# Fifth Avenue Surgery Center
# 1049 FIFTH AVENUE
# NEW YORK, N.Y. 10028

# Initial Provider Application

Please complete the application and answer all questions thoroughly

Dear: _____,

We are pleased to provide you with the enclosed **Initial Appointment** Application for Medical staff. Please fill out the application in its entirety. Please make correct changes where necessary and **include any and all new procedures you are practicing**. This packet has been developed to facilitate and expedite both the appointment of qualified applicants to the Professional staff and enrollment with the Center.

Your application will be considered complete and ready for processing once all requested information has been received and verified by the Credentialing Department. **The submission of your application for membership does not automatically grant you Professional Staff membership and privileges**. The application must be filled out correctly and to meet the State of New York requirements. All applications must proceed through verification and review process and must be approved by the Governing Body. Note initial appointments for privileges are valid for (3) **three** years. After the (3) three years you will be asked to complete a re-appointment application.

Once your completed, signed, and dated application is received by the Credentialing Department, the credentialing process may begin.

Provide complete, detailed information – Complete all areas of the application, providing as much detail as possible. Incomplete applications cannot be processed and will be returned to the applicant for completion. If additional space is required to provide all of the information required, please submit additional pages with your application.

Provide accurate information – the process may require less time if contact information, including accurate mailing addresses, telephone numbers, fax numbers and email addresses is provided. Be prepared to help – Your assistance may be required when, after several attempts, we are unable to obtain a response from a primary source.

If we can further assist you in this process, please contact the Credentialing Department at
FIFTH AVENUE SURGERY CENTER

Sincerely,

Eugene Diaz
Credentialing Coordinator
Ediaz@5thavesc.com

## Required Documents Checklist

The following documents are required for all Practitioners in order to fully process your application. If any of the documents listed below are not available at the time of submission of your application, please indicate in your application when the documents will be submitted separately.

— Copy of Original **professional license** with date of issue and copies of current renewal license with dates of expiration to appropriate licensing board. Note: If you do not have a license, documentary evidence of submission of application must be provided prior to submitting this paperwork.

— Copy of current (unexpired) U.S Government issued **photo** ID (i.e., driver's license, passport)

— Copy of **current malpractice/professional liability** insurance certificate (deck page)

— Copy of current Federal **DEA** Registration Certificate (as applicable)

— Copy of unexpired resuscitation certifications (**ACLS, BLS, PALS**) as applicable

— Copy of current **Curriculum Vitae** outlining education and practice history

— Copy of advanced degree diploma (i.e., MSN, Ph.D., etc.) and any additional Advanced Training Certificates.

— **Completed, Signed and Dated Provider Application**

— **Privilege** Delineation Request for Specialty forms enclosed

— 2 Two **Peer Reference** letters- forms enclosed

— Letter of Good Standing from Hospital and or ASC WITH **APPROVED PRIVILEGES- (Center to request)**

— CME's (Continuing Medical Education credits) Infection Training- form enclosed

— Job Description- Enclosed

— Consents- Enclosed

### HEALTH FORMS

— H&P (History and Physical – must be dated within a year) signed by attending physician

— Titers MMR (Hep B &C, Measles, Mumps, Rubella and Varicella)

— 2 step current PPD – must be dated within a year

— TB Questionnaire if you are a positive PPD reactor

— (copy of chest x-ray- if positive PPD reactor)

— Hepatitis Waiver if you have not received the series of injections

— Flu Vaccine form documentation of where and when, or Declination

**Please Make Sure All Copies Sent to the Center Are Clear and Legible**

## Initial Provider Application for Privileges

Last Name: _____ First Name: _____ MI _____

Degree: MD, DO, DC, DDS, DPM, DMD, OTHER _____ Sex_____

Place of Birth: _____ U.S. Citizen _____ Yes _____ No_____ Specialty: _____

Scrub Top Size: S____M ____L ____ XL _____XXL ____ 3X ____4X_____ Tops ____ **Bottoms** _____

Emergency Contact: _____ Phone Number: _____ Relation: _____

Identifying Numbers:

Social Security#: _____ State License #: _____

Year Issued: _____ Expiration Date: _____ Tax ID#: _____

NPI # _____ Medicare#: _____ Medicaid #: _____

Office Location:

**Primary Location**: _____ Group Practice _____ Solo Practice

Name of Practice: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (  ) _____ Fax: (  ) _____

**Secondary Location**

Address: _____

City: _____ State: _____ Zip: _____

Phone: (  ) _____ Fax: (  ) _____

Other group members/ partners: _____

Covering Physicians: _____

Home Address

Address: _____

City: _____ State: _____ Zip: _____

Phone: (  ) _____ **CELL** (  ) _____

Email _____

Last Name: _____ First Name: _____ MI _____

Employment History

*Please list professional employment history for the past five (5) years.* **May enclose CV**

| Activity / Position | Facility / Program Location and Phone | Dates: From and To |
|---|---|---|
| | | |
| | | |
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| | | |
| | | |

**Hospital Affiliations:** ***Please list primary admitting facility first***

1. Hospital Name: _____

Appointment Dates: _____ Staff Status: _____

2. Hospital Name: _____

Appointment Dates: _____ Staff Status: _____

3. Hospital Name: _____

Appointment Dates: _____ Staff Status: _____

*Have you voluntarily resigned to avoid investigation or been dismissed from any facility?* *Yes_____ No_____*

*If yes, explain:*

## Foreign Medical School Graduates:

Are you a Graduate of a Foreign Medical school? *Yes_____ No_____*

Are you certified by the Education Council for Foreign Medical Graduates? *Yes_____ No_____*

ECFMG Number: _____

Last Name: _____ First Name: _____ MI _____

## Professional Liability

1. In the last five years, has your professional liability insurance coverage ever been *denied or canceled*? _____Yes _____No
2. In the last five years, has your current or any previous professional liability carrier ever made an out-of-court settlement or paid a judgment of professional liability claim on your behalf? _____Yes _____No
3. Are you or have you ever been involved in a malpractice suit(s), grievance(s) filed with a county or state medical society or licensing agency, or arbitration proceeding(s)? _____Yes _____No

A total number of _____ professional liability actions resulting in final judgment against you.
Are there any still pending? _____Yes _____No
Did you ever have a criminal indictment, guilty plea or verdict in a criminal proceeding (other than traffic violation) or any government investigation? ____ Yes _____ No: If yes please explain
Have you ever been refused for coverage by a professional liability insurance carrier _____Yes _____No

| **Do any of the following apply:** | Yes | No |
|---|---|---|
| Dismissed from any training program? | _____ | _____ |
| On probation in any training program? | _____ | _____ |
| Had disciplinary action taken against you in any training program? | _____ | _____ |
| Resigned voluntarily from any training program? | _____ | _____ |

## Professional Actions

Has any action ever been taken against your license to practice in any state/ country or jurisdiction including but not limited to denial, suspension, revocation, restriction, limitation, probation or reprimand, or have you ever voluntarily or involuntarily relinquished your license? _____ Yes _____ No

Has an application for privileges or your existing privileges at any hospital ever been denied, suspended, revoked, or have you ever voluntarily or involuntarily relinquished privileges at any hospital in lieu of disciplinary or peer review action or investigation? _____Yes_____ No

Have you ever agreed to have your privileges or medical staff appointment at any hospital limited, reduced, or terminated to avoid investigation? _____ Yes_____ No

Are you aware of any investigation by a state/ country or any governmental licensing authority concerning your license? _____ Yes _____ No

Have you ever been suspended, sanctioned or otherwise restricted from participating in any private, federal, or state health insurance program (i.e. Medicare, Medicaid, HMO's, PPO's etc.)? _____Yes_____ No

Have you ever been reported to the National Practitioner Data Bank, AMA, State, etc. for any adverse action or any malpractice insurance payment? _____Yes_____ No

Have you ever been censured by a Medical Society or other Professional Society or other professional board or association? _____Yes _____No

Have you ever had your Drug Enforcement Administration number (**DEA#**) restricted, suspended, revoked or otherwise limited or DEA license application refused? _____Yes _____No

Have you ever had your Drug Enforcement Administration number (**CDS #**) restricted, suspended, revoked or otherwise limited or CDS license application refused? _____Yes _____No

Have you ever been required or agreed to pay civil monetary penalties under Medicare or Medicaid? _____Yes _____No

**If you answered "Yes" to question any of the above questions, you must supply a detailed explanation. All information is held in strict confidence and used for credentialing and re-credentialing purposes only. Failure to supply sufficient details may prevent your application from being approved**

Last Name: _____ First Name: _____ MI _____

## Health Status

Please answer following questions if you answer "Yes" to any of the questions please explain on a separate sheet.

1. I certify that I am in good health and have no physical or mental limitations which may impair my ability to render patient care? _____ Yes _____ No

2. If you are unable to care for your patients do you have an agreement with another professional to provide continuity of care? _____ Yes _____ No

3. Did you have a complete physical examination within the last year? _____Yes _____No

4. Where there any findings that indicated, in any degree, an inability to render patient care? _____ Yes _____ No

5. Do you have any condition/ limitation which affects your ability to render essential functions of patient care? _____ Yes _____No

**Chemical Substance of Alcohol Abuse**

1. Are you currently engaged in illegal use of any legal or illegal substances? _____ Yes _____No
2. Do you use any chemical substances that would in any way impair or limit your ability to practice? medicine and perform the functions of your job with reasonable skill and safety? _____ Yes _____No

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Do you understand that subject to proper confidentiality restrictions and authorizations, your office medical records might be subject to on site review by the CENTER representatives for peer review, utilization review, and quality assurance purposes? _____ Yes _____No

Is there anything that would prevent you from performing the essential functions and duties of your clinical practice with or without reasonable accommodations? _____ Yes _____No

Last Name: _____ First Name: _____ MI _____

**In order to evaluate my application, I agree to the following terms and conditions:**

**That the information contained in the Initial Provider Application is true and accurate and that information important to my application has not been falsified and/or omitted intentionally.**

**I fully understand that any misstatements or omissions from this application constitute cause for immediate denial of appointment.**

**I understand that this is an application process and does constitute acceptance or approval by the Governing body or a Credentialing Committee. I also acknowledge that my cooperation by consenting to the production of such information about me does not guarantee that FIFTH AVENUE SURGERY CENTER and its affiliates will contract with me as a provider of services. I further understand that the burden of providing the necessary information to process my application is upon me (the applicant).**

**I give full permission and authorization FIFTH AVENUE SURGERY CENTER to collect, research, and verify any and all references, licenses, certificates, insurance related matters, appointments and such matters that relates to consideration of my application, this permission extends to and includes the current application and periodic checks as required by the credentialing institution, or the State, accreditation, etc. and for re-credentialing. The aforementioned shall be in effect as long as the applicant is affiliated with the credentialing institution.**

**I hereby release without time limitation from liability and hold harmless the: FIFTH AVENUE SURGERY CENTER, all employees, previous employees, staff, authorized representatives, management and affiliates of all institutions or individuals or group for all acts and statements made in connection with collection, verification, review and evaluation of my credentials and qualifications. These aforementioned shall be in effect as long as the applicant is affiliated with the credentialing institution to include but are not limited to: FIFTH AVENUE SURGERY CENTER, governmental and non-governmental agencies, insurance companies, educational Institutions, previous employees, public or private record providers, and interviews.**

**The foregoing immunities from liability shall be in addition to those provided by law.**

**I, the undersigned, agree to waive any written notice from any present or past organization, individual or employer that prohibits release of information important to my application.**

**I, the undersigned, agree to accept a "faxed" or photocopy of this authorization to be accepted with the same authority as the original.**

_____ _____

**Applicant Signature** **Applicant Printed Name**

_____

**Date**

**FIFTH AVENUE SURGERY CENTER**

**WAIVER OF LIABILITY & CONSENT FOR RELEASE OF INFORMATION**

I, _____, hereby request and consent to release of information.

I authorize the CENTER to inspect and receive copies of all records and information pertaining to me which are presently in possession of hospitals, boards of medical licensure, national, county and state medical societies, government agencies, military organizations, specialty medical societies, specialty accreditation boards, national medical data banks, medical clinics, HMO's, PPO's, medical practices or other types of health care organizations and institutions. I further consent to the inspection and release of all my records pertaining to professional liability insurance carriers.

I also authorize any college, school, or medical school to release information about me to the CENTER in accordance with the Family Education Rights and Privacy Act of 1974.

I hereby release from liability all representatives and agents of CENTER for their acts performed in good faith and without malice in connection with my participation in the centralized verification program. I hereby further release from liability all individuals, organizations and agencies providing information to The CENTER under terms of this authorization.

I understand that the release of any information concerning me by the CENTER will only be in connection with obtaining information for a healthcare organization contracted with the CENTER where I have, or have applied for, membership, participation or clinical privileges. This includes information which is required in connection with my appointment, reappointment, or re-credentialing. This information may be produced on a professional profile.

A photocopy of this signed consent form shall be deemed to have my authorization and approval for release of the requested information to the CENTER

| **Applicant Printed Name:** | |
|---|---|
| **Applicant Signature:** | **Date:** |

## FIFTH AVENUE SURGERY CENTER

## RELEASE OF LIABILITY FROM PHYSICIAN APPLICANT FOR APPOINTMENT TO THE MEDICAL STAFF

I hereby authorize the Governing Body Credentialing Committee of the Center to contact any references listed by me on my application form for medical staff privileges, or to any other physician, person, agency, or organization concerning my professional background, character, citizenship, or qualifications to serve as a member of the medical staff and in so instructing the above governing body and persons to make this investigation. I hereby agree to hold them and any person or organization answering their inquiries about my qualifications, education, experience, character, and citizenship harmless from any claims by me for any statements which they may make concerning me.

I agree that a copy of this really shall be sent to those references listed in this application together with the request for information concerning me and my background in order that the people writing references may free to express their honest opinions about my abilities as a Physician and my reputation as a professional to those who are considering my application for membership on the Medical Staff of the Center.

| | |
|---|---|
| **Applicant Printed Name:** | |
| **Applicant Signature:** | **Date:** |

### RESPONSIBILITY FOR INFORMED CONSENT

I recognize that it is my responsibility as the attending Physician to explain the procedures, alternate treatment options, possible complications, and expected outcomes to all of my patients being admitted to the Center.

| | |
|---|---|
| **Applicant Signature:** | **Date:** |

### A RIGHT OF CONFIDENTIALITY

As a member of the medical staff of the CENTER I recognize the patient's right to confidentiality and agree to abide by the patients' Bill of Rights as posted within the Center.

Additionally, I agree that informed relating to a patient's physical and or emotional status will not be released except as set forth within the policy in procedural manual.

| | |
|---|---|
| **Applicant Signature:** | **Date:** |

## FIFTH AVENUE SURGEY CENTER

### ACKNOWLEDGEMENT OF NOTIFICATION

Medicare payments to the Center are based on each patient's principal and secondary diagnosis in the major procedures performed on the patient as attested to by the patient's attending physician, by virtue of his or her signature in the medical record anyone who misrepresents falls fries were conceals essential information required for payment of federal funds may be subject to find imprisonment or civil penalty under applicable federal laws.

I hereby acknowledge receipt of the above notice provided to me by the Center acting in accordance with 42 CFR Part 405, #405.472.

| | |
|---|---|
| Applicant Printed Name: | |
| Applicant Signature: | Date: |

### SECURITY CONFIDENTIALITY AGREEMENT

The Governing Body and Staff of the Center deem confidentiality of Protected Health Information (PHI). PHI is any information, whether oral or recorded in any form or medium (a) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (b) that identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

The patient and the Center have the right to expect that PHI will be treated as confidential.

Strict confidentiality requirements are enforced to assure that medical records are used within this Center only by recipients authorized under HIPAA or authorized by the patient. Board and committee meeting minutes and Center business activities are kept strictly confidential.

Information, which is considered to be privileged, may not be released to anyone without the written authorization of the patient unless required by law.

Information which is considered non-privileged is that which has been de-identified, i.e., names, addresses, patient numbers, admission or procedure dates have been removed. However, discretion must be exercised in release of non-privileged information.

All Providers and employees will monitor Center compliance with HIPAA Confidentiality Standards in securing patient charts, work area safeguards and electronic security.

Violations of HIPAA regulations can result in sanctions against the employee and facility. These sanctions include fines up to $25,000 for multiple violations of the same standard in a calendar year and fines up to $250,000 and/or imprisonment up to 10 years for knowing misuse of individually identifiable health information.

It is the responsibility of all employees, Medical staff, allied health staff, students and volunteers, to preserve and protect confidential patient, employee and business information.

The federal Health Insurance Portability Accountability Act (the "Privacy Rule"), as well as individual state codes govern the release of patient identifiable information by hospitals and other health care providers and the

acquisition and use of data that pertains to individuals. All of these laws establish protections to preserve the confidentiality of various medical and personal information and specify that such information may not be disclosed except as authorized by law or the patient or individual.

Confidential Patient Care Information includes: Any individually identifiable information in possession or derived from a provider of health care regarding a patient's medical history, mental, or physical condition or treatment, as well as the patients and/or their family member's records, test results, conversations, research records and financial information. (Note: this information is defined in the Privacy Rule as "protected health information.") Examples include, but are not limited to:

- Physical medical and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
- Patient insurance and billing records;
- Mainframe and department based computerized patient data and alphanumeric radio pager messages;
- Visual observation of patients receiving medical care or accessing services; and
- Verbal information provided by or about a patient

Confidential Employee and Business Information includes, but is not limited to, the following:

- Employee home telephone number and address:
- Spouse or other relative names;
- Social Security number or income tax withholding records;
- Information related to evaluation of performance;
- Other such information obtained from the patient's records which if disclosed, would constitute unwarranted invasion of privacy; or
- Disclosure of Confidential business information that would cause harm to the Center.

Peer review and risk management activities and information are protected under the attorney-client privilege.

I understand and acknowledge that:

1. I shall respect and maintain the confidentiality of all discussions, deliberations, patient care records and any other information generated in connection with individual patient care, risk management and/or peer review activities.
2. It is my legal and ethical responsibility to protect the privacy, confidentiality and security of all medical records, proprietary information and other confidential information relating to the Center and its affiliates, including business, employment and medical information relating to our patients, members, employees and health care providers.
3. I shall only access or disseminate patient care information in the performance of my assigned duties and where required by or permitted by law, and in a manner which is consistent with officially adopted policies of the Center, or where no officially adopted policy exists, only with the express approval of my supervisor or designee. I shall make no voluntary disclosure of any discussion, deliberations, patient care records or any other patient care, peer review or risk management information, except to persons authorized to receive it in the conduct of the Center affairs.

4. My user ID is recorded when I access electronic records and that I am the only one authorized to use my user ID. Use of my user ID is my responsibility whether by me or anyone else. I will only access the minimum necessary information to satisfy my job role or the need of the request.

5. I agree to discuss confidential information only in the work place and only for job related purposes and to not discuss such information outside of the work place or within hearing of other people who do not have a need to know about the information.

6. I understand that any and all references to HIV testing, such as any clinical test or laboratory test used to identify HIV, a component of HIV, or antibodies or antigens to HIV, are specifically protected under law and unauthorized release of confidential information may make me subject to legal and/or disciplinary action.

7. I understand that the law specially protects psychiatric and drug abuse records, and that unauthorized release of such information may make me subject to legal and/or disciplinary action.

8. My obligation to safeguard patient confidentiality continues after my termination of employment with the Center.

## SECURITY AND CONFIDENTIALITY AGREEMENT

**I have read and understand the foregoing information and that my signature below signifies my agreement to comply with the above terms. In the event of a breach or threatened breach of the Confidentiality Agreement, I acknowledge that the Center may, as applicable and as it deems appropriate, pursue disciplinary action up to and including my termination.**

**I understand this is condition of staff appointment and will make a concerted effort to protect the privacy and rights of all parties concerned.**

**Please sign and return to the Credentialing Department.**

**This will be retained in the appropriate Human Resources Personnel File.**

| **Applicant Printed Name:** | |
|---|---|
| **Applicant Signature:** | **Date:** |

# CODE of CONDUCT

**INTRODUCTION- These 5 Pages are to be read and adhered to during the course of employment or patient Care at the CENTER**

The CENTER's Code of Conduct applies to all Affiliated Physicians and other professionals, all employees at every level of the organization, independent contractors, students and volunteers.

The Code provides guidance to all Staff in carrying out their daily work activities within appropriate ethical and legal standards. These obligations apply to relationships with patients, one another, third-party payers, contractors, vendors, and all others doing business with the CENTER. The Code is a critical component of our Compliance Program and was developed to ensure that staff know and understand the conduct required of them. The Code is not intended to deal fully with each subject covered. In most cases, the Code provides a general statement or overview of the standards that apply. Staff-Providers must refer to and abide by CENTER's comprehensive policies and procedures, which expand upon or supplement many of the principles articulated in this Code of Conduct.

**QUALITY OF CARE AND PERSONAL CONDUCT OF STAFF**

Staff are expected to act with honesty, integrity, good faith, professionalism and high ethical standards in all aspects of their job. Staff directly involved in the care of patients take personal responsibility for the quality of care they provide, and all staff are responsible for performing their job duties in a manner that optimizes our patients' overall experience and CENTER'S proper functioning as a business. CENTER staff are expected to be well-qualified and appropriately trained for their positions, perform their job responsibilities well and to the best of their ability, and continuously seek ways to improve their performance and CENTER'S practices and procedures. Staff participate fully in CENTER'S quality initiatives and risk management programs. Staff must report to their supervisors or management if they know of any incident of patient care that does not appear to meet CENTER'S standards or there are concerns about the quality, safety and efficiency of the care we provide or the way we operate our business.

**PRINCIPLES OF CONDUCT**

Staff work collaboratively through positive communication, and treat coworkers, patients and visitors with courtesy and respect. Physicians, as owners and leaders of CENTER, are expected to demonstrate professionalism, equanimity and accountability. Similarly, CENTER'S supervisors and manager's act as positive role models for their departments, make reasonable efforts to keep up with regulatory changes that affect their areas of responsibility, ensure that departmental policies, procedures and standards are up to date, and seek out opportunities for staff development.

**LEGAL AND REGULARY COMPLIANCE**

We provide all services and operate our business in a manner that complies with applicable Federal, State and local laws and regulations, and the conditions of participation for Federal and State health care programs. Staff are expected to familiarize themselves with, and to follow both the letter and spirit of the laws, regulations and policies that relate to their position.

**PATIENT'S RIGHTS AND PATIENT INFORMATION**

The CENTER makes no distinction in the availability of services or in the care we provide based on a patient's age, gender, disability, race, color, religion, national origin, sexual orientation, ancestry, military status, marital status or citizenship. We recognize and respect the diverse backgrounds and cultures of our patients and make every effort to equip our staff with the resources to provide high quality medical care in an efficient manner and to respect each patient's cultural heritage and personal values. Each patient is provided with a Notice of Privacy Practices. We seek to involve patients in all aspects of their care, including giving consent for treatment and making health care decisions. In the promotion and protection of each patient's rights, each

patient is accorded respect, autonomy, privacy and the opportunity for the resolution of complaints. Staff are responsible for protecting every patient's right to privacy of his or her health and financial information maintained by the CENTER, in keeping with HIPAA and other Federal and State requirements. Compliance with CENTER'S strict Privacy and Security policies and procedures is essential to meet our obligations with respect to our patients' protected health information. Staff may only access, use and disclose the minimum necessary patient information needed to perform their job or otherwise authorized under the circumstances.

**RECORD KEEPING AND FINANCIAL REPORTING**

Staff are responsible for the integrity and accuracy of CENTER'S business and clinical records, not only to comply with legal requirements but also to ensure that records are available to support our business practices and medical decision making. As appropriate to the type of record, documentation must fully and accurately reflect the transaction or circumstances being recorded, the persons or entities involved and the individual who created the record. Staff may alter records only in appropriate circumstances, to the extent permitted by the policies and procedures. Staff adhere to the highest standards in recording, maintaining and reporting financial information so that CENTER may properly manage its business and meet its obligations to patients, staff and others with whom we do business, including the government and private entities. Financial records must be accurate and complete and conform to generally accepted accounting principles, as applicable. All funds, assets, liabilities, revenues and expenses must be properly recorded. Staff follow CENTER'S systems of internal controls so that business plans and transactions are executed in accordance with management's authorization, audited on a regular basis, and are documented in a proper manner to maintain accountability with respect to the organization's assets. Medical and business records are retained in accordance with the law and our record retention policy and disposed of with due regard for their confidentiality. Staff must never alter or destroy records to impede threatened or actual litigation or to deny governmental authorities that to which they may be legally entitled in connection with an audit or investigation.

**CONFIDENTIAL BUSINESS INFORMATION**

Staff safeguard CENTER'S confidential business information. Confidential business information includes virtually all information related to finances and business operations, including our patients' clinical, financial and demographic information; fee schedules and reimbursement rates; financial data, reports and analyses; details regarding surveys and investigations; strategic and marketing plans; and proprietary information belonging to third parties that CENTER is obligated to protect. Staff use and disclose business and competitive information only to perform their job responsibilities within CENTER and only in furtherance of CENTER's interests.

**EMPLOYMENT PRACTICES AND WORKPLACE CONDUCT**

CENTER promotes diversity and is committed to providing an inclusive work environment where everyone is treated with fairness and respect. We do not discriminate against anyone based on race, color, religion, sex, sexual orientation, national origin, age, ancestry, disability, military status, marital status or citizenship status with respect to any offer, term or condition of employment. Staff have the right to work in an environment free of harassment or disruptive or violent behavior. Staff in positions that require professional licenses, certifications or other credentials are responsible for maintaining the status of their credentials in order to work at the CENTER and compliance with the standards that apply to their respective disciplines. Staff must promptly notify the CENTER if there is any change in, or investigation relating to, their licensure or other credentials or if they become ineligible to participate in Federal or State reimbursement programs. The CENTER is committed to providing a workplace that is drug-, alcohol- and smoke-free, and free of undue health risks and unsafe conditions. To accomplish this, Staff comply with policies and procedures, and all laws relating to workplace safety and preservation of the environment as they relate to our operations. Staff properly handle and dispose of hazardous materials and medical or chemical wastes, and immediately alert the appropriate

managers if a violation of an environmental or occupational safety or health law is known or suspected. Staff have a duty to preserve and protect the CENTER's assets and to ensure their efficient use, as theft, carelessness and waste have a direct impact on our success. Staff use CENTER personnel and property, including equipment, supplies, materials and services, only for CENTER business purposes.

**ELECTRONIC MEDIA AND SECURITY REQUIREMENTS**

Because of our commitment to the use of information technology, it is essential that Staff use due care to protect CENTER'S electronic communication systems, including its computers, hardware, software, networks, electronic mail, Intranet, Internet access, telephones and voice mail. Staff follow policies and procedures to maintain the confidentiality, availability, integrity and security of CENTER'S information and information technology assets. Staff must use their passwords appropriately, exercise care in accessing, transferring, disclosing and storing electronic information, and making sure that encryption and authentication processes are followed. Electronic communications systems are to be used only for CENTER'S business purposes, in accordance with electronic communications policies and standards. Staff must adhere to CENTER'S standards of confidentiality, transparency and appropriateness when using social media, as described in our policies and procedures.

**CONFLICTS OF INTEREST**

Staff/Providers have an obligation to avoid situations and conduct that create a conflict of interest or even the appearance of one. A conflict of interest may occur if a Staff member's outside activities, personal financial interests or other private interests influence or appear to influence his or her ability to act in CENTER'S best interest. Conflicts of interest also arise when a Staff member uses his or her position to profit personally or assist others in profiting personally at the expense of CENTER. Staff/Providers must disclose any financial interests that they or members of their immediate family have that may affect or be affected by the Staff member's work.

**NON-RETAILIATION AND NON-INTIMIDATION**

CENTER will not retaliate against staff who, in good faith, raise concerns or questions about misconduct or report an actual or suspected violation of this Code of Conduct. Making a report in good faith means providing information that the staff member believes to be true. If a staff member who reports an issue believes he or she is experiencing retaliation, the staff member should report this situation to the appropriate manager. CENTER will investigate and take appropriate action with respect to all suspected acts of retaliation. Any individual who is found to have retaliated against Staff/Provider or intimidated Staff is subject to disciplinary action.

**ENFORCEMENT**

A staff member who violates the Code of Conduct is subject to disciplinary action, up to and including termination. The specific action will depend on the nature and severity of the violation.

**By Signing This Acknowledgment, I Am Confirming That:**
I have received, read and understand the three (3) preceding Introduction pages of the CENTER's Code of Conduct; I understand that I can and should seek guidance on compliance-related issues at any time; I understand that I must comply with CENTER'S Code of Conduct and policies and procedures and I agree to abide by and promote the principles, objectives and standards included within those documents; I understand that CENTER may amend the Code of Conduct, the Compliance Plan and its policies and procedures at any time, and that I have an obligation stay informed of those changes as they apply to my job responsibilities and to perform my duties consistent with those new requirements; I acknowledge that any violation of the Code of Conduct, Compliance Plan or related policies and procedures may subject me to adverse action in regard to my employment or privileges to practice at the CENTER.

| | |
|---|---|
| **Applicant Printed Name:** | **Date:** |
| **Applicant Signature:** | **Date:** |

FIFTH AVENUE SURGERY CENTER

## Peer Reference for Practitioner Initial Medical Staff Appointment

Date: _____

Re: _____

Dear Dr. _____,

The above practitioner has applied for medical staff appointment (or clinical privileges) to the staff of FIFTH AVENUE SURGERY CENTER. The applicant has given your name as reference, and we are asking you to render an opinion in the following categories. This is an important part of the evaluation of this practitioner's application for surgical privileges in our Center. Your responses will be treated as confidential.

Please do not hesitate to call us if you feel your comments could be best expressed directly.

| | | | |
|---|---|---|---|
| Clinical Knowledge | □ reliable | □ usually reliable | □ problems |
| Clinical Judgment | □ reliable | □ usually reliable | □ problems |
| Technical Proficiency | □ reliable | □ usually reliable | □ problems |
| Professional Relations w/ Patients | □ reliable | □ usually reliable | □ problems |
| Ethical Conduct | □ reliable | □ usually reliable | □ problems |
| Record keeping | □ reliable | □ usually reliable | □ problems |
| Ability to understand & speak English | □ reliable | □ usually reliable | □ problems |
| Participation in Medical Staff Affairs | □ reliable | □ usually reliable | □ problems |

What is your opinion regarding competency in performing cases in their specialty?

_____

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_____

Additional Comments:

_____

_____

Recommendation:

_____

_____

Signature Title Date

_____

Name (please print)

Please return this form to the address provided above

FIFTH AVENUE SURGERY CENTER

## Peer Reference for Practitioner Initial Medical Staff Appointment

Date: _____

Re: _____

Dear Dr. _____,

The above practitioner has applied for medical staff appointment (or clinical privileges) to the staff of FIFTH AVENUE SURGERY CENTER. The applicant has given your name as reference, and we are asking you to render an opinion in the following categories. This is an important part of the evaluation of this practitioner's application for surgical privileges in our Center. Your responses will be treated as confidential.

Please do not hesitate to call us if you feel your comments could be best expressed directly.

| | | | |
|---|---|---|---|
| Clinical Knowledge | □ reliable | □ usually reliable | □ problems |
| Clinical Judgment | □ reliable | □ usually reliable | □ problems |
| Technical Proficiency | □ reliable | □ usually reliable | □ problems |
| Professional Relations w/ Patients | □ reliable | □ usually reliable | □ problems |
| Ethical Conduct | □ reliable | □ usually reliable | □ problems |
| Record keeping | □ reliable | □ usually reliable | □ problems |
| Ability to understand & speak English | □ reliable | □ usually reliable | □ problems |
| Participation in Medical Staff Affairs | □ reliable | □ usually reliable | □ problems |

What is your opinion regarding competency in performing cases in their specialty?

_____

_____

_____

_____

Additional Comments:

_____

_____

Recommendation:

_____

_____

Signature Title Date

_____

Name (please print)

Please return this form to the address provided above