for any two hospitals, and $750 for three hospitals. ***The application fee must be paid prior to issuing the full application online. You will receive a link to pay the application fee online.*** The application fee is non-refundable.

MEDICAL STAFF: *Renewal of Clinical Privileges and Membership*

Applicants must establish and maintain current licensure, relevant training or experience, current competence and ability to perform the privileges requested. It is the burden of the applicant to produce any information requested to resolve issues or concerns regarding the application for renewal of medical staff membership and clinical privileges.

The application fee for renewal of medical staff membership and clinical privileges is as follows:

- Application returned within 30 days following mail out from MSS $125.00
- Application returned within 31- 60 days following mail out from MSS $250.00
- Application returned within 61 days or more following mail out from MSS $500.00

ALLIED HEALTH PROFESSIONAL STAFF: New Applicants

The application fee is $100 for one Emory Healthcare Facility; $200 for two Emory Healthcare Facilities; and $250 for three Emory Healthcare Facilities. The application fee is non-refundable.

ALLIED HEALTH PROFESSIONAL STAFF: Renewal of Clinical Activities and Membership

The application fee for renewal of Allied Health Staff membership and clinical activities is as follows:

- Application Returned within 30 days following mail out from MSS $100.00
- Application Returned within 31- 60 days following mail out from MSS $200.00
- Application Returned within 61 days or more following mail out from MSS $300.00

FAILURE TO DISCLOSE

Practitioners are responsible for the completeness and accuracy of the information on the application. Any misstatement or omission, whether intentional or not, may result in the immediate cessation of the processing of the application and forfeiture of the application fee. The discovery of a misstatement or omission following appointment or reappointment may constitute grounds for automatic relinquishment of clinical privileges and Medical Staff appointment. Practitioners must report all public and private orders. The Emory Healthcare Credentials Committee/Medical Executive Committee may elect to levy a fine on any actions which fail to be reported.

National Provider Identifier (NPI)

All applicants for the Medical Staff and Allied Health Professional Staff will be required to have an NPI number. Applications are considered incomplete without an NPI and will not be submitted to the Medical Staff or Allied Health Professional Staff for review. An NPI can be applied for via the following website: https://nppes.cms.hhs.gov.

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Checklist

All items listed below must be received, in order for the credentialing process of the pre-application to begin. Items not included will cause the pre-application packet to be returned to the applicant.

☑ **Completed Pre-Application Forms (All Questions/sections must be completed)**
- **Signed Authorization & Consent Form**
- **Completed Intended Practice Plan**

☑ **Copy of current Curriculum Vitae (CV) – Must list work history & EDUCATION in Month/Year format**

☑ **Copy of your Georgia medical license (Wallet Card)**

☑ **Copy of current federal DEA certificate (you will need a DEA registered in Georgia for appointment - GA mailing address must be listed on the certificate at the time of the Full Application phase, once the Pre-Application phase is approved)**

☑ **National Practitioner Identifier (This should be documented on Pg. 6 of the Application)**

☑ **Copy of your Certificate of Insurance reflecting your coverage limits and coverage of defense costs outside of policy limits coupled with the Best rating of your carrier. Please see enclosed. Failure to meet coverage requirements will result in denial of your pre-application.**

☑ **Confidentiality and Nondisclosure Agreement (Return All Pages of the Agreement)**

☑ **Schedule A (Condition of Release)**

☑ **Schedule B**

☑ **GA Medicaid Enrollment Attestation Form**

☑ **Required Meaningful Use Email Form**

☑ **Applicant Identification Form**

☑ **Color copy of a Government Issued ID (driver's license/passport)**

All items listed above are attached to the pre-application I'm submitting.

_____ _____

Signature Date

EMORY
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Emory Decatur Hospital ♦ Emory Long-Term Acute Care ♦ Emory Hillandale Hospital

PRE-APPLICATION FOR MEDICAL STAFF MEMBERSHIP

PLEASE CHECK *(AS APPROPRIATE)* THE FACILITIES FOR WHICH YOU ARE APPLYING:

☑ **Emory Decatur Hospital** ☐ **Emory Long-Term Acute Care** ☐ **Emory Hillandale Hospital**

Last Name	**First Name**	**Middle Initial**	**Degree Type**	**Date of Application**
PROVIDERS_LASTNAME	PROVIDERS_FIRSTNAME	PROVIDERS_MIDDLENAME	PROVIDERS_DISPLAYDEGREES_SHORT	

Practice Address (must provide)	**City**	**State**	**Zip**	**Phone**
PROVIDER_ADDRESSES_PRIMARY_ADDRESSLINE2	PROVIDER_ADDRESSES_PRIMARY_CITY	PROVIDER_ADDRESSES_PRIMARY_STATE	PROVIDER_ADDRESSES_PRIMARY_ZIPCODE	404-365-0966
Home Address (must provide)	**City**	**State**	**Zip**	**Phone**
				404-365-0966

Name of Practice you are joining or currently a member of that is associated with Emory Healthcare	**Date of Association**
The Southeast Permanente Medical Group	

List of Current/Future Associates:
The Southeast Permanente Medical Group

	YES	**NO**
Have you satisfactorily completed an approved postgraduate training program in the specialty in which you seek clinical privileges or are you currently in a postgraduate training program?		
If appointed to the medical staff, will you agree to participate in providing coverage in the Emergency Department and in the outpatient clinics as required by the Medical Staff Bylaws, Policies, and Rules?		
Do you hold a current unrestricted license to practice your profession in Georgia? *(enclose copy of license)*		
Do you hold a current unrestricted DEA registration certificate? *(enclose copy of certificate)*		
Do you have current, valid professional liability insurance coverage with limits of liability at a minimum of $1, 000, 000 and $3, 000, 000? *(enclose a copy of the face sheet)*		
Are you currently a defendant in a malpractice suit?		
Have you been a defendant in a malpractice suit within the last 5 years, which has been settled or gone to court? *(If yes, enclose the name of the court, and the court term of each action where you have been named a defendant.) Please include a typed Schedule B.*		
Do you participate in Medicare?		
Do you have a National Provider Identifier (NPI)? *(An NPI number must be provided at the time of submission of the initial application). Please enclose a copy of the NPI confirmation email you received at time of registration, if applicable.*		
Please List Your Numbers: NPI: _____		
Do you participate in Medicaid?		

IF YOUR ANSWER IS YES TO ANY OF THE QUESTIONS BELOW, PLEASE PROVIDE AN EXPLANATION.)	YES	NO
Have you ever been convicted of Medicare, Medicaid, or other governmental or third party payor fraud or program abuse, or been required to pay civil money penalties for the same?		
Have you ever been terminated, excluded or precluded from participation in Medicare or Medicaid programs?		
Have you ever been convicted of a felony, or any misdemeanor?		
Have you ever been convicted of or entered a plea for any criminal offense (excluding parking tickets)?		
Have you ever had your medical staff appointment or clinical privileges denied, revoked, resigned, relinquished, or terminated by a health care entity or organization?		
Is there record of denial, revocation, or termination of appointment or clinical privileges by any hospital, healthcare facility, or managed care organization?		
Are there presently any proceedings or investigations taking place at any hospital, healthcare facility, or managed care organization?		
Have you ever had any disciplinary actions, suspensions or terminations from any residency, fellowship or training program?		

What is your primary clinical specialty?	SPECIALTIES_SPECIALTY_RTK1		
What is your secondary clinical specialty?			
Are you board certified?	**Yes**	**No**	
If *yes*, the certifying board is recognized by:	☐ **ABPS**	☐ **AMA**	☐ **AOA**
If *no*, is certification in progress?	**Yes**	**No**	
Do you plan to establish or have you established an office near the medical center?	**Yes**	**No**	
If *yes*, where?	**N/A**		
When will office hours begin at that location?	**N/A**		
Are you currently appointed to the medical staff of any hospitals?	**Yes**	**No**	
Hospital	**Address**		
Hospital	**Address**		
Hospital	**Address**		

I understand that completing this pre-application in no way obligates the Medical Center and/or Medical Staff to afford me medical staff membership or privileges. I fully understand that any significant misstatements in, or omissions from, this pre-application constitutes cause for denial of an application for membership. All information submitted by me in this pre-application is true to my best knowledge and belief.

I hereby release from liability any representatives of the Medical Center and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating my request for medical staff membership and privileges at any Emory Healthcare, and I hereby release from liability any and all individuals and organizations who provide information to the Medical Center, and/or its Medical Staff in good faith and without malice concerning my professional competence, ethics, character and other qualifications, and I hereby consent to the release of such information.

_____ _____

Signature of Applicant **Date**

Providers_LongName

Printed Name

ADMINISTRATIVE APPROVAL – Office Use Only

[ ] Approved [ ] Denied [ ] Defer To Credentials Committee

_____ _____

Signature Printed Name & Title

_____

Date

Comments: _____

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INTENDED PRACTICE PLAN

Practitioner's Name: Providers_LongName
Please Print

	Yes	No
1. Define your scope of practice:		
A. I intend to establish (or join) a practice in the following location:	x	
B. Please state the Location (City/Area):		
C. Solo Practice		x
D. Group Practice	x	
Group Name: The Southeast Permanente Medical Group		
Partners:		
2. Office Type		
A. Office Based Practice (Clinic/Ambulatory)	x	
B. Hospital Based/ Hospital Admissions		x
3. What Facilities are you Applying for Privileges		
A. Emory Decatur (EDH)	x	
B. Emory Hillandale (EHH)		x
C. Emory Long Term Acute Care (ELTAC)		x
4. I will personally admit my patients in need of hospitalization to EDH, EHH or ELTAC. If yes, approximately how many patients per month will you admit? _____ If no, to what institution will you be admitting your patients in need of hospitalization? _____		
5. I will not be admitting my own patients, however, I will be referring my patients to the following Emory facility (ies) (checked above) when they are in need of acute services.		
6. I will perform procedures at EDH, EHH or ELTAC.		
A. Approximate Number of Outpatient Procedures: _____		
B. Approximate Number of Inpatient Procedures: _____		
C. If no, where will you perform procedures? _____		
7. I will perform consultations at the request of other physicians at all facilities I am applying for staff membership. (If No, please attach an explanation)		
8. Describe your practice plan by checking any of the following that apply		
A. I will admit my own patients that are initially seen, evaluated and followed in my private office.		
B. I will function as a hospitalist by seeing patients referred to me by the Emergency Department.		
C. I serve as a medical director in a nursing home only and use the hospital for those nursing home patients in need of hospitalization.		
D. I will refer my patients from my private practice to hospitalists who practice in the hospital.		
E. I will serve as a proceduralist admitting patients from my office setting and provide consultations/procedural work on referrals I receive from other physicians (outpatient and Inpatient referrals).		
9. The following physician(s) have explicitly agreed to provide continuing coverage for my patients when I am not available: TSPMG Providers		
10. I will not use Emory Healthcare for the care of my patients, but desire medical staff appointment to secure participation with various health maintenance or managed care organizations.		

		Yes	No
11.	I agree to treat employees, patients, visitors, and other physicians at all facilities I am applying for staff membership.		
12.	I agree to complete my patient records in the timeframes specified and required by the institution.		
13.	I agree to provide back-up specialty coverage (emergency department if required by your specialty or inpatient consults) at the request of the Medical Executive Committee.		
14.	I agree to participate in relevant clinical practice guidelines when such guidelines have been determined by the Medical Executive Committee to influence positively patient outcomes and overall performance.		
15.	I own a significant interest, either personally or corporately, in a healthcare organization that competes with Emory Healthcare.		
16.	I understand that my answers to the above questions will be considered by Emory Healthcare for pre-application approval for medical staff membership. If approved for an initial appointment application, adherence to the above practice plan is expected.		

To assist the credentials committee in the pre-application screening process all practitioners are asked to provide the following reference information.

A. If joining a group please provide the following:
   1. Name of Senior Partner: _____
   2. Contact Information: Office: _____Cell:_____
      Email: _____

If establishing a solo practice please provide the following information:

A. Are you a recent graduate from a residency/fellowship program: □ Yes □ No
   IF YES, date program completed: _____N/A_____
   Name of Program Director: _____
   Contact Information: Office: _____ Cell: _____
   Email: _____

   IF NO, please list a current hospital affiliation with contact information for the Chief of Staff and the Chief of the Department for the hospital information listed below.
   Hospital Name: _____Department_____
   Chief of Staff: _____
   Contact Information: Office: _____ Cell: _____
   Email: _____
   Department Chief: _____
   Contact Information: Office: _____ Cell: _____
   Email: _____

   □ I am currently not affiliated with any hospital. (List a previous hospital affiliation)
   Hospital Name: _____Department_____
   Chief of Staff: _____
   Contact Information: Office: _____ Cell: _____
   Email: _____

   Department Chief: _____
   Contact Information: Office: _____ Cell: _____
   Email: _____

_____ _____
Signature Date

PEER REFERENCES

Please list five (5) references from licensed professional peers who through recent observation have the personal knowledge of and are directly familiar with your professional competence, conduct and work. Do not include relatives and program directors. At least one reference must be a practitioner in your same professional discipline.

Name of Reference: AFFILIATIONS_REFERENCES_OTHERS_REFERENCE_NAME1	
Specialty: Dates of Association: Email: AFFILIATIONS_REFERENCES_OTHERS_REFERENCE_EMAIL1 Telephone Number AFFILIATIONS_REFERENCES_OTHERS_REFERENCE Fax Number: None	Complete Address: AFFILIATIONS_REFERENCES_OTHERS_REFERENCE_ADDRESS 11, AFFILIATIONS_REFERENCES_OTHERS_REFERENCE_CITY1, AFFILIATIONS_REFERENCES_OTHERS_REFERENCE_STATE1, AFFILIATIONS_REFERENCES_OTHERS_REFERENCE_ZIPCODE1
Name of Reference: AFFILIATIONS_REFERENCES_OTHERS_ACTIVE_NAME2	
Specialty: Dates of Association: Email: AFFILIATIONS_REFERENCES_OTHERS_ACTIVE_NAME2 Telephone Number AFFILIATIONS_REFERENCES_OTHERS_ACTIVE_PHO Fax Number: None	Complete Address: AFFILIATIONS_REFERENCES_OTHERS_REFERENCE_ADDRESS 11, AFFILIATIONS_REFERENCES_OTHERS_REFERENCE_CITY2, AFFILIATIONS_REFERENCES_OTHERS_REFERENCE_STATE2, AFFILIATIONS_REFERENCES_OTHERS_REFERENCE_ZIPCODE2
Name of Reference:	
Specialty: Dates of Association: Email: Telephone Number Fax Number: None	Complete Address:
Name of Reference:	
Specialty: Dates of Association: Email: Telephone Number Fax Number: None	Complete Address:
Name of Reference:	
Specialty: Dates of Association: Email: Telephone Number Fax Number: None	Complete Address:

Schedule A

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this Application, including all subparts and attachments, I acknowledge, understand, consent and agree to the following:

1. As an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [*e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), managed care organization, network, medical society, professional association, medical school faculty position, or other healthcare delivery entity or system (hereinafter referred to as a "Healthcare Entity")* indicated on this Application, I have the burden of producing adequate information for proper evaluation of this Application.

2. I also understand that I have the continuing responsibility to resolve any questions, concerns or doubts regarding any and all information in this Application. If I fail to produce this information, then I understand that the Healthcare Entity will not be required to evaluate or act upon this Application. I also agree to provide updated information as may be required or requested by the Healthcare Entity or its authorized representatives or designated agents.

3. The Healthcare Entity and its authorized representatives or designated agents will investigate the information in this Application. I consent and agree to such investigation and to the disciplinary reporting and information exchange activities of the Healthcare Entity as a part of the verification and credentialing process.

4. I specifically authorize the Healthcare Entity and its authorized representatives and designated agents to obtain and act upon information regarding my competence, qualifications, education, training, professional and clinical ability, character, conduct, ethics, judgment, mental and physical health status, emotional stability, utilization practices, professional licensure or certification, and any other matter related to my qualifications or matters addressed in this Application (my "Qualifications").

5. I authorize all individuals, institutions, schools, programs, entities, facilities, hospitals, societies, associations, companies, agencies, licensing authorities, boards, plans, organizations, Healthcare Entities or others with which I have been associated as well as all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my Qualifications to consult with the Healthcare Entity and its authorized representatives and designated agents and to report, release, exchange and share information and documents with the Healthcare Entity, for the purpose of evaluating this Application and my Qualifications.

6. I consent to and authorize the inspection of records and documents (including medical records and peer review information) that may be material to an evaluation of this Application and my Qualifications and my ability to carry out the clinical privileges/services/participation I have requested. I authorize each and every individual and organization with custody of such records and documents to permit such inspection and copying as may be necessary for the evaluation of this Application. I also agree to appear for interviews, if required or requested by the Healthcare Entity, in regard to this Application.

7. I further consent to and authorize the release by the Healthcare Entity to other Healthcare Entities and interested persons on request of information the Healthcare Entity may have concerning me (including but not limited to peer review information which is provided to another Healthcare Entity for peer review purposes), as long as in each instance such release of information is done in good faith and without malice. I hereby release from all liability the Healthcare Entity and its authorized representatives or designated agents from any claim for damages of whatever nature for any release of information made in good faith by the Healthcare Entity or its representatives or agents.

Schedule A--continued

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this Application, including all subparts and attachments, I acknowledge, understand, consent and agree to the following:

8. I release from any liability, to the fullest extent permitted by law, all persons and entities (individuals and organizations) for their acts performed in a reasonable manner in conjunction with investigating and evaluating my Application and Qualifications, and I waive all legal claims of whatever nature against the Healthcare Entity and its representatives and designated agents acting in good faith and without malice in connection with the investigation of this Application and my Qualifications.

9. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies. I agree to conduct my practice in accordance with applicable laws and ethical principles of my profession. I also agree to provide for continuous care for my patients.

10. Any investigations, actions or recommendations of any committee or the governing body of the Healthcare Entity with respect to the evaluation of this Application and any periodic reappraisals or evaluations will be undertaken as a medical review and/or peer review committee and in fulfillment of the Healthcare Entity's obligations under Georgia law to conduct a review of professional practices in the facility, and are therefore entitled to any protections provided by law.

11. I have read and understand this Authorization and Release of Information Form. A photocopy of this Authorization and Release of Information Form shall be as effective as the original and shall constitute my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this Application. This Authorization and Release shall apply in connection with the evaluation and processing of this Application as well as in connection with any periodic reappraisals and evaluations undertaken. I agree to execute such additional releases as may be required from time to time in connection with such periodic reappraisals and evaluations.

Signature:	
Printed Name: Providers_LongName	Date:

I grant permission for the release of the credentials information contained in this Application to the following Healthcare Entity(ies):

Emory Healthcare

Georgia Medicaid Enrollment Attestation

Effective May 14, 2018, section 2.A.1.o the medical staff credentialing policy states one of the qualifications for being on the medical staff is for physicians and mid-level providers is:

> Must be enrolled in the Georgia Medicaid Program either as a participating provider accepting patients or as an Ordering, Prescribing or Referring (OPR) Provider for integrity purposes. Any individual who does not satisfy this requirement may submit a written request to the Chief Executive Officer for the requirement to be waived. No individual is entitled to a waiver, nor is any individual entitled to the hearing procedures described in this Policy in the event the Board determines not to grant a waiver.

I Providers_LongName _____ (print name) acknowledge the following:

- Medicaid enrollment is required
- Lack of current Medicaid enrollment will not delay the approval of my pre-application
- Submission of this form is required. Failure to submit this form will delay approval of your completed full application.
- My current status with Medicaid enrollment is (please check all that apply)

☐ I am currently enrolled with GA Medicaid as a participating provider or as an ordering, prescribing or referring provider (OPR). My GA Medicaid registration ID number is: _____

☐ I am currently not enrolled; I have applied to GA Medicaid. Application submittal date is: _____. I understand that final application approval for medical staff membership will not be approved until enrollment is complete and verified by the medical staff services office.

☑ I am currently not enrolled and plan to enroll. I understand that final application approval for medical staff membership will not be approved until enrollment is complete and verified by the medical staff services office.

☐ I wish to request a waiver of the requirement: Must give reason for requesting the waiver. All waivers must be approved by the Board of Directors. If requesting a waiver, pre-application will not be approved until the Board has decided on this request.

_____

_____

_____

_____

Applicant signature: _____ Date: _____

Meaningful Use Stage 3

In preparation for Meaningful Use Stage 3 we will be implementing an important initiative; Secure Health Messaging (SHM). This initiative is required for Emory Healthcare to achieve Meaningful Use. We would like to make all applicants aware of what will be required for each member of the medical staff, including Advance Practice Providers.

To implement this initiative, each provider will need two email addresses. The first email address will be for use by medical staff services office to send general communications to the medical staff. The second email address will be used for SHM. The email address used for general communications and SHM can be the same email address.

The SHM email will be used for the following:

- *to register you in SureScripts – the medication/pharmacy health information exchange used by SCM*
- *to permit use of new functionality that will allow you to send electronic 'Cancel' messages to pharmacies*
- *to allow you to send and receive Secure Health Messaging notifications*

It is important to note the SHM email will be available to any registered user in SureScripts, including pharmacy vendors. The SHM email will be used to share clinical information about the care of your patients. Once an email is registered with Surescripts, it cannot be removed from the database.

Provider Email Address

Provider Name: Providers_LongName

Medical Staff Services:

Please use the following email address(s) for medical staff communication (please type or print

legibly): PROVIDERS_CONTACTEMAILADDRESS

Secure Health Messaging:

You can use the same email as used for Medical Staff Services (above)

Please note: **for Emory Healthcare employed providers, your Emory Healthcare Email will be used for SMH.** Please contact your office manager for assistance in obtaining your Emory email address. The IT department will provide a "_@emoryhealthcare.org email address within one week of notification.

Use the following email address for SHM (please type or print legibly):
PROVIDERS_CONTACTEMAILADDRESS

Schedule B

Claim of

GEORGIA UNIFORM HEALTHCARE PRACTITIONER CREDENTIALING APPLICATION FORM

PROFESSIONAL LIABILITY CLAIMS INFORMATION FORM

The following information is necessary to complete the credentialing verification process and will be kept confidential. Please print or type answers to the following for any malpractice claims reported to your malpractice insurance carrier, opened, closed, settled or paid. For initial credentialing, please complete a separate form for each claim; for recredentialing, complete forms only for new/changed status claims since your last recredentialing. One case per sheet *(please photocopy if additional sheets are needed).*

PROVIDER'S NAME: *(Required even if N/A)*	Providers_LongName			**Does Not Apply** ☐ *Note: Signature Required even if checked.*
Name of Patient Involved	**Age**	**Month and Year of Occurrence** *(Event precipitating claim)*	**Month and Year of Lawsuit**	**Insurance Carrier at Time**
		/	/	

What is/was your status?	**List other defendants:**
☐ Primary Defendant ☐ Co-Defendant ☐ Other, please explain:	

What was the patient's outcome?

How were you alleged to have caused harm or injury to this patient?

Please provide specifics in reference to the adverse event:

What is/was your role in this event?

CURRENT STATUS

☐ **Still pending (as of) Date:** /		**Who is handling the defense of the case?**	
☐ **Trial date set - awaiting trial**		**Trial Date:** /	
☐ **Dismissed**		**Date of Dismissal:** /	
☐ **Defense Verdict**		**Date of Defense Verdict:** /	
☐ **Settled out of court**	**Date:** /	**Total Amount of Settlement:** $	**Amount Paid by You:** $
☐ **Judgment**	**Date:** /	**Total Amount of Judgment:** $	**Amount Paid by You:** $

This Professional Liability Claims Information Form is required on all claims/lawsuits that are reported by your malpractice insurance carrier and/or the National Practitioner Data Bank. Clinical details are required for all suits, regardless of status or settlement amount.

I certify that the information contained in this form is correct and complete (even if N/A) to the best of my knowledge.

Signature: (Required)		**Date:**	

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Applicant Identification Verification

In accordance with JC Standard MS.06.01.03 EP 5, the hospital verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing one of the following: 1) A current picture hospital ID card 2) A valid picture ID issued by a state or federal agency (e.g., driver's license or passport)

Instructions:

1. **Complete section 1, sign, date form and return with your application**
2. **Applicant must present to medical staff services valid proof of identification for verification. Your credentials coordinator will contact you to schedule an appointment to meet with you to complete the verification process.**

Section 1. Applicant Information

Last Name	First Name	Middle Initial	Other Names Used (If Any)
PROVIDERS_LASTNAME	PROVIDERS_FIRSTNAME	PROVIDERS_MIDDLENAME	PROVIDERS_OTHERNAME_LAST, PROVIDERS_OTHERNAME_FIRST

Address (Street number and name)	Apt. Number	City or Town	State	Zip Code
			PROVIDER_ADDRESSES_PRIMARY_STATE	PROVIDER_ADDRESSES_PRIMARY_STATE

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	E-mail Address	Telephone Number
PROVIDERS_DATEOFBIRTH		PROVIDERS_CONTACTEMAILADDRESS	

Applicant Signature:_____	Date:_____

DO NOT WRITE BELOW

Section 2. Authorized Representative Review and Verification

Document Presented for Identification (Multiple Documents can be obtained; complete the appropriate information for each):

☐ Driver License	☐ Passport	☐ Current Hospital ID	☐ Other_____
Issuing Authority:	**Issuing Authority:**	**Issuing Authority:**	**Issuing Authority:**
Document Number:	**Document Number:**	**Document Number:**	**Document Number:**
Expiration Date (if Any):	**Expiration Date (if Any):**	**Expiration Date (if Any):**	**Expiration Date (if Any):**
Copy Attached: ☐ Yes ☐ No	**Copy Attached:** ☐ Yes ☐ No	**Copy Attached:** ☐ Yes ☐ No	**Copy Attached:** ☐ Yes ☐ No

I attest, 1) I have examined the document(s) presented by the above-named applicant (2) the above listed document(s) appear to genuine and relate to the applicant named

Signature of Authorized Representative:	Date:	Print Name:	Title:

EMORY
HEALTHCARE

Re: Emory Healthcare Medical Staff Professional Liability Policy

Dear Applicant:

You are receiving this letter because you are applying for membership and/or clinical privileges to the Medical Staff of one or more of the hospitals owned and operated by Emory Healthcare. Those hospitals are Emory Decatur Hospital, Emory Hillandale Hospital and Emory Long Term Acute Care. As you are likely aware, the Bylaws and associated Policies and Rules and Regulations (the "Bylaws") of each hospital require you to maintain professional liability insurance in amounts and a form acceptable to the Board of Directors. The maintenance of adequate insurance issued by an organization with sufficient financial health to pay a claim is an important protection to you, to the hospital and to the community. Under the Bylaws, failure to maintain the required coverage is grounds for automatic relinquishment or suspension. The Board of Directors has recently clarified its existing policy. The clarifications are designed to ensure that your policy provides adequate limits to pay for or settle a claim if one should arise, ensure that costs of defending a claim are separately covered and that the organization issuing your coverage has adequate assets to pay a claim. A copy of the clarified policy is attached.

One of the requirements during the pre-application phase is to provide evidence of your current malpractice and that it meets the minimum requirements as specified by the Board of Directors. ***Specifically, we are seeking confirmation that your policy meets the limits and defense costs requirements in Section I and that the issuing organization meets the financial criteria set forth in Section IV.***

This confirmation must come in the form of a certificate of insurance ***reflecting your coverage limits and coverage of defense costs outside of policy limits coupled with the Best rating of your carrie***r. If your insurer does not have a Best A+, A, or A- rating, please ask the insurer to provide the information requested in IV.B. In the event your existing coverage does not meet these requirements, please obtain the required coverage immediately and provide evidence of coverage. Failure to meet coverage requirements will result in denial of your pre-application.

Please include this documentation along with your certificate of insurance before submitting the pre-application.

Thank you for your prompt attention to this important matter.

EMORY
HEALTHCARE

CONFIDENTIALITY AND SYSTEM ACCESS TERMS– (Revised 7/2022)

In order for Emory Healthcare and its affiliated entities and healthcare facilities (which are individually and collectively referred to as "EHC" in these Terms) to permit authorized users access to certain of EHC's electronic systems, including but not limited functionality related to EHC's electronic health records (which are referred to as "EHC Systems" in these Terms), users must agree to be bound by these Confidentiality and System Access Terms (which are referred to as the "Terms"). Users may require access to EHC Systems based on their work for or other affiliation with EHC (which are referred to as the "EHC Affiliation" in these Terms). Examples of EHC Affiliation for which a user requires access to EHC Systems include, but aren't limited to, working for EHC as an employee, contractor or other service provider, being a medical staff member, and providing treatment or certain other services to current or former EHC patients on behalf of a non-EHC provider or vendor. Users who do not agree to these Terms are not permitted to access or use any EHC Systems.

Certain provisions of these Terms may be superseded by expressly designated legal notices or terms located on particular pages within an EHC System. The Terms may be updated from time to time. The most current version of the Terms will be posted in the EHC Policy Management System. Accordingly, it is the user's responsibility to periodically review this page to ensure familiarity with the most current version of these Terms. A user's continued access and use of any EHC System after modifications of the Terms are posted will constitute the user's agreement to be bound by such updated Terms.

It is the policy of EHC that any patient, financial, employee, vendor, payroll and related information is strictly confidential and/or proprietary information.

I understand that, in the course of my EHC Affiliation, I may learn information which is confidential or privileged under federal or state law or which is considered sensitive, confidential and/or proprietary by EHC (all such information is referred to as "Confidential Information" in these Terms). Depending on the nature of my EHC Affiliation and responsibilities, Confidential Information to which I have access to may include, but is not limited to, patient medical, financial and personal information, employee and payroll information and other non-public and proprietary financial, technical, operational, as well as vendor and other third-party information. I agree to keep confidential all such Confidential Information, whether verbal, written or electronic, which I learn in the course of my EHC Affiliation and to only use or disclose Confidential Information as specifically permitted by EHC for purposes of my specific EHC Affiliation. I will not discuss patient or family information with anyone not immediately concerned with or involved with a particular patient's care or treatment. I will not discuss patient information or other Confidential Information with anyone who does not have a legitimate business-related need to know. In addition, I will not discuss patient or other Confidential Information in public areas (such as elevators, cafeterias, public hallways, etc.).

I will not access or attempt to access or use any EHC System or information unless the information is relevant to my EHC Affiliation and I am clearly authorized to access it. I understand that the logon ID, computer password, time and attendance identification number and other credentials (individually and collectively called the "Credentials" in these Terms) that may be assigned to me by EHC are to be used solely by me in connection with my authorized access to and use of EHC Systems and information. **I understand that use of my Credentials by anyone other than me is strictly prohibited**. I will not share any Credentials with anyone, and I will take all necessary steps to protect the confidentiality of my Credentials.

I understand that the EHC (xxx.xxx@emoryhealthcare.org) and Emory University (xxxx@emory.edu) electronic mail, including messaging within the EHC electronic medical record, is EHC property and subject to organizational review and should be used only for business purposes unless otherwise permitted by relevant EHC policies. I also understand and certify that use of my electronic or digital signature to authenticate documents is the equivalent of my handwritten signature on the documents.

I understand it is my responsibility to read and to abide by any and all policies and procedures regarding the access and use of EHC Systems and the access, use and disclosure of Confidential Information and other information or data owned by EHC, as such policies are currently in effect or which may be implemented or revised from time to time. I understand that EHC Systems and information access may be monitored and violation of EHC's policies and procedures may result in disciplinary action against me, which depending on the nature of my EHC Affiliation may include, but is not limited to, loss or limitation of access to EHC Systems, termination of employment or other affiliation(s) with EHC, including loss of clinic and/or hospital privileges, reporting to my employer (if different from EHC) or law enforcement, as well as civil and criminal prosecution to the fullest extent of the law.

I understand that when my EHC Affiliation ends for any reason, whether because of termination of my employment or contractor status or otherwise, I am not permitted to keep or take, or have in my possession or continue or attempt to access or use, any confidential or proprietary information from EHC or access any EHC Systems, unless specifically authorized by EHC policy. I understand that when my EHC Affiliation ends for any reason my obligations with regard to the use and disclosure of patient and employee information will continue indefinitely and that my confidentiality obligations with regard to all other Confidential Information will continue for so long as the information is not generally available to the public without fault by me.

I UNDERSTAND THAT EHC IS GRANTING ME ACCESS TO CONFIDENTIAL INFORMATION AND EHC SYSTEMS IN CONSIDERATION OF AND RELIANCE ON MY AGREEMENT TO THESE TERMS. BY SIGNING, I ACKNOWLEDGE THAT I HAVE READ AND AGREE TO COMPLY FULLY WITH THESE TERMS.

_____ _____

Signature Date

INSTRUCTIONS FOR COMPLETING AND RETURNING FORMS:

- If you are accessing and signing these Terms within the EHC New Applicant System, the signed Terms will be automatically sent to EHC following signature.
- If you are requesting Emory Healthcare Link (EpicCare Link) access, you must attach these signed documents to your Emory Healthcare Link access request.
- If you are requesting EpicCare (Epic Hyperspace) access, you must attach these signed documents to your EpicCare access request.
- Otherwise, you must sign and date the Terms, and **email the scanned signed and dated Terms to your access coordinator.**
- You may contact your Access Coordinator with questions regarding logon ID access.
- **DO NOT** FAX THIS form to the EHC Office of Compliance Programs.
- Please note that the completed and signed Acknowledgement of Privacy and Security Awareness Training document must also be received by EHC before access may be granted.

EMORY
HEALTHCARE

PRIVACY AND SECURITY AWARENESS TRAINING (Revised 07/2022)

Scope:
For Emory Healthcare Employees, Temporary Employees, Contractors, Vendors, Students, Emory University Employees, Physicians, and All Other Users with Access to ePHI/PHI.

The Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules regulate the use, disclosure, privacy, confidentiality and security of Protected Health Information (PHI) in written, verbal and the transmission, storage and disposal of PHI in electronic form (ePHI).

In this document you will learn:
- To identify PHI and ePHI
- How to protect PHI and ePHI and the risks when using and storing PHI and ePHI
- How to reduce the risks of breach and inappropriate disclosure of PHI and ePHI

What are we going to cover?
- PHI and ePHI
- Privacy and Security Reminders
- Protection from Malicious Software
- Log-In Monitoring
- Password Management
- Sanctions

The Standards for Privacy of Individually Identifiable Health Information (IIHI):
- Protect and enhance the rights of consumers by providing them access to their health information and controlling the inappropriate use of that information.
- Improve the quality of health care in the United States by restoring the trust in the health care systems among consumers, health care professionals, and the multitude of organizations and individuals committed to the delivery of care.
- Improve the efficiency and effectiveness of health care delivery by creating a national framework for health privacy protection that builds on efforts by states, health systems and individual organizations and individuals.

Definitions:
- **Privacy:** The right of an individual to be left alone, including freedom from intrusion into one's private affairs and the right to maintain control over certain personal information.
- **Confidentiality:** The responsibility for limiting disclosure of private matters including the responsibility to use, disclose, or release such information with the knowledge and consent of the individual.
- **De-Identification of PHI/ePHI and Limited Data Sets:** Health Information that does not identify an individual and for which there is no reasonable basis to believe that the information can identify an individual.

  Health information is considered de-identified if:
  - It has been determined and documented by an appropriate qualified data expert applying generally accepted statistical and scientific principles and methods that the risk is very small that the information could be used to identify an individual.

- It meets the safe harbor method which is the removal of **all** of the individual identifiers from the health information.
- EHC may de-identify information and use codes or other similar means of marking records so they may be re-identified if certain regulatory conditions are met.

➢ **Electronic Patient Health Information (ePHI):** ePHI includes any PHI created, received, stored on hard drives, networks, laptops, memory sticks and personal digital assistance(s) e-mail or transmitted electronically.

Examples of ePHI include, but are not limited to:

Financial records	Medical information in an e-mail
Test results	Diagnosis
Medical information stored on the intranet/internet	Patient's identification bracelet
A Patient's tattoo if unusual	A Patient's phone number
Medical record number	Laboratory results that are emailed to a patient
Demographic information about a patient contained in EHC information systems such as Epic	A note regarding a patient stored on a mobile phone or other mobile device
Billing information that is saved to a CD	A photograph of a patient in electronic format (i.e. digital, scanned)

➢ **Security:** The means to control access and protect information from accidental or intentional disclosure to unauthorized personnel and from alteration, destruction or loss.

➢ **Protected Health Information (PHI**): Is any individual identifiable health information that may identify the patient and that relates to:

- Past, present or future physical or mental health condition; or
- Healthcare services provided; or
- Payment for healthcare
- Includes all communication media – written, electronic and verbal
- Extends to <u>all</u> individually identifiable health information in the hands of EHC

➢ **Individual Identifiable Information: H**ealth information that is created or received by EHC and relates to the past, present, or future physical or mental health or condition of an individual or payment for the provision of care to the patient, the provision of health care to the patient, and identifies the patient or there is a reasonable basis to believe the information can be used to identify the patient.

Individual Identifiers include, but are not limited to:

Name	Photographic images
Address	Social Security Number
Zip	Medical record number
Names of relatives	Health plan beneficiary number
Name of employer	Account number
Date of birth and all other elements of dates (except year) for dates directly related to an individual, including dates of service	IP address any other unique identifier, character, code
Telephone number	Vehicle or other device serial number
Fax number	Certificate/license number
E-mail address	Any other identifying information that could reasonable identify the patient
Finger or voice prints	

Accessing Patient Information
Users should only access PHI in order to perform their job duties; the type and amount of PHI that they access should be limited to that which is necessary to perform the job duty at hand.

- Do not access the medical records and/or PHI/ePHI of family members, friends, or co-workers through the EHC Electronic Medical Record (EeMR) unless you are actively involved in the patient's care or have been specifically asked to consult in the patient's care by a member of the patient's care team.
- If you are accessing a family member, friend, or co-worker's confidential medical record as a care provider, this role must be documented in the patient's medical record for each stage of care. Inappropriate viewing of these medical records may be grounds for disciplinary action.
- EHC Policy does not permit you to access your own medical record through the EeMR. You may access your own medical record information on the same basis as any other EHC patient. For example, you may access your information through the appropriate Patient Portal or by requesting access from Medical Records/Health Information Management (HIM).
- Do not ask another employee or provider with access to the EeMR or EHC Systems to access your medical record or health information for you as a favor. Doing so may result in disciplinary action against both you and the other employee or provider.

Security
Keeping EHC patients' information private and secure is everyone's responsibility. Users should always report suspected security and privacy incidents/breaches to management.

Passwords

- Protect your user-ID and password
  - **You are responsible for actions taken with you user-ID and password.**
  - The HIPAA Security Rule requires EHC to be able to audit an individual's actions using ePHI
  - Do NOT post, write down or share your passwords with anyone
  - Protect your user-ID and password from fraudulent use or unethical behavior
- Use STRONG passwords that are hard to guess, easy to remember, and change them often
  - Do NOT use a word from a dictionary - English or otherwise
  - Create a password between 9 to 30 characters (letters, numbers, and special characters).
  - Or use a pass phrase and add 2 numbers or a symbol to help you remember your password:
    - **EGbDF42dY** (every good boy does fine for today) or
    - **ILV2GLF4fn** (I Love to Golf for fun)
- Use password protected screen savers on EHC workstations, laptops, and cell phones and tablets
- Always logoff/disconnect from all workstations
  NOTE: If you do not logoff, someone else could use your User-ID to inappropriately access ePHI.

Logon and Access Monitoring

- You must ONLY access EHC Information Systems through your own user ID and password
- EHC monitors your logons and logon attempts to the EHC electronic Information Systems
- To increase security on select applications, EHC has implemented Duo Security. This two-factor authentication adds a second layer of security for your protection by requiring two factors to confirm your identity - something you know (your password) and something you have (e.g., app push, text message, or call to your mobile phone or landline). You must enroll in Duo to access some EHC systems from off campus (off the EHC network or EHC Wi-Fi network), as well as for accessing some HR and/or payroll related systems on campus. Learn more at https://ourehc.org/departments/is/Security/duo/index.html

Workspace and Device Security

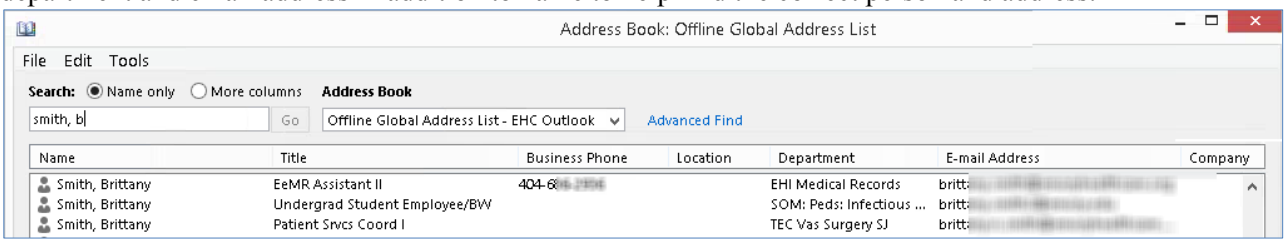
- Protect your workspace by:
  - Locking your workstation when unattended by pressing Ctrl + Alt + Del and then choose lock workstation, or by pressing the Windows key and L.

  - Avoid displaying any sensitive information on screen or monitor in a public area
  - Ensuring unattended offices and file cabinets that store PHI are locked
  - Do NOT leave Medical records laying out on desks or at a nursing station
  - Always securely dispose of printed PHI
- **Physically secure devices:**
  Never leave any laptop, mobile device or thumb drive containing ePHI in your vehicle Do not store ePHI on non-encrypted mobile devices or thumb drives
- **Protection from Malicious Software:**
  - Do NOT open an email attachment, unless you know who sent it and why. If in doubt, call the sender of the email to confirm that the attachment is safe and valid.
  - Always run an updated antivirus tool.
  - If on an EHC workstation, do NOT load software that you or your department is not licensed to use.
  - Always close "pop-ups" when they solicit a response to advertisements or other messages. Click the "x" box to close the pop-up ads. Clicking "No" is the same as clicking "Yes" and allows the virus or hacker access to your workstation. Don't do it!
- **Security Reminders and Updates**
  Be on the lookout for and review security reminders and update sent from EHC. Reminders and updates could include:
  - Periodic security updates that are issued to the workforce concerning EHC policies and procedures
  - Warnings are issued to the workforce of potential, discovered or reported threats, breaches, vulnerabilities or other security incidents
  - EHC Information Services Security Policies
  - Security best practices (e.g., how to choose a good password, how to report a security incident)

Email

Be aware that e-mail is never 100% secure. It can be forwarded by the recipient to other persons or printed and left where others can see it.

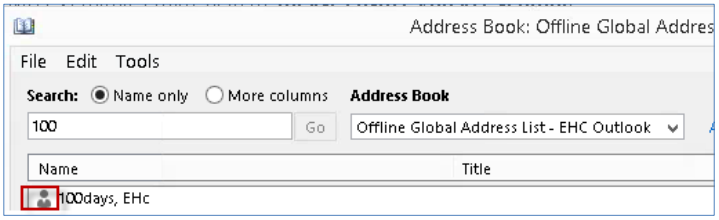
- Encourage patients to utilize the Patient Portal for communication instead of communicating with providers via e-mail.
- Don't forget an e-mail address is a patient identifier.
- **Please ensure you are sending emails securely to an approved user!**
  Make sure you choose the correct recipient. It is easy to pick the wrong name from the address book without realizing it, so double check your address list before you press send. Use title, department and email address in addition to name to help find the correct person and address.



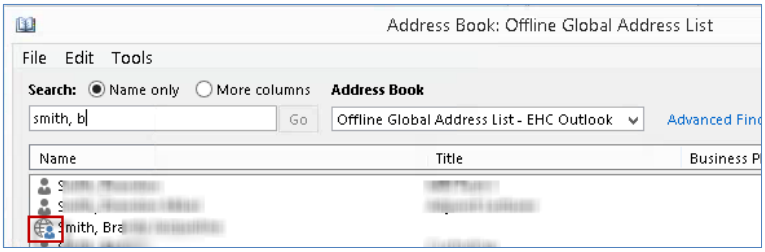
➢ If using the Emory/EHC MS Exchange email system, be aware of the following additional security features and information.

- Emails to Emory.edu addresses.
  Many physicians and clinical staff have @emory.edu addresses. For an Emory University (@emory.edu) email address, you must do the following to ensure it is secure:
  - Locate the person in the Global Address list or address book
  - Verify the icon to the left of the person's name:

If it is a person icon 
then the email is secure and it is OK to email this person.



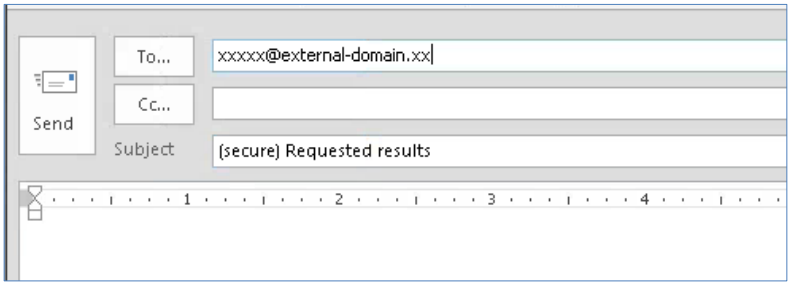
If it is person in front of a globe 
DO NOT send the user any emails containing ePHI or sensitive information unless it is otherwise encrypted.



Hint: the globe icon indicates the email address is external to or outside EHC/Emory University.

- **Encryption of Outgoing External Emails**
  - EHC uses Office 365 Message Encryption (OME) to encrypt outgoing email messages.
  - You do not need to encrypt e-mail messages sent solely to other emory.edu or emoryhealthcare.org e-mail addresses.
  - When sending sensitive information via e-mail to external parties, you should encrypt the message. OME allows EHC users to send emails to external users, ensure the message is transmitted securely, and visible only by the intended recipient.

    To send a secure email to an external email address, you must add either **(encrypt)** OR **(secure)**, including the parentheses, or to the subject line of your e-mail message.



  - Do not include ePHI or sensitive information in the Subject line of your message. Adding one of these two tags in the email subject line designates to the email system that this message will be sent encrypted. Compose and send your message as usual.

- The EHC Patient Portal should continue to be utilized as the primary method of communicating with patients. Office Message Encryption must be used when communicating with a patient via email directly outside of the Patient Portal, even if the patient has requested communications via email or initiated the email exchange.

Information that you can send to the external recipient on how to retrieve the secure message can be found at http://it.emory.edu/office365/ome.html.

- **Internal EHC Email**
  - All emails sent between EHC (@emoryhealthcare.org) email addresses are secure!
- **Additional information about EHC Email**
  - Use email in support of your job. Do NOT forward humor stories, chain letters, political or religious views, etc.
  - Email belongs to EHC and must always be used consistently with EHC policies.
  - Email and email attachments can be subpoenaed.
  - Emails are not "gone" when deleted.
  - **NEVER** click on a web link in an email message and then provide your Logon ID and password and **NEVER** reply to an email message asking for your Logon ID and password. These are most often phishing attempts, even if they look legitimate. Phishing is an identity theft scheme where someone tries to lure or trick you into revealing your password, credit card number or other confidential information. Don't fall for it!

Incident Handling

- Report erratic workstation behavior or unusual e-mail messages to your department manager, EHC Information Services or EHC Service Desk.
- Report any suspected issues or incidents to a manager or the EHC Service Desk.
- Report lost or stolen EHC issued devices to EHC Service Desk and the Emory Police Department and, when appropriate, to the local police.
- EHC Service Desk can be contacted at 404-778-4357.

Patient Privacy Rights

- Right to receive a notice describing the covered entity's privacy practices.
- Right to file complaint with the Department of Health and Human Services. Inform patients how to file complaints.
- Right to access, inspect, and copy protected health information that is used, in whole or in part, to make decisions about them.
- Right to request amendment of protected health information.
- Right to receive an accounting of disclosures made by a covered entity for purposes other than treatment, payment, and health care operations made within six years prior to the request.
- The accounting must be provided within 60 days after receipt of the request.
- Right to request restrictions on the use and disclosure of their protected health information.
- Patients may ask health care providers to communicate health information to them by "alternative means" or at "alternative locations".

Sanctions

- A violation of the security rule could also be a violation of the privacy rule and state laws.
- Civil Monetary Penalties
  - Ranging from $127 to in excess of $1,500,000.
- Criminal Penalties
  - Range from $50,000 - $250,000 and imprisonment for a term of 1 to 10 years.
- EHC corrective and disciplinary actions, up to and including termination of employment or other EHC relationship.

EMORY
HEALTHCARE

Acknowledgement of Privacy and Security Awareness Training

Scope:
For Emory Healthcare Employees, Temporary Employees, Contractors, Vendors, Students, Emory University Employees, Physicians, Community Physicians and All Other Users with Access to ePHI/PHI.

I am, or in the future may become, a user of one or more EHC information technology devices or systems that may include ePHI and PHI in any other medium and I hereby certify that:

1. I have read and understand the EHC "Privacy and Security Awareness Training" handout.

2. I understand the importance of maintaining the confidentiality and integrity of all ePHI and PHI.

3. I understand that it is against EHC policy to access my PHI and ePHI through EHC Systems including the EeMR except as permitted for patients generally (for example, using the EHC patient portal). I also understand that it is against EHC policy to ask another employee or provider with access to the EeMR or other EHC Systems to access my PHI and ePHI.

4. I agree to abide by the EHC policies and procedures, as further explained in the EHC "Privacy and Security Awareness Training" handouts.

5. I understand that, by not following EHC policies and procedures, I am subject to disciplinary actions up to and including termination of employment, loss of hospital and clinic privileges, or other affiliations with EHC, loss of access to systems with ePHI, civil action and penalties, and criminal action and penalties.

6. I understand I can call 404-778-2757 if I have questions regarding the training or EHC policies or procedures related to PHI/ePHI I agree to call this number if I have any question regarding the "Privacy and Security Awareness Training. When in doubt reach out!

_____ _____
SIGNATURE and AFFILIATION **DATE**

Providers_LongName
PRINT NAME

SPECIALTIES_SPECIALTY_RTK1
DEPARTMENT/SECTION

INSTRUCTIONS FOR COMPLETING AND RETURNING FORMS:

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- If you are requesting EpicCare (Epic Hyperspace) access, you must attach these signed documents to your EpicCare access request.
- Otherwise, you must sign and date the Terms, and **email the scanned signed and dated Terms to your access coordinator**.
- You may contact your Access Coordinator with questions regarding logon ID access.
- **DO NOT** FAX THIS form to the EHC Office of Compliance Programs.
- Please note that the signed and dated Confidentiality and System Access Terms must also be received by EHC before access may be granted.