**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 [insert title of appropriate leader] or designee has the option to grant, deny, suspend, modify, restrict or terminate emergency privileges. The [insert title of appropriate leader] 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 [insert title of appropriate leader] 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 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.

**Scope of Clinical Activities and Monitoring**

The practitioner will be assigned to provide services appropriate to her or his specialty. 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, telemedicine, and other clinical activities for which they already hold privileges at another institution. The professional performance of the volunteer practitioner granted disaster privileges will be monitored be either direct observation, mentoring and/or clinical record review.

**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 [insert title of appropriate leader] 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 (should it be determined that the volunteer practitioner did not provide patient care, treatment, or services, at the time emergency privileges are no longer needed, no verifications will be necessary):

* Licensure in [state] verified by the licensure board
* NPDB query
* AMA profile
* Verification of privileges in good standing at another facility (may be waived based on situation, i.e. practitioner not on staff at another facility)

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, with the exception of NPDB query, in lieu of obtaining these verifications directly from the source.

If the hospital is part of a hospital system, emergency privileges for practitioners currently privileged at any facility in the system may be extended system-wide so that practitioners may be assigned to provide care in person or via telehealth as patient care needs may dictate. In such a case, the practitioner must be licensed in the state in which the care is to be provided.

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 ant 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**

Anesthesiology

Ophthalmology

Psychiatry

Dentistry/Oral Surgery

Orthopedics

Radiology

Family Medicine

Pathology

Reproductive Medicine

Medicine

Pediatrics

Surgery

Neurosciences

Podiatry

Other (list)

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

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELLPHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**PROFESSIONAL LIABILITY INSURANCE CARRIER(S):**

NAME OF CARRIER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRACTITIONER IDENTIFICATION NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**= = = = = = = = = = = = = = = = = = = = = = =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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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