**SAMPLE DISASTER PRIVILEGES POLICY AND PROCEDURE**

**POLICY STATEMENT:**

Emergency privileges may be granted to health care professionals who volunteer their services when the hospital has activated its Emergency Operations Plan and requires additional health personnel to meet immediate patient needs and/or needs of the community.

During a disaster in which the Emergency Operations Plan has been activated, the Medical Director or designee has the option to grant, deny, suspend, modify, restrict or terminate emergency privileges. The Medical Director or designee is not required to grant privileges to any individual, and is expected to make such decisions on a case-by-case basis at her/his discretion.

**PROCEDURE:**

**Initial Authorization**

The Medical Director or designee may grant emergency privileges upon presentation of a valid government-issued photo ID any one of the following:

* A current picture ID card from a healthcare organization that clearly identifies the volunteer’s professional designation
* A current license to practice
* Primary source verification of licensure
* ID indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response hospital or group
* ID indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
* Confirmation by a LIP currently privileged by the hospital or a staff member with personal knowledge of the volunteer practitioner’s ability to act as LIP during a disaster.

**Scope of Clinical Activities and Monitoring**

The practitioner will be assigned to provide services appropriate to her or his training and/or experience. A current medical staff member will be designated to initially oversee the activities of the practitioner. Initial clinical activities may include assisting with initial triaging and stabilizing of patients and/or clinical activities for which they already hold privileges at another institution and such other services as may be required to meet patient care needs. The professional performance of the volunteer practitioner granted disaster privileges will be monitored be either direct observation, mentoring and/or clinical record review.

A listing of all volunteer licensed independent practitioners (LIP) granted disaster privileges will be kept. This listing will include the name and specialty of the volunteer LIP, date/time privileges were granted, and the name of the LIP who has responsibility for oversight of the volunteer practitioner. After the first 72 hours of disaster privileges, the hospital will determine, based on the recommendation of the monitoring LIP, whether privileges should continue. Volunteer LIPs that have been granted disaster privileges may continue to provide care, treatment and services for the period of time the hospital continues to operate under its Emergency Operations Plan. The hospital will periodically assess the number and specialty of volunteer practitioners initially granted disaster privileges to ensure the ongoing needs of the patient population are being met and that the medical staff can maintain oversight over practitioner performance.

**Identification**

Practitioners granted privileges during a disaster will be given special identification so they will be easily recognized as an unaffiliated volunteer who is authorized to participate in response operations. An ID number will be assigned.

Messages identifying the names and clinical specialty of volunteer practitioners will be distributed to appropriate parties throughout the response organization.

**Credentials Verification**

Verification of the credentials and privileges of individuals who receive emergency privileges will be given high priority.

The timing for verification of credentials will be based on the judgment of the Medical Director or designee based on the demands of the emergency and the resources available. In severe or out-of-control emergencies, verification should begin when the immediate situation is under control. In less severe situations, verification should be done before the individual is assigned to provide patient care, treatment, or services.

Depending on the communications resources available during the emergency situation, the following will be verified as soon as possible:

* Licensure in [state] verified by the licensure board
* NPDB query
* AMA profile (if time and circumstances permit)
* Verification of privileges at another facility or peer recommendation (if time and circumstances permit)

Should it be determined that the volunteer practitioner did not provide patient care, treatment, or services, no verifications will be necessary.

The hospital may have an arrangement with another hospital or healthcare facility to “share” medical personnel during a disaster. Should such an arrangement exist, the hospital can accept verification information provided by the contracted facility in lieu of obtaining these verifications directly from the source.

Emergency privileges may be terminated at any time during the verification process if areas of concern are identified. Emergency privileges will terminate when the service being provided by a volunteer is demobilized.

**Records**

The hospital shall maintain records of volunteer healthcare providers that include:

* The starting and ending time for hours worked by each practitioner
* The type of service provided by each practitioner
* The location where these services were provided
* Documentation of any evaluations of the care provided by the provider
* [Add any additional information required by for federal and State reimbursement]

**TITLE: Disaster Privileges for Volunteer Licensed Independent Practitioners EMERGENCY/DISASTER PRIVILEGES FOR LICENSED INDEPENDENT PRACTITIONERS**

**APPLICATION FORM**

|  |
| --- |
|  **LAST NAME FIRST NAME MIDDLE NAME DEGREE****Other Name Used/Maiden Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Primary Specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sub-Specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **GENERAL INFORMATION**  |
| Specialty | Subspecialty | Social Security Number  | Date of birth | Medicare UPIN |
| **PRIMARY OFFICE ADDRESS:** |
| Street and Suite Number | City | State | Zip |
| Telephone Number ( )  |  |
| **PRIMARY HOSPITAL AFFILIATION** |
| Name of Organization, Hospital, or Office Practice | Address, City, State, Zip |
| From: To: | Position  |
| **LICENSES AND REGISTRATION** |
| State | License Number | Date Granted | Expiration Date |
| State Controlled Substance | License Number | Date Granted | Expiration Date |
| Federal DEA Number |  | Date Granted | Expiration Date |

**SPECIALTY IN WHICH VOLUNTEER DISASTER PRIVILEGES ARE DESIRED**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL CENTER REFERENCE**:

Name of current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer’s ability to act as a licensed independent practitioner during a disaster. (Applicable when ID is confirmation by an LIP currently privileged by the hospital or a staff member with personal knowledge of the volunteer practitioner’s ability to act as LIP during a disaster.)

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROFESSIONAL LIABILITY INSURANCE CARRIER(S) Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATES OF COVERAGE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF INFORMATION CONSENT/ATTESTATION**

I agree to defend, indemnify and hold harmless [HOSPITAL] for all acts and omissions. I understand that I shall not be granted the general privileges accorded to attending medical staff, but will adhere to the standards of patient care of the Medical Center and Medical Staff. I certify that I have not had a professional license that has been revoked or suspended in any State or possession of the United States.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: Signature

**THIS SECTION TO BE COMPLETED BY MEDICAL STAFF ADMINISTRATION**

PRACTITIONER TO BE SUPERVISED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN IDENTIFICATION NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE PRIVIELGES GRANTED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time Granted:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### DATE PRIVILEGES TERMINATED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time Terminated:\_\_\_\_\_\_\_\_\_\_\_\_

**= = = = = = = = = = = = = = = = = = = = = = =VERIFICATIONS = = = = = = = = = = = = = = = = = = = = = =**

1. HOSPITAL AFFILIATION VERIFICATION DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GOOD STANDING: ☐ Yes ☐ No

2. MEDICAL STAFF REFERENCE VERIFICATION DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Applicable when ID is confirmation by an LIP currently privileged by the hospital or a staff member with personal knowledge of the volunteer practitioner’s ability to act as LIP during a disaster.)

3. LICENSE VERIFICATION DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. DEA: DATE VERIFIED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. NPDB VERIFICATION DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. OIG VERIFICATION DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. AMA PROFILE DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_