"MEMBERSHIP ONLY" APPLICATION

Dear Physician:

Southeast Health invites you to complete our "Membership Only" application. This membership will allow you to gain access to your patients' information via the SE Health electronic medical record for better patient care. The below steps are needed to start and maintain the Membership Only status:

1. Complete the "Membership Only" Application
2. Read and sign the Patient Information Access Form
3. Copy of Driver's License for identification verification
4. "Provisional status": The application will be processed through Medical Staff Credentialing. If in the process adverse information is collected that results in permanent membership not being granted, the "Provisional" status and electronic access will be withdrawn.
5. You will receive a letter of welcome from the CEO upon the completion of the credentialing process.
6. The initial credentialing process fee is $150. There will be a "re-credentialing process" every two years to update our system with any changes in your information. Re-credentilaing fee is $150
7. The following is not required for Membership Only status:
    - TB/Flu/HepB/Covid
    - DEA
    - Board Certification
    - Certificate of Insurance

Application is not deemed complete until the fee is received.

Mail to:

Southeast Health Medical Staff Services
1108 Ross Clark Circle
Dothan AL 36301

MEMBERSHIP ONLY APPLICATION

Last Name: _____ First Name: _____ Middle Name:_____

____MD _____DO _____DDS/DMD _____DPM

Date of Birth: _____ Social Security Number: _____

Physician Email: _____

Group Name: _____

Office Address:_____ Phone: _____

_____ Fax: _____

Office Manager _____ Email:_____

EDUCATION AND TRAINING INFORMATION

Professional school attended: _____From (mm/yy):_____ To (mm/yy):_____
City: _____ State: _____

ECFMG # (if applicable): _____

Completed internship/residency: Location: _____
Specialty: _____From (mm/yy): _____ To (mm/yy):_____

Completed fellowship: Location: _____
Specialty: _____From (mm/yy): _____ To (mm/yy):_____

PROFESSIONAL DATA

Current State Medical License #:_____ Date issued: _____ Date of expiration: _____

Specialty:_____ NPI # _____

Hospital(s) where you have held membership/clinical privileges during the immediate past five years:
Hospital name: _____
Address: _____
City: _____ State: _____ ZIP code: _____

Hospital name: _____
Address: _____
City: _____ State: _____ ZIP code: _____

Hospital name: _____
Address: _____
City: _____ State: _____ ZIP code: _____

MEMBERSHIP ONLY APPLICATION

Attestation Questions Provide a complete explanation, as indicated, at the bottom of this questionnaire.		
Yes	**No**	**Answer all questions.**
		I hold a current Alabama, Florida, or Georgia license to practice medicine, osteopathy, or dentistry.
		Have you ever been charged, indicted, or convicted of a felony or any criminal offense or are your presently under investigation (other than minor traffic violations)? ***(If your answer to this question is YES, attach a complete explanation.)***
		Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs? ***(If your answer to this question is YES, attach a complete explanation.)***
		To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? ***(If your answer to this question is YES, attach a complete explanation.)***
		Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program? ***(If your answer to this question is YES, attach a complete explanation.)***
		I attest to abiding by the ethics of my profession as evidenced by a positive professional history that is free of acts or omissions that constitute unprofessional conduct.

EMAIL NOTIFICATIONS

Do you want notification of patients' admission and discharge? Yes or No

If yes, please provide e-mail address for notification: _____

I attest by signing this form that all of the above information is accurate and complete:

Signature: _____ Date: _____

(Signature stamps not accepted)

Printed name: _____

Provider Release

To Whom It May Concern:

I hereby request, consent to, and authorize your furnishing to the Medical Staff Services Office at Southeast Health for consideration by the appropriate entities any information (including current and past records and opinions) regarding my professional practice and experience, and my educational, professional, competence, character and other qualifications provided for staff membership.

I specifically covenant that I will not in any manner ask for or demand that information which you so furnish be disclosed to me unless you give your prior written consent to such disclosure and I acknowledge that your response will be induced by and made in reliance upon this covenant.

I further agree and direct that a copy or facsimile of this request shall have the same binding force and effect as the original.

Printed Name of Applicant: _____

Signature of Applicant: _____

Date: _____

ACCESS USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

As a referring physician/physician office staff member with access to patient information from Southeast Health, you will have access to what this agreement refers to as Protected Health Information (PHI). The purpose of this agreement is to help you understand your duty in safeguarding PHI. Protected Health Information includes a patient's demographic, financial, or clinical information. You may learn of or have access to some or all types of information via different mediums, to include electronic format. PHI is valuable and sensitive and is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), state law and by SE Health policies. The intent of these regulations, laws and policies is to assure that PHI is safeguarded- that is, that it will be used only as necessary to provide authorized patient care. As a physician/physician office staff member, you are required to conduct yourself in strict conformance to applicable regulations, laws and policies governing PHI. Your principal obligations in this area are explained below. You are required to read and to abide by these duties. The violation of any of these duties could subject you to disciplinary action, which may include suspension of privileges at SE Health.

Accordingly, as a condition of and in consideration of access to PHI:

1. I will use PHI only as needed to perform my legitimate duties as a physician/ physician office staff member receiving information from SE Health. This means:
    a. I will only access patient PHI for which I have a need to know.
    b. I will safeguard PHI by not disseminating, discussing, or relating the contents of any patient's PHI except as necessary in the course of my care of the patient.
    c. I will refrain from careless management or otherwise misuse of a patient's PHI.
2. I am the only one who has access to my Personal Identifier Number (PIN) and password and I am the only one who will use them.
3. I will safeguard my access code or any other authorization I have that allows me to access PHI. I am responsible for my misuse or wrongful disclosure of PHI as well for failure to safeguard my access code or other authorization access to PHI.
4. I understand if at any time in the credentialing process adverse information is collected that results in permanent membership not being granted, the "Provisional Membership Only" status and electronic access will be withdrawn. I further understand if at any time the "Provisional Membership Only" status or medical staff membership is suspended, denied or terminated, electronic access will be withdrawn.
5. I understand that my obligations under this Agreement will continue after termination of membership at SE Health. I understand that my membership is subject to periodic review, revision and if appropriate, renewal.

Printed Name of Applicant: _____

Applicant Signature: _____ **Date**_____

Revised: 11/2022

To be completed by :
Office Manager/Physician for Employee Requesting Access

REQUEST FOR SECURITY AUTHORIZATION

Employee Name _____ Employee # (if applicable)_____

Job Title_____

Department or Location _____ Ext._____

Access Requested _____
_____

Justification / Comments_____
_____
_____

By signing this form, I acknowledge the following:

I am responsible for reasonably ensuring that the access I authorize is needed by the individual, is appropriate to the individual's job, and meets the minimum necessary principle (given technical limitations of the system).

I will be held accountable for inappropriate authorizations I grant and for any resulting privacy and security breaches.

I will promptly notify the Information Systems Security Specialist at 334-793-8088 of any change in my contact information, my areas of responsibility which may affect this role, or any inability to continue to act as an Authorizer.

Director/Administrator's Signature _____ Date_____

Title_____

Security Access Request Form can be faxed to the Information Systems Security Specialist at 334-678-2875.

Effective: 01/05
Revised: 01/16,1/19

To be completed by:
Employee Requesting Access

SECURITY ACCESS AGREEMENT

Name: _____ Employee # (if applicable):_____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Department or Location: _____

Access Requested: _____

This agreement acknowledges that I am receiving the access listed above. This form also ensures that I will use my access strictly for the purposes in which it has been assigned to me. I also agree to keep this access private according to the policy and procedures defined by Southeast Health.

I will be held accountable for inappropriate use of this access and for any resulting privacy and security breaches.

I will promptly notify the Information Systems Security Specialist at 334-793-8088 of any change in my contact information, my areas of responsibility which may affect this role, or any inability to continue to act as an employee of Southeast Health or any organization accessing SE Health's computer systems.

Signature_____Date_____

Title_____

Security Access Agreement Form can be faxed to the Information Systems Security Specialist, at 334-678-2875.

Effective: 01/05
Revised: 01/16, 1/19