CHAPTERS
HEALTH® SYSTEM

Dear Provider,

Thank you for your interest in caring for your patient(s) on the LifePath Hospice Inpatient Unit (IPU) at Tampa General Hospital.

Please complete the two attached documents - **Application for Privileges at Inpatient Unit** and the **Confidentiality and Security Agreement - and include your current certificate of liability insurance**. Once these documents are submitted, we will process your request for privileges within two business days. Our staff will advise when you are approved to complete a clinical visit with your patient at the IPU.

If serving as hospice attending physician, a required educational component must also be completed prior to your seeing patients at the IPU. Once completed, an attestation, confirming your review of this information, can be emailed or faxed to the credentialing office.

The application references the use of a designee to care for your patient in your absence. Please note that the designee must be a physician or ARNP who has also completed the application process and has received credentialing approval prior to visiting the patient. If you believe a designee will be required during the patient's stay at the IPU, please have that provider complete the credentialing process well in advance of their need to see the patient.

These documents may be submitted electronically by email to medcredentialing@chaptershealth.org or by fax to: 813-533-0493.

We look forward to working together to provide the highest quality of care to your patients. Should you have any questions about the credentialing process, please call Gina Robinson, Chapters Health System Medical Services Credentialing Specialist, at (813) 871-8079.

Thank you,

Chapters Health System
Medical Services Department

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

☐MD ☐DO ☐ARNP ☐PA I intend to serve as (select one) ☐ Attending ☐ Consulting for my patient(s).

ARNP/PA: List Supervising Physician Name: _____
Supervising physician must also complete application and be approved for privileges prior to ARNP/PA completing a clinical visit.

Practice/Group Name: _____ Office Manager/Credentialing Contact: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Office Telephone Number: _____ Cell Number: _____

Specialty: _____ Subspecialty: _____

Partners in Practice: _____

Mailing Address (if different from office location): _____

City: _____ State: _____ Zip Code: _____

Identifying Information

☐Male ☐Female Date of Birth: _____

License Information

Florida License Number: _____ Date Issued: _____ Expiration Date: _____

DEA Number: _____ Expiration Date: _____ NPI: _____

Hospital Affiliations

Name of Hospital: _____

Category of Appointment: _____ Inclusive Dates: _____

Name of Hospital: _____

Category of Appointment: _____ Inclusive Dates: _____

Professional Liability Insurance **(Please submit a copy of current Certificate of Insurance. Application will not be considered complete until this certificate is received.)**

Carrier Name: _____

Policy Number: _____ Amount of Coverage: _____

Effective Date: _____ Expiration Date: _____

I understand that the Clinical Privileges I am requesting for inpatient level of care at a Chapters Health System inpatient unit include the following requirements: If I am serving as Attending, I, or my designee, am required to see the patient on a daily basis, seven (7) days per week and must document my findings with each visit. I must complete a History and Physical within twenty-four (24) hours of the patient's admission. I or my designee must be available by telephone twenty-four (24) hours a day while my patient is receiving inpatient level of care. If I am serving as Consulting, I will see the patient when medically necessary. Verbal orders must be signed within twenty-four (24) hours.

_____ _____
Physician Signature Date

☐By checking this box, I authorize Chapters Health to complete the credentialing process for my privileges.

_____ _____
Chief Medical Officer or Designee Approval of Privileges Date

CHAPTERS HEALTH® SYSTEM
GOOD SHEPHERD HOSPICE • LIFEPATH HOSPICE
HPH HOSPICE • HPH HOME HEALTH • PALLIATIVE CARE

Affiliate: ☐GSH ☐HPH ☐LPH

APPLICATION FOR MEDICAL PRIVILEGES AT INPATIENT UNIT

CHS-IU006 REV 05/18 PH: 813-871-8111

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