

CREDENTIALING AND PRIVILEGING (C&P)

Protocol:

Bridgeway Center provides internal Credentialing and Privileging (C&P) to all Licensed and Certified employees as well as employees who are determined to be Supervisors for Licensure/Certification and Clinical Interns/Volunteers. The scope of privileges is defined in the Privileges and Criteria Definitions [Attachment 1]. The term of privileges is for two years in accordance with the State of Florida's licensure and certification renewal cycle.

On a monthly basis, SRQ staff uploads the names and birth dates of **all** our employees into the Valenz Assurance website, which checks the following sites for expiring licenses/renewals pending, license restrictions or revocations, disciplinary actions, malpractice awards and negative privilege actions at other hospitals:

- System of Award Management (SAM)
- The Agency for Healthcare Administration (AHCA)
- The Office of the Inspector General (OIG)
- Florida Department of Health (DOH)

The results of the Valenz Assurance checks are filed electronically in the HR folder. These are available to be reviewed by auditors and surveyors.

On a biennial basis, SRQ staff reviews the Florida Department of Health website to verify active licenses and certifications, the National Practitioner Data Bank, the Office of the Inspector General for any complaints filed against BCI staff, and BCI's complaint and grievance log.

All concerns, findings, and discrepancies will be brought to the attention of the Human Resources & Quality Program Director and the President/Chief Executive Officer (CEO) for review and follow-up action. It may be necessary to notify ABH for certain sanctions.

The Credentialing and Privileging Committee reviews the Credentialing packets prepared by the SRQ Department four times per year.

Newly hired employees who require privileging will be presented to the C&P Committee subsequent to their hire date. If a previous BCI employee returns to employment and the credentialing of their privileges has not expired, they will have all previous privileges credentialed. Re-credentialing of their privileges will occur during the normal schedule.

In accordance with the BCI Board of Trustees By-Laws, employees with recommended credentialing and specific privileges will be presented to the Board of Trustees Quality and Planning Committee for review and approval. Upon approval by the Board of Trustees Quality and Planning Committee, the employees will be presented to the full Board of Trustees of Bridgeway Center for final approval. The C&P Committee Minutes are reviewed and approved by the Quality and Planning Committee, as well.

The President/CEO is the Chairperson for the Credentialing and Privileging Committee. The HRQ Coordinator is the official recorder of the meeting.

Definitions:

1. Credentialing - The process of assessing and confirming the qualifications of a license or certified BCI employee.
2. Licensed or Certified Employees – An individual required to be licensed, registered, or certified by the State of Florida or other regulatory agency.
3. Primary Source Verification- Verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual employee.
4. Privileging/Competency – The process of authorizing a licensed or certified employee’s specific scope and content of services for a person served. This is performed in conjunction with a review of the employee’s clinical qualifications.

New Employees requiring Credentialing/Privileging:

1. New employees who require Credentialing/Privileging will receive the initial documents from the Human Resources [HR] Department during their in-processing. Once the documents are completed, the documents are sent to SRQ.
2. A credentialing file is created for the new employee by the SRQ Department. The file will include items from the C/P Record Checklist based on privileges being sought (Attachment 2):
 - a. Privacy Act Statement – SRQ-15 (Attachment 3)
 - b. Statement of Applicant – SRQ-16 (Attachment 4)
 - c. Application for C/P LIP – SRQ-17 (Attachment 5)
 - d. Application for C/P Ancillary Staff – SRQ-18 (Attachment 6)
 - e. Confidentiality Statement – SRQ-22 (Attachment 7)
 - f. Professional Recommendation of Healthcare Practitioners x 2 – SRQ 156 a (Attachment 8)
 - g. Consent and Release – SRQ-160 (Attachment 9)
 - h. Professional Diploma(s) and/or Certified Transcripts
 - i. State License(s)
 - j. Certification Number
 - k. Required Experience, training and/or education for specific privileges
 - l. Proof of Liability Insurance (Contractors only)
 - m. Primary Source Verification / Practitioner Profile – [FL DOH] (Online)
 - n. National Practitioner Data Bank [NPDB] – (US Dept of Health and Human Services – Online)
 - o. Proof of Office of the Inspector General [OIG] Review for Sanctions
 - p. Letter “Provisional Award of Privileges” – SRQ-19a (Attachment 10)
 - q. Recommended Award of Staff Privileges from C&P Committee – SRQ-158 (Attachment 11)
 - r. Controlled Substances Registration Certificate [DEA]
 - s. Residency, Internship and/or Specialty Board Certificates
 - t. Copy of Curriculum Vitae (CV) [physician only]
3. Upon receipt of the Credentialing packet and within 30 days of hire, searches of all verifications (OIG / NPDB / Primary Source) will be completed by the SRQ Department and placed in the employee’s credentialing file.
4. Based on the employee’s license, experience, and certifications, a “Provisional Award of Privileges” letter [SRQ-019a] is filled out identifying the specific privileges that will be temporarily granted

(Attachment 10). The length of the temporary privileges will extend until the next scheduled appropriate C&P meeting. (*See Protocol for schedule*). This letter is then given to the President/CEO for their approval and signature.

5. Once approved by the President/CEO, the original is sent to the employee, a copy is sent to their supervisor, and another copy is kept in their credentialing file.
6. A Recommended Award of Staff Privileges (SRQ-158) form is generated based on the privileges stated on their “Provisional Award of Privileges” letter. This form is then placed in the employee credentialing file and presented at the next scheduled appropriate C&P meeting.
7. Upon review and recommendation of the credentialing/privileging of the employee, the signed Recommended Award of Staff Privileges form will be presented to the applicant for their signature.
8. Upon review by the Board of Trustees Quality and Planning Committee, and final approval by the full Board of Trustees, an “Award of Privileges” letter signed by the President/CEO and given to the employee. A copy will be placed in the employee’s credentialing file, and a copy will be provided to the supervisor.

Re-Awarding of Privileges:

SRQ Department staff will review and prepare the employee’s credentialing packet for the bi-annual re-award.

1. SRQ will complete the Bi-Annual Review of Privileges form (Attachment 12) listing all privileges awarded in the previous award. The form will be given to the employee for their review and signature. Upon employee signing the form, they are to provide the form to their supervisor, who will review the privileges, circle concurrence or non-concurrence on the form, and provide a signature. Upon supervisor’s signature, the form will be returned to SRQ to be included in the employee’s credentialing file.
2. SRQ will obtain copies of all licenses, certificates, and national verifications as applicable and place in credentialing packet.
3. A Recommended Award of Staff Privileges (SRQ-158) form is generated based on the privileges stated on their Bi-Annual Review of Privileges (SRQ- form. This form is then placed in the employee credentialing file and presented at the next scheduled appropriate C&P meeting.
4. Upon review and recommendation of the credentialing/privileging of the employee, the signed Recommended Award of Staff Privileges form will be presented to the applicant for their signature.
5. Upon review by the Board of Trustees Quality and Planning Committee, and final approval by the full Board of Trustees, an “Award of Privileges” letter signed by the President/CEO and given to the employee. A copy will be placed in the employee’s credentialing file and a copy will be provided to the employee’s supervisor.

Additional Privileges:

1. A “Provisional Award of Privileges” letter should be prepared and sent to the President/CEO for approval for those employees who have requested additional privileges and have sent the appropriate

copies of licenses, certificates, or attestations but are not scheduled to be presented at the upcoming meeting.

2. Once approved by the President/CEO, the original letter is sent to the employee, a copy is sent to their supervisor, and a copy is placed in their credentialing file.
3. A "Recommended Award of Staff Privileges" form is then filled out based on the privileges stated on the "Provisional Award of Privileges" letter. This form is then placed in the employee's credentialing file for presentation at the next appropriate scheduled C&P meeting.

Supervision of Clinical Interns and/or Volunteers ONLY:

1. Employees that are to receive the privilege of Supervision of Clinical Interns and/or Volunteers only will need to complete the items on SRQ-096a with the assistance of the SRQ Department and which include the following:
 - a. Memo from HR stating number of years in specialty field and/or supervisory experience
 - b. Student Intern Primary and Site Supervisor Responsibilities Attestation (PERS-92)
 - c. Bi-Annual Review of Privileges (SRQ-20a)
 - d. Recommended Award of Staff Privileges (SRQ 158)
2. The Credentialing file for this one privilege will be reviewed as above, either as a new award or re-award by committees and will receive the same notifications as listed above if the privilege is awarded.

Licensed Practical Nurses (LPNs) ONLY:

1. Licensed Practical Nurses will receive the following specific privileges: Administer Injections; Patient Medication Consultation with Providers; Call in Prescribers Orders to Pharmacy; and Complete Vitals and Documentation. . All LPNs will be credentialed and presented, as above, for approval from the C&P Committee, the Board of Trustees Quality and Planning Committee and the full Board of Trustees. Items required in the LPN Credentialing file are as follows:
 - a) Privacy Act Statement – SRQ-15 (Attachment 3)
 - b) Statement of Applicant – SRQ-16 (Attachment 4)
 - c) Application for C/P LIP – SRQ-17 (Attachment 5)
 - d) Confidentiality Statement – SRQ-22 (Attachment 7)
 - e) Consent and Release – SRQ-160 (Attachment 9)
 - f) State License(s)
 - g) Primary Source Verification / Practitioner Profile – [FL DOH] (Online)
 - h) National Practitioner Data Bank [NPDB] – (US Dept of Health and Human Services – Online)
 - i) Proof of Office of the Inspector General [OIG] Review for Sanctions
2. Upon approval, LPNs will receive a letter signed by the President/CEO stating they have been credentialed/re-credentialed.

Approved by: Carrie Parker
 Carrie Parker
 Human Resources & Quality Program Director

08/03/2023
 Date

EXCEPTIONS

None

ATTACHMENTS

1. Privileges and Criteria Definitions
2. Credentialing/Privileging Record Checklist [SRQ-096]
3. Privacy Act Statement [SRQ-15]
4. Statement of Applicant [SRQ-16]
5. Application for C/P LIP [SRQ-17]
6. Application for C/P Ancillary Staff [SRQ-18]
7. Confidentiality Statement [SRQ-22]
8. Professional Recommendation of Healthcare Practitioners [SRQ 156a]
9. Consent and Release [SRQ-160]
10. Provisional Award of Privileges [SRQ 19a]
11. Recommended Award of Staff Privileges from C&P Committee [SRQ 158]
12. Bi-Annual Review of Privileges [SRQ-020a]

CREDENTIALING AND PRIVILEGING CRITERIA DEFINITIONS

Privilege	Criteria	Notes
Adult Psychiatry	<p>a) Must possess a Doctor of Medicine (MD) degree or Doctor of Osteopathy (DO) degree from an accredited medical school, and</p> <p>b) Board certified in psychiatry as defined by the American Board of Psychiatry and Neurology OR</p> <p>c) Certified by the American Society of Addiction Medicine (ASAM) or the American Board of Psychiatry and Neurology OR</p> <p>d) Graduated from an accredited residency program, and</p> <p>e) Licensed to practice medicine in the State of Florida, and</p> <p>f) Must possess a current Drug Enforcement Administration (DEA) Certificate, and</p> <p>g) Have a minimum of three (3) years residency experience in a mental health/substance abuse setting providing direct patient care, and</p>	<p><u>Privileges include:</u></p> <p>a) Individual Psychiatric Evaluation</p> <p>b) Psychiatric Treatment</p> <p>c) Medication Education</p> <p>d) Initiation of Baker Act</p> <p>e) Initiation of Marchman Act</p>
Animal Assisted Therapy	<p>a) Be currently registered or certified as a pet partner team by an animal assisted therapy organization and provide proof of registration or certification.</p> <p>b) Provide a current animal health screening form which includes vaccination dates, test results, parasite control and an overall assessment of the animal's health.</p> <p>c) Provide a current rabies vaccination certificate for animal.</p> <p>d) Provide an overall team qualification assessment.</p>	
Baker Act Initiation – assessing the current mental condition of the client in crisis to determine if Baker Act criteria has been met.	<p>a) Licensed in the State of Florida as a Licensed Psychiatrist/MD/DO, Licensed Psychologist, Advanced Practice Registered Nurse (APRN), Licensed Clinical Social Worker, or Licensed Mental Health Counselor, Physician Assistant supervised by a state licensed psychiatrist and</p> <p>b) Complete Online Baker Act Training Modules to include: 1) Introduction to the Baker Act; 2) Minors and the Baker Act; and 3) Emergency Medical Treatment: Florida's Baker Act and Marchman Act. [https://flcertificationboard.org/education-training/continuing-education]</p>	
Basic Driver Improvement Instructor	Currently certified as a Basic Driver Improvement Instructor by the National Traffic Safety Institute (NTSI).	

CREDENTIALING AND PRIVILEGING CRITERIA DEFINITIONS

Buprenorphine (Suboxone) MAT Provider	a) Licensed in the State of Florida as a Medical Doctor (MD), Advanced Practice Registered Nurse (APRN), or a Physician Assistant (PA), and b) DEA License with a Suboxone waiver, and c) 24 hours of provider specific training through the Providers Clinical Support System (PCSS)	
Certified Behavioral Health Case Manager Supervisor (CBHCMS)	Currently certified as a Certified Behavior Health Case Manager Supervisor (CBHCMS) through the Florida Certification Board.	
Certified Behavioral Health Case Manager (CBHCM)	Currently certified as a Certified Behavior Health Case Manager (CBHCM) through the Florida Certification Board.	
Certified Behavioral Health Case Manager – PROVISIONAL (CBHCM-P)	Has completed 50 hours of the required training and currently holds a provisional certification as a Behavior Health Case Manager (CBHCM-P) through the Florida Certification Board, and is working towards completing the required 2,080 hours of experience.	
Certified Behavioral Health Technician (CBHT)	Currently certified as a Certified Behavior Health Technician (CBHT) through the Florida Certification Board.	

CREDENTIALING AND PRIVILEGING CRITERIA DEFINITIONS

<p style="text-align: center;">Certified Recovery Peer Specialist (CRPS)</p>	<p>a) Must hold a high school diploma, general equivalency degree or higher.</p> <p>b) Must obtain at least one endorsement: Adult; Family; Veteran; and/or Youth.</p> <p>Adult (A): Lived experience as an adult in recovery for a minimum of 2-years from a mental health and/or substance use condition.</p> <p>Family (F): Lived experience as a family member or caregiver to another person who is living with a mental health and/or substance use condition.</p> <p>Veteran (V): Lived experience as a veteran of any branch of the armed forces who is in recovery for a minimum of 2-years from a mental health and/or substance use condition.</p> <p>Youth (Y): Are between the ages of 18 and 29 at the time of application and have lived experience as a person who, between the ages of 14 and 25 experienced a significant life challenge and is now living a wellness and/or recovery oriented lifestyle for at least two years.</p>	
<p style="text-align: center;">Child Psychiatry</p>	<p>a) Must possess a Doctor of Medicine (MD) degree or Doctor of Osteopathy (DO) degree from an accredited medical school, and</p> <p>b) Board certified in psychiatry as defined by the American Board of Psychiatry and Neurology OR</p> <p>c) Certified by the American Society of Addiction Medicine (ASAM) or the American Board of Psychiatry and Neurology OR</p> <p>d) Graduated from an accredited residency program, and</p> <p>e) Licensed to practice medicine in the State of Florida, and</p> <p>f) Must possess a current Drug Enforcement Administration (DEA) Certificate, and</p> <p>g) Have a minimum of three (3) years residency experience in a mental health/substance abuse setting providing direct patient care, and</p>	<p><u>Privileges include:</u></p> <p>a) Individual Psychiatric Evaluation</p> <p>b) Psychiatric Treatment</p> <p>c) Medication Education</p> <p>d) Initiation of Baker Act</p> <p>e) Initiation of Marchman Act</p>

CREDENTIALING AND PRIVILEGING CRITERIA DEFINITIONS

<p style="text-align: center;">Child-Parent Psychotherapy (CPP)</p>	<p>a) Must possess a Masters Degree in Psychology or related field. b) Attend initial 3 day learning session with approved CPP trainer. c) Attend two 2 day learning sessions with endorsed CPP trainer. d) Attend at least 32 consultation calls that are offered twice a month. e) Present two cases during consultation calls. f) Provide CPP services to at least four cases over an 18 month period. (*Note: Therapist can still provide CPP services during the 18 month training period.) g) Complete fidelity forms for all CPP cases. h) Read the CPP manuals Don't Hit my Mommy and Psychotherapy with Infants and Young Children.</p>	
<p>Commercial Driving Instructor – behind the wheel driving instruction</p>	<p>Currently certified as a Commercial Driving School Instructor through the Department of Highway Safety and Motor Vehicles (DHSMV).</p>	
<p>Competency-Based Wraparound Practitioner / Facilitator</p>	<p>Currently certified as a Competency-Based Wraparound Practitioner / Facilitator through the National Center For Innovation & Excellence (NCFIE).</p>	

CREDENTIALING AND PRIVILEGING CRITERIA DEFINITIONS

<p>DHSMV Clinical Supervisor (Department of Highway Safety and Motor Vehicle) – provides clinical oversight to DUI staff and monitors treatment compliance for referred clients, treatment agencies' compliance with Memorandum of Agreement, and treatment modalities.</p>	<p>Currently certified as a DUI Clinical Supervisor through the Department of Highway Safety & Motor Vehicles (DHSMV).</p>	
<p>DUI Evaluator – provides substance abuse evaluations to DUI Students.</p>	<p>Currently certified as a DUI Evaluator through the Department of Highway Safety & Motor Vehicles (DHSMV) OR Granted a temporary DHSMV certification for this position, not to exceed six (6) months, and function under the supervision of a fully certified DUI Evaluator.</p>	
<p>DUI Instructor – Level I and Level II provides classroom instruction both didactic and group to DUI students in accordance with the DHSMV curriculum.</p>	<p>Currently certified as a DUI Instructor through the Department of Highway Safety & Motor Vehicles (DHSMV) OR Granted a temporary DHSMV certification for this position, not to exceed six (6) months, and function under the supervision of a fully certified DUI Instructor.</p>	
<p>Gambling Addiction and Intervention Counselor</p>	<p>Currently certified as a National Certified Gambling Counselor through the National Gambling Counselor Certification Board.</p>	

CREDENTIALING AND PRIVILEGING CRITERIA DEFINITIONS

HIV/AIDS 501 Counselor	<p>a) Completion of the pre-requisite, requisite, and post-requisite “HIV/AIDS 501 Counselor” training requirements, AND</p> <p>b) A minimum of 32 hours annually of HIV/AIDS counseling</p>	
Hypnotherapy	<p>a) Licensed in the State of Florida as a Licensed Psychiatrist, Advanced Practice Registered Nurse, Licensed Psychologist, Licensed School Psychologist, Licensed Clinical Social Worker, Licensed Mental Health Counselor, or Licensed Marriage and Family Therapist, AND</p> <p>b) Completion of 50 hours of training by a Florida certified hypnotherapy instructor.</p>	
Individual Psychiatric Evaluation	<p>1. Must possess a Doctor of Medicine (MD) degree or Doctor of Osteopathy (DO) degree from an accredited medical school, AND</p> <p>a) Board certified in psychiatry as defined by the American Board of Psychiatry and Neurology OR</p> <p>b) Certified by the American Society of Addiction Medicine (ASAM) or the American Board of Psychiatry and Neurology in Addiction Medicine OR</p> <p>c) Graduated from an accredited residency program, AND</p> <p>d) Licensed to practice medicine in the State of Florida, AND</p> <p>e) Must possess a current Drug Enforcement Administration (DEA) Certificate, AND</p> <p>f) Have a minimum of three (3) years residency experience in a mental health/substance abuse setting providing direct patient care.</p> <p>OR</p> <p>2. Must be an Advanced Practice Registered Nurse, AND</p> <p>a) Licensed in the State of Florida.</p>	

CREDENTIALING AND PRIVILEGING CRITERIA DEFINITIONS

<p style="text-align: center;">Licensed Practical Nurse</p>	<p>Possess an active and current Florida license as a Licensed Practical Nurse.</p>	<p><u>Privileges include:</u></p> <ul style="list-style-type: none"> a) Administer Injections b) Patient medication consultation in coordination with Prescriber c) Call in Prescriber orders, accept Prescriber orders, call in prescriptions to pharmacy, coordinate with pharmacy regarding prescription refills and medications. d) Complete vitals for patients and record in EHR.
<p style="text-align: center;">Medication Management</p>	<p>1. Must possess a Doctor of Medicine (MD) degree or Doctor of Osteopathy (DO) degree from an accredited medical school, AND</p> <ul style="list-style-type: none"> a) Board certified in psychiatry as defined by the American Board of Psychiatry and Neurology OR <p>Certified by the American Society of Addiction Medicine (ASAM) or the American Board of Psychiatry and Neurology in Addiction Medicine OR</p> <p>Graduated from an accredited residency program, AND</p> <ul style="list-style-type: none"> b) Licensed to practice medicine in the State of Florida, AND c) Must possess a current Drug Enforcement Administration (DEA) Certificate, AND d) Have a minimum of three (3) years residency experience in a mental health/substance abuse setting providing direct patient care. <p>OR</p> <p>2. Must be an Advanced Registered Nurse Practitioner, AND</p> <p>Licensed in the State of Florida.</p> <p>OR</p> <p>3. Must be a Physician Assistant, AND</p> <p>Licensed in the State of Florida</p>	

CREDENTIALING AND PRIVILEGING CRITERIA DEFINITIONS

Mental Health First Aid Instructor (Youth & Adult)	Currently certified as a Mental Health First Aid Instructor through the National Council for Behavioral Health.	Instructors must teach the course at least three times per year to maintain their certification
Non –Violent Crisis Intervention (NVC) Instructor	Currently certified as a CPI Instructor through the Crisis Prevention Institute.	Certification is renewed annually. 18 hours of instruction is needed annually to renew certification.
Physical Assessment –Outpatient	<p>a) Must possess a Doctor of Medicine (MD) degree or Doctor of Osteopathy (DO) degree from an accredited medical school, or must be an Advanced Practice Registered Nurse and have a nursing license in the State of Florida; or a licensed Physician Assistant</p> <p>AND</p> <p>b) For APRN physical assessment for Outpatient, must be included in his/her APRN Protocol.</p>	
Play Therapy	<p>a) Licensed in the State of Florida as a Licensed Psychiatrist, Advanced Practice Registered Nurse, Licensed Psychologist, Licensed School Psychologist, Licensed Clinical Social Worker, Licensed Mental Health Counselor, or Licensed Marriage and Family Therapist,</p> <p>AND</p> <p>b) Certification by a national/international play therapy association</p>	
Preceptor for APRN Intern	<p>a) Board Certified Psychiatric Nurse Practitioner</p> <p>b) Three years post licensure clinical experience</p> <p>c) Possesses and demonstrates a broad knowledge of psychiatric medicine.</p> <p>d) Ability to provide practical skills to the intern</p>	
Psychotherapy	Licensed in the State of Florida as a Licensed Psychiatrist, Advanced Practice Registered Nurse, Licensed Psychologist, Licensed School Psychologist, Licensed Clinical Social Worker, Licensed Mental Health Counselor, or Licensed Marriage and Family Therapist	
Red Cross Instructor (Adult and Pediatric First Aid/AED/CPR)	Currently certified as an Adult and Pediatric First Aid/AED/CPR Instructor by the American Red Cross.	Must teach at least one 8 hour class annually and must renew every 2 years.

CREDENTIALING AND PRIVILEGING CRITERIA DEFINITIONS

Sex Therapy	<p>a) Licensed in the State of Florida as a Licensed Psychiatrist, Advanced Registered Nurse Practitioner, Licensed Psychologist, Licensed School Psychologist, Licensed Clinical Social Worker, Licensed Mental Health Counselor, or Licensed Marriage and Family Therapist, AND</p> <p>b) A minimum of 120 hours of approved sex therapy education, AND</p> <p>c) A minimum of 40 client contact hours in the clinical practice of sex therapy, and a minimum 20 hours of supervision by a Sex Therapy Supervisor during a minimum 6 month time period.</p>	
SSS Evaluator (Special Supervision Services) – provides case monitoring of SSS clients that are eligible for the program- for multiple offenders.	<p>a) Currently certified as a SSS Evaluator through the Department of Highway Safety & Motor Vehicles (DHSMV). OR</p> <p>b) Granted a temporary DHSMV certification for this position, not to exceed six (6) months, and function under the supervision of a fully certified SSS Evaluator.</p>	
Substance Abuse Assessment/ Evaluation	One year of direct service substance abuse experience.	
Substance Abuse Counseling	One year of direct service substance abuse experience.	
Supervision of Clinical Interns, Interns, and / or Volunteers	<p>a) Three years experience in specialty field AND / OR</p> <p>b) Two years supervisory experience.</p>	
Supervision for Licensure/ Certification	<p>a) Licensed Psychiatrist, Advanced Practice Registered Nurse, Licensed Psychologist, Licensed School Psychologist, Licensed Clinical Social Worker, Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, or Certified Addiction Professional, AND</p> <p>b) Three years post licensure clinical experience. Required coursework of State approved qualified supervisor, if applicable.</p>	

Credentialing/Privileging Record Checklist

Associate: _____

Program: _____

Privilege Award Dates: Temporary: ____/____/____ Initial: ____/____/____ Re-Award: ____/____/____

Associate Credentialing Status:

____ Physician	____ Licensed Mental Health Counselor	____ Certified Addictions Professional
____ Psychologist	____ Licensed Clinical Social Worker	____ Certified Instructor
____ ARNP	____ Licensed Marriage and Family Therapist	____ Other
____ Physician Assistant	____ Licensed Practical Nurse	

✓ Included	Physicians/ Prescribers	LCSW/LMHC LMFT/CAP	LPN	Instructor	Description
	X = Required				
Initial Application and Award					
	X	X	X	X	Privacy Act Statement [SRQ-15]
	X	X	X	X	Statement of Applicant [SRQ-16]
	X	X	X		Application for C/P LIP [SRQ-17]
				X	Application for C/P Ancillary Staff [SRQ-18]
	X	X	X	X	Confidentiality Statement [SRQ-22]
	X	X			Professional Recommendation of Healthcare Practitioners (x2) [SRQ-156a]
	X	X	X		Consent and Release [SRQ-160]
	X	X			Professional Diploma(s) and/or Certified Transcripts
	X	X	X		State license(s) Lic. # Exp Date:
				X	Certification # (i.e. NVCI/Red Cross/BDI/HIV/AIDS): Exp Date:
	X	X		X	Required Experience, training and / or education for specific privileges (If applicable)
	X	X			Proof of Liability Insurance (<i>Contractors only</i>)
	X	X			Primary Source Verification / Practitioner Profile – [FL DOH] (ONLINE)
	X	X	X		National Practitioner Data Bank [NPDB] – (US HHS) (ONLINE)
	X	X	X		Proof of Office of the Inspector General [OIG] Review for Sanctions If Yes – Copy of Attestation/Investigation
	X	X		X	Letter “Provisional Award of Privileges” [SRQ-19a]
	X	X		X	Recommended Award of Staff Privileges From C&P Committee [SRQ-158]
	X				Controlled Substances Registration Certificate (DEA) [<i>Physicians Only</i>]
	X				Residency, Internship and/or Specialty Board Certificates (If no-N/A)
	X				Copy of Curriculum Vitae (CV) [<i>Physicians Only</i>]
Annual Review and Re-Award ONLY					
	X	X		X	Bi-Annual Review of Privileges (Supervisor Signature) [SRQ-20a]
	X	X	X		State license(s) Lic. # Exp Date:
				X	Certification # (i.e. NVCI/Red Cross/BDI/HIV/AIDS): Exp Date:
	X	X	X		Primary Source Verification / Practitioner Profile – [FL DOH] (ONLINE)
	X	X	X		National Practitioner Data Bank [NPDB] – (US HHS) (ONLINE)
	X	X	X		Proof of Office of the Inspector General [OIG] (ONLINE) Review for Sanctions If Yes – Copy of Attestation/Investigation
	X	X	X		# of BCI Complaints Review/Results
	X	X		X	Recommended Award of Staff Privileges From C&P Committee [SRQ-158]

CREDENTIALING/PRIVILEGING

PRIVACY ACT STATEMENT

(Please Read Carefully Before Signing)

A Credentials/Privileges file is maintained on all Mental Health Care and Addictions/Substance Abuse providers, and Certified Instructors at Bridgeway Center, Inc. The Credentials/Privileges file repository exists in the Office of the Recorder of the Credentialing/Privileging Committee. The documentation in each file includes information furnished or solicited in order to evaluate the professional qualifications of the provider and documentation pertaining to training and education.

The purpose for requesting personal information from identified Bridgeway Center, Inc. staff, relating to his/her formal education, training, clinical experience, and evidence of physical, moral and ethical capacities, is to assist the Credentialing/Privileging Committee in reviewing and making recommendations with regard to the associates competence to provide services to Bridgeway Center, Inc. consumers.

The information contained in the Credentialing/Privileging files is used to award privileges to associates. It may also be used as background data to respond to applications submitted by individuals, admission to professional medical societies, employment and privileges at other institutions.

Disclosure is voluntary. If the information is not furnished, the Credentialing/Privileging Committee has the discretion to restrict, revoke, or withhold the awarding of Privileges, which may subject the associate to administrative or contact remedies.

The foregoing one-time Privacy Act Statement will apply to all requests for personal information made by the Credentialing/Privileging Committee. The undersigned understands that he/she is entitled to a copy of the statement, should one be requested.

Printed Name

Social Security Number

Signature

Date

CREDENTIALING/PRIVILEGING STATEMENT OF APPLICANT

(Please Read Carefully Before Signing)

All information submitted by me in this application is true to the best of my knowledge and belief. In making this application for privileges at Bridgeway Center, Inc., I acknowledge my obligation to provide quality care to consumers and to cooperate with the Bridgeway Center, Inc. Credentialing/Privileging Committee.

I authorize Bridgeway Center, Inc. to consult with administrators and members of the Mental Health and Drug Abuse Staff of other institutions with which I have been associated and with others who may have information bearing on my professional competence, character and ethical qualifications.

I understand that the Bridgeway Center, Inc. may communicate to other Mental Health organizations, hospitals or other persons and/or organizations with a legitimate interest therein, any information concerning my professional competence, character and ethics that Bridgeway Center, Inc. may have or acquire, and where such communication is made in good faith and without malice; I hereby give my consent to release such information.

I understand and agree that I, as an applicant for privileges, have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I also agree to conduct myself in accordance with high ethical traditions, and I agree to subject my performance to and faithfully participate in the Bridgeway Center, Inc. Continuous Quality Improvement Program.

Signature

Date



APPLICATION FOR CREDENTIALING AND PRIVILEGING LICENSED PRACTITIONER [LP]

I. PERSONAL DATA

Last Name:		First Name:		MI:	Maiden Name:
Social Security#:	DOB:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	
Home Address:	City:	State:	Zip:	Home Phone#:	
Office Address:	City:	State:	Zip:	Office Phone#:	
Current Military Status: <input type="checkbox"/> N/A <input type="checkbox"/> Active Duty <input type="checkbox"/> Reservist	Are you a U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth City & State:		Birth Country:	
Driver License # & State:		NPI #: (if applicable)			

II. EDUCATION BACKGROUND

Education Institution		Degree	From (mm/yyyy)	To (mm/yyyy)
Undergraduate/ Premedical Education	Institution:			
	Address:			
	City, State, Zip:			
Graduate Education	Institution:			
	Address:			
	City, State, Zip:			
Professional / Medical School	Institution:			
	Address:			
	City, State, Zip:			
Internship / Post Graduate / Practicum / Residencies	Institution:			
	Address:			
	City, State, Zip:			
Fellowship / Assistantships / Teaching Appointments	Institution:			
	Address:			
	City, State, Zip:			

If you are a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No *If answered yes, please include a copy of your certificate*



APPLICATION FOR CREDENTIALING AND PRIVILEGING LICENSED PRACTITIONER [LP]

III. LICENSURE [when applicable]

State / Province:		Date Issued:	
License Number:		Registry Number:	
State / Province:		Date Issued:	
License Number:		Registry Number:	

Has your license to practice in any jurisdiction ever been suspended or revoked? ☐ No ☐ Yes

Have you ever been convicted in a court of law for a criminal act? ☐ No ☐ Yes

Physicians Only				
Has your Federal Narcotics License ever been suspended or revoked?				<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you agree, on an annual basis, to submit your federal narcotic registration number and the date of its issuance?				<input type="checkbox"/> No <input type="checkbox"/> Yes
DEA Number:		Issue Date:		Expiration Date:

IV. PHYSICAL HEALTH

Have you ever had or currently have any health conditions that would adversely affect your ability to practice? ☐ No ☐ Yes

V. MEMBERSHIP / EMPLOYMENT IN OTHER HEALTH CARE INSTITUTIONS

Have you ever been refused membership / employment in another mental health or other health care facility / institution? ☐ No ☐ Yes

Has your request for any specific clinical privilege ever been denied or granted with limitation? ☐ No ☐ Yes

Have your privileges at another institution ever been suspended, diminished, or not renewed? ☐ No ☐ Yes

Have you ever been subject to disciplinary proceedings in any organization? ☐ No ☐ Yes

Note: If the answer to any of the above questions is "yes", please give full details on a separate sheet of paper.

Membership on other hospital / behavioral health care agency staffs [past and present]

1. _____
2. _____
3. _____
4. _____

Membership in medical societies: _____



APPLICATION FOR CREDENTIALING AND PRIVILEGING LICENSED PRACTITIONER [LP]

VI. SPECIALTIES

Are you certified in any area of mental health or addiction/substance abuse specialization? ☐ No ☐ Yes

If yes, please specify: _____

Professional Organization Membership [List]: _____

Honors and Positions Held [List]: _____

Publications [List]: _____

Other contributory information, for example: exhibits, movies, lectureships, academic positions held. [Please title each section and list sequentially.] _____

Physicians Only					
Are you certified by an American Board(s)?					<input type="checkbox"/> No <input type="checkbox"/> Yes
<i>If yes, please provide the name of the board(s):</i>					
(Non-Certified Providers) Are you board eligible?					<input type="checkbox"/> No <input type="checkbox"/> Yes
Certificate No.:		Issue Date:		Expiration Date:	

VII. NARRATIVE SUMMARY OF PRIVILEGES AWARDED BY ANOTHER CLINIC, CENTER, HOSPITAL, ETC.

Institution	Privileges

VIII. Professional References

Please provide three (3) references of individuals who can verify your training and professional capabilities. The references may be past employers.

Note: *If you have not had two previous employments and worked with someone who can verify your training and professional capabilities; or, if you are recently licensed, the two references may be from teachers, professional acquaintances or from other supervisors.]*

Name	Title	Address	Telephone
------	-------	---------	-----------

Name	Title	Address	Telephone
------	-------	---------	-----------

Name	Title	Address	Telephone
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**APPLICATION FOR CREDENTIALING AND PRIVILEGING
LICENSED PRACTITIONER [LP]**

IX. The undersigned applies for membership on the professional staff of Bridgeway Center, Inc. and for privileges of practice as indicated below:

Certification [if applicable]

- | | | |
|----|-------|-------|
| a. | _____ | _____ |
| b. | _____ | _____ |
| c. | _____ | _____ |
| d. | _____ | _____ |
| e. | _____ | _____ |
| f. | _____ | _____ |
| g. | _____ | _____ |

X. Malpractice History

Have you ever been a defendant in a malpractice case during the past two years? ☐ No ☐ Yes

If yes, please explain in detail: _____

Malpractice Liability Insurance Data

Name of Carrier: _____ Amount of Coverage \$ _____

Expiration Date: ____/____/____ Policy Number: _____

Agent: _____ Phone Number: _____

To the best of my knowledge, I have no physical, emotional or mental health conditions, or drug/alcohol dependency that will affect my ability to complete the duties of my job and the privileges awarded. I fully understand that any significant misstatements in or omissions from this application constitute cause for summary dismissal from staff.

Applicant's Signature _____/_____/_____
Date

RECOMMEND: ☐ APPROVAL ☐ DISAPPROVAL

Supervisor Signature:

Date:

C&P Committee Representative Signature:

Date:

**APPLICATION FOR CREDENTIALING AND PRIVILEGING
ANCILLARY STAFF****I. PERSONAL DATA**

Name: _____ Date: ____/____/____

Social Security Number: ____-____-____ Date of Birth: ____/____/____

II. CREDENTIALS**Certifications:**

Specialty: _____ Certificate Number: _____

Specialty: _____ Certificate Number: _____

Specialty: _____ Certificate Number: _____

Specialty: _____ Certificate Number: _____

Specialty: _____ Certificate Number: _____

I am requesting privileges to provide training/services based on the above certifications.

To the best of my knowledge, I have no physical, emotional/mental health conditions, or drug/alcohol dependency that will affect my ability to complete the duties of my job and the privileges awarded. I fully understand that any significant misstatements in or omissions from this application constitute cause for summary dismissal from staff.

Applicant's Signature____/____/____
Date**RECOMMEND: ☐ APPROVAL / ☐ DISAPPROVAL**_____
Supervisor____/____/____
Date_____
C&P Committee Representative____/____/____
Date



CONFIDENTIALITY STATEMENT

(Print Name)

Circle One: Associate Board Member Crisis Line Volunteer Other Volunteer Student

I understand that all information about a client is strictly confidential. Bridgeway Center's Policy, State and Federal Laws require this confidentiality. Violation of these laws incurs a monetary fine and possible imprisonment. Proven violation of confidentiality of client information by associates, may be cause for immediate termination with prejudice for rehire.

I understand that by reason of my association or employment with Bridgeway Center, I may come into possession of information concerning services provided about Bridgeway Center's client(s) and that I am responsible for protecting that information from unauthorized disclosure, subject to the penalties for violation of this trust. (Under 42 U.S.C. 290 ee-3 (f) and 42 U.S.C. 290 dd-3 (f), any person who violates any provision of Department of Health and Human Services, Public Health Service 42CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, shall be fined not more than \$500 in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense.)

I shall respect the privacy of the people we serve and hold in confidence all information obtained in the course of employment, whether that information is obtained through written records or daily interaction with the client. Therefore, I will not disclose an individual's confidence to anyone, except as mandated by law. I shall be responsible to store or dispose of client records and Bridgeway confidential information such as trade secrets and proprietary information in ways that maintain confidentiality. I shall possess a professional attitude that upholds confidentiality toward the people we serve, associates, and sensitive situations arising within Bridgeway Center, Inc.

I, upon terminating my duties with Bridgeway, shall maintain client and co-worker confidentiality and I shall hold confidential any trade secrets or proprietary information I have learned.

I have read and understand the above and agree to abide by the standards and rules of confidentiality as stated in the Bridgeway Center's Confidentiality Policy and Procedure, CSA 40-1. I have received a copy of this statement.

Signature

Date

Witness Signature

Date

Associates, Board Members, Volunteers and Students will complete this form and the original will be filed in the HR Department.

Professional Recommendation of Healthcare Practitioner

Section 1: To be completed by Practitioner

	NPI:
Printed Name of Practitioner – <i>Last, First, Middle Initial</i>	Title:
<p align="center">Release of Liability</p> <p>I hereby release from liability all officials of Bridgeway Center, Inc. (BCI) including all representatives of the BCI and its medical staff for their acts performed in good faith and without malice in connection with evaluating or action concerning my application and my credentials and qualifications. I hereby release from liability any and all individuals and organizations who in good faith and without malice, provide any and all information to officials of BCI, or to the authorized medical staff representatives, concerning my professional practice, competence, ethics, character and other qualifications for staff appointment and clinical privileges, and hereby consent to the release of any and all such information.</p>	
Practitioner Signature:	Date:

Section 2: To be completed by Evaluator

Facility Name of Practice: _____ Dates ~ From: _____ To: _____

Status of Practitioner (Staff, Resident, etc) _____

Specialty(ies) Privileged at Facility _____

The following evaluation is based on demonstrated performance compared to that reasonably expected of a practitioner at his/her level of training, experience and background:

<i>Mark an "X" in appropriate block for each item listed</i>	Poor	Fair	Good	Superior	Not Observed
Basic Professional Knowledge					
Professional Judgment					
Sense of Responsibility					
Ethical Conduct					
Competence and Skill					
Cooperativeness, Ability to Work With Others					
History and Physical Exam					
Record Keeping					
Case Presentations					
Patient Management					
Practitioner-Patient Relations					
Ability to write and speak English					
Participation in staff and committee activities					
Regularly obtained consultations when needed					

Professional Recommendation of Healthcare Practitioner

If the answer to any of the following questions is "Yes" please give full details in the Remarks Section. If additional space is needed, continue on a separate sheet of paper and attach to this form. Be sure to identify item by number.

To your knowledge, has the applicant:

<i>Please check ✓ Yes or No for each question</i>		YES	NO
1.	Ever had his/her license to practice in any jurisdiction limited, suspended, or revoked?		
2.	Ever been refused membership on a medical staff?		
3.	Ever had a request for specific privileges denied or granted with stated limitations?		
4.	Ever had privileges at any hospital or behavioral center suspended, limited or revoked?		
5.	Ever had a narcotic registration suspended or revoked?		
6.	Ever been arrested or treated for drug or alcohol abuse?		
7.	Ever been a defendant in a felony case?		
8.	Ever had any significant medical or mental health problems which could affect work?		
9.	Ever been a defendant or the subject of a malpractice action?		
	<i>If yes, was the matter:</i>		
a.	Settled prior to court action		
b.	Judgment rendered by a court		
c.	Defendant found liable?		
d.	Matter still pending?		

Number of years you have known the applicant: _____ Best Telephone # to Contact You: _____

Remarks: _____

Statement of Clinical Competency: _____

Printed Name / Title of Evaluator _____

Evaluator Signature: _____

Date: _____

CREDENTIALING/PRIVILEGING PEER REVIEW & REFERENCE**CONSENT AND RELEASE**

I, _____, specifically authorize Bridgeway Center, Inc., and its authorized representatives to contact and consult with, for information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on my satisfaction of the criteria for appointment or reappointment to the (medical) staff, as well as to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties relating to such questions. I also specifically authorize said third parties to release information to Bridgeway Center, Inc., and its authorized representatives upon request.

Signature

Title

Print Name of Above Signature

Date

Date

Staff Name

Facility

Address

Ft. Walton Beach, FL 32548

RE: Provisional Award of Privileges

Dear :

You are temporarily awarded the following privileges. The Credentialing/Privileging Committee will complete final review and approval for biannual award of these specific privileges date of next C&P meeting:

1 .

Congratulations! Please be sure that you are aware of the standards and responsibilities attached to exercising these privileges and the requirements of maintaining certification or licensure and continuing education credits, if applicable.

Sincerely,

Daniel Cobbs, MPA, FACHE
Chief Executive Officer

cc: Supervisor
C&P File

SRQ-19a 11/15/11

Award of Privileges

BCI ASSOCIATE: _____

DATE: _____

Recommended Award of Staff Privileges

	Code
1	
2	
3	
4	
5	

	Code
6	
7	
8	
9	
10	

The above privileges have been reviewed and C&P Committee's decision is reflected by the Code.

The following additional privileges should be awarded:

	Code
1	
2	

	Code
3	
4	

The following privileges should be rescinded:

1		Explanation	_____
2		Explanation	_____

C&P Committee Representative

Date

C&P Committee Chairperson

Date

I acknowledge that I understand the privileges recommended for award by Bridgeway Center's Credentialing & Privileging Committee.

BCI Associate

Date

Return the original copy of this letter to the SRQ Office to be filed with your Credentials/Privileges file. Retain the other copy for your records.

Key to Codes

1=Fully competent within defined scope of practice

2= Approval Pending until additional information or training is received

TO: Associate's Name
FROM: Credentialing & Privileging Committee
DATE: Date
SUBJECT: Bi-Annual Review of Privileges

The Bridgeway Center, Inc. Credentialing and Privileging Committee will accomplish an annual review of the privileges previously awarded you. The committee will re-award, confer additional privileges or rescind privileges previously awarded, consistent with competence maintained, continuing education and licensing requirements, and job description.

Please complete the following portion of this form and then give it to your supervisor to complete their section. If you have any questions, please ask your supervisor or the Safety, Regulatory and Quality Office.

To the best of my knowledge, I, _____ have no physical, emotional/mental health conditions, or drug/alcohol dependency that affects my ability to complete the duties of my job and the privileges awarded. I request the following staff privileges be re-awarded: **(cross-out and initial any privilege you want deleted).**

- | | | |
|----|--|----|
| 1) | | 5) |
| 2) | | 6) |
| 3) | | 7) |
| 4) | | 8) |

Signature

Date

Please list any additional privileges that should be awarded. **Attach proof of training/experience you have had in the areas:**

- | | |
|----|-------|
| 1) | _____ |
| 2) | _____ |
| 3) | _____ |
| 4) | _____ |

SUPERVISOR'S COMMENTS: _____

CONCURRENCE / NON-CONCURRENCE

Supervisor's Signature

Date

Note to Supervisor: Please return this Form to the SRQ Office once you have completed your section.