OO6 – EXEMPLARY PROFESSIONAL PRACTICE

Provide a description and/or policies, or equivalent evidence of, the process by which the CNO (or designee) participates in the following:

- *Credentialing, privileging, and evaluating of all Advanced Practiced Registered Nurses (APRNs).*
- *Reprivileging of all APRNs. Include the frequency of reprivileging.*

NewYork-Presbyterian/Columbia University Irving Medical Center (NYP/Columbia) promotes advanced practice registered nurses (APRNs), specifically nurse practitioners (NPs), as expert clinical providers. (Certified registered nurse anesthetists are not considered APRNs in New York State.)

Introduction

Credentialing/appointments and reappointments of advanced practice registered nurses (APRNs) to the medical staff are reviewed by the APRN's direct supervisor with input from the collaborating physician when applicable and department chair, and approved by Bernadette Khan, DNP, RN, NEA-BC, Group Vice President and Chief Nursing Officer (CNO) for NYP/Columbia, and the NewYork-Presbyterian (NYP) Credentials Committee, Medical Board, and Board of Trustees in accordance with Nursing and Medical Staff By-Laws, Rules, and Regulations. The NYP medical staff credentials process follows regulations and standards issued by The Joint Commission/Centers for Medicare & Medicaid Services (CMS) and New York State Department of Health.

All APRNs complete an initial application and must be reappointed within 24 months via the NYP Credentials Committee, Medical Board, and Board of Trustees in accordance with Nursing and Medical Staff By-Laws, Rules, and Regulations.

Initial Credentialing and Privileging

The prospective APRN employee undergoes credentialing/primary source verification by the NewYork-Presbyterian Medical Staff Office (MSO). The

credentialing process begins after the APRN has been accepted and hired by a designated department. APRNs use an online application process.

The APRN applicant completes the required documents with an assigned MSO analyst who serves as a point person for the APRN throughout the credentials primary source verification, review, and approval process. The Delineation of Privileges (DOPs) details the privilege criteria, qualifications, and various roles and specialties. Once the applicant's packet is completed, it is forwarded to the collaborating physician and chief of service for signatures. Within the first 3,600 hours of APRN clinical practice in New York State, the APRN is required to have a Collaborative Practice Agreement with a collaborating physician. The CNO or Registered Nurse (RN) designee then reviews and signs the completed credentialing checklist from the MSO in approval of the candidate to move forward to the recommendation and approval process.

Following CNO (or RN designee) approval, the application is forwarded to the NYP Credentials Committee, Medical Board, and Board of Trustees for final approval and granting of privileges. The APRN's direct supervisor, with input from the collaborating physician and chief of service, attests that the APRN can perform the procedures within the scope of their DOP and ensures the inclusion of the APRN in the service's quality assurance process.

After the NYP Credentials Committee reviews the applicant's privileges, the packet is forwarded to the Medical Board for action and, if recommended, the Board of Trustees will review and issue final approval. Once the application is approved, the MSO sends a letter of appointment to the APRN applicant and clinical department. OO6.1— Credentialing Application

Reappointment and Recredentialing/Privileging – Every Two Years

The MSO maintains the APRN's credentialing file and notifies the clinical department and the APRN when reappointment is due. Reappointment is not to exceed 24 months as stipulated by New York State Department of Health regulations. The organization requires APRNs to complete 30 hours of continuing education annually.

A reappointment packet is distributed electronically to the APRN by the MSO five months prior to their current expiration date. The APRN completes the reappointment packet, which is then forwarded to the MSO analyst for primary source verification and review and then follows the same review, recommendation, and approval process as initial credentialing. OO6.2— Reappointment Application

Evaluating Advanced Practice Registered Nurses

APRNs with a Collaborative Practice Agreement

APRNs with less than 3,600 hours of clinical experience or APRNs who choose not to function under the New York State Nurse Practitioner Modernization Act must maintain a Collaborative Practice Agreement with a physician. These APRNs practice in accordance with written practice protocols and a written practice agreement with a collaborating physician.

APRNs Functioning through the New York State Nurse Practitioner Modernization Act

APRNs practicing in New York State with more than 3,600 clinical hours have the option to sign the Collaborative Relationships Attestation form instead of continuing the Collaborative Practice Agreement.

If the APRN chooses not to sign the attestation form, then a Collaborative Practice Agreement must exist. As mandated by the New York State Nurse Practitioner Modernization Act, there is a three-month probation period during which time the APRN is evaluated monthly with chart reviews. Following this three-month time frame, the APRN is eligible to sign the Collaboration Relationships Attestation form. OO6.3—Collaborative Agreements

The Focused Professional Practice Evaluation (FPPE) and the Ongoing Professional Practice Evaluation (OPPE) are used to evaluate the performance of APRNs who hold clinical privileges:

- The FPPE is conducted when new privileges are requested and for initial appointments. The FPPE occurs within the first three months of the granting of a new privilege(s) with the collaborating physician who reviews charts quarterly to determine completeness of history and physical and appropriateness of diagnostic and treatment regimens. An FPPE can also be triggered if there are concerns regarding clinical activity and performance quality. An example may be a sentinel event directly or indirectly attributed to the APRN or failure to follow standard of care based on evidence-based practice.

- The APRN's direct supervisor, with input from the collaborating physician when applicable, reviews the APRN's OPPE twice a year. The physician collaborator reviews and validates the APRN's medical record documentation and makes remarks if necessary, when applicable, and not covered under the New York State Nurse Practitioner Modernization Act changes.

Request for New Privileges

- If the APRN is seeking a new privilege to be added, privileges are granted for independent practice after visual supervision and vetting by medical staff.

OO6.4—Focused and Ongoing Professional Practice Evaluation and Medical Record Review

Annual Performance Review Process

The annual performance review is completed by the APRN's direct supervisor with input from the collaborating physician when applicable. Additionally, peer feedback and a self-evaluation are completed annually. All APRN annual evaluations are reviewed/approved by the CNO or RN designee, who directly or indirectly reports to the CNO.

NewYork-Presbyterian

Medical Staff Office
New York-Presbyterian Hospital
Weill Cornell Medical Center
Columbia University Medical Center
466 Lexington Avenue
New York, NY 10017

November 1, 2023

[redacted]

Dear [redacted],

We are pleased to inform you that you have been appointed to the Medical Staff of New York-Presbyterian Hospital. The effective date of your appointment is **11/1/2023**. If you have requested clinical privileges, a copy of the approved Delineation of Privileges is attached to this communication for your records.

Your appointment is in accordance with the Medical Staff By-Laws, Section 3.5.1. The initial appointment period for you will expire on **10/31/2025**, at which time you must be reappointed to the Medical Staff.

Entity: **NYP Columbia University**
Staff Category: **Nurse Practitioner**
Department and Specialty: **Obstetrics & Gynecology / Gynecologic Surgery**
Your Campus identification number: [redacted]
Your CWID: [redacted]

In support of New York Presbyterian's ongoing Organizational Readiness initiatives, members of the medical staff are required to complete "Medical Staff New Hire Required Training (2022) within **30** days from approval of clinical privileges. Failure to complete the course may result in an interruption of your clinical privileges (ATO-Administrative Time Out).

In order to complete the course, please go to https://www.myworkday.com/nyp/email-universal/inst/17816$2286/rel-task/2998$29489.htmld.
Enter your CWID: [redacted]
Default Password: first **3** letters of CWID (1st letter uppercase, 2nd & 3rd letters lowercase) and first five digits of SSN.
Example: **Dew12345**

To change your password go to www.pod.nyp.org. Additionally, you will need to enroll in NYP DUO by going to http://twofa.nyp.org. If you have any questions, please call the Help Desk at 1-212-746-4357.

We are excited that you have joined the staff of New York-Presbyterian Hospital. Please take some time to familiarize yourself with the Medical Staff By-Laws, which are available online at https://infonet.nyp.org/medstaff from any Hospital computer.

Again, congratulations. Please feel free to contact the Medical Staff Office with any questions.

Sincerely,

Steven Kaplan, MD
System Vice President and Chief Medical Officer for Medical and Professional Affairs (CUMC)
Stk2002@nyp.org

CC: Chair, Department of Obstetrics & Gynecology

NewYork-Presbyterian

Medical Staff
Credentialing Application

The following guidelines apply throughout the Application:

- Fields displayed in **RED** are mandatory and must be answered for the Application to be successfully submitted.

  Note: A completed Application can be forwarded for processing by clicking **Submit** (located at both the top and the bottom of the Application).

- **Attachments, where applicable, can be added while completing the Application by selecting**
  - Add Attachment from the Menu drop-down
  - Examples of requested attachments include the following:
    - Personal Photo
    - Signature
    - Proof of Insurance
    - Copies of credentials (Degree, Diplomas, and Licenses)

The following guidelines apply to specific forms/sections of the Application:

Part/Section	Notes
Attestation Questions	**Responding "yes" to any of the Attestation Questions will open a comment box or Explanations Form where further details must be provided.**
Application Attestation	**An Electronic Signature must be entered together with the last four digits of your SSN and date.**
Additional Records	Copy page **For areas of your application requiring more space: Select the "Check here" box or click on the copy page towards the top of the page to create a duplicate page.**
Reappointment Application	**For your assistance, information is pre-populated where possible. Please review all this information, making changes where appropriate. Please provide updated information since your LAST NYP Appointment (2 year period)**

Practitioner Rights

As NewYork-Presbyterian Hospital's Medical Staff Administration proceeds with the credentialing process required by regulatory and accreditation standards, we want you to be aware of your rights and responsibilities as an applicant.

Action on your application for initial appointment or reappointment will be withheld until all required documentation is available. The credentialing process will begin no later than five business days following receipt of the completed application. The credentialing process will be terminated on any application which remains incomplete for more than thirty days.

In the event information is obtained during our credentialing and verification process that varies substantially from the information you have provided, you will be given an opportunity to clarify the discrepancy.

Deliberate omission or falsification of critical information on your application (i.e., disciplinary actions taken by other State licensing boards, malpractice claims history, board certification decisions) may be reportable to the Office of Professional Medical Conduct.

You have a right to review information obtained by NewYork-Presbyterian Hospital's Medical Staff Administration to evaluate your application. This will include information from organizations such as malpractice insurance carriers and state licensing boards. Peer review/reference or quality assurance information will not be available for review. You may contact the Medical Staff Administration at any time to request information regarding the status of your application for initial appointment or reappointment.

You will receive notification from NewYork-Presbyterian Hospital within fifteen days of the final decision regarding your membership to the Medical Staff and your clinical privileges.

All Medical Staff and Affiliate Staff credentials files are maintained by the Medical Staff Administration and treated as confidential information. Any disclosure of information is regulated and must be requested in writing.

I certify I am aware of my rights as stated above and it is my intent to be fully credentialed by the NewYork-Presbyterian Hospital's Medical Staff Administration. In order for verification of credentials and clinical competence to be obtained on my behalf, I acknowledge consent via my signed attestation.

I acknowledge I have reviewed the Practitioner rights ☒

MEDICAL STAFF CONSENT AND IMMUNITY

REPRESENTATIONS

I have had an opportunity to read a copy of the Hospital bylaws and such Hospital policies and directives as are applicable to members of the medical staff, including the Medical Staff Bylaws and Rules and Regulations. I specifically agree to abide by the bylaws, policies, rules and regulations, and directives that are in force during the time that I am a member of the medical staff.

NOTICE OF IMMUNITY

I understand that the Hospital and its authorized representatives are entitled to seek immunity under New York State Public Health Law §2805-m(3), New York State Education Law §6527(5) and the Health Care Quality Improvement Act (42 USC §11101 *et seq*) (HCQI) and all remedies thereunder in the event that I sue the Hospital or its authorized representatives for good faith actions, recommendations, reports, statements, communications, or disclosures involving me and related to- my professional qualifications (credentials), clinical competence, character, physical and mental condition, ethics, behavior, or any other matter bearing on my qualifications for membership to the medical staff.

RELEASE, IMMUNITY AND CONSENT

Regardless of whether I am appointed/reappointed to the medical staff of the Hospital I agree to the following:

1. I authorize the Hospital and its authorized representatives to consult with any third party who may have information bearing on my professional qualifications (credentials), clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter bearing on my qualifications for membership to the medical staff. I also authorize said third parties to release to the Hospital and its authorized representatives upon request, any documents, recommendations, reports, statements, or disclosures relating to my professional qualifications (credentials), clinical competence, character, physical and mental condition, ethics, behavior, or any other matter bearing on my qualifications for membership to the medical staff.

2. In accordance with HCQI and the aforementioned State laws, I release from liability and agree not to sue any third party who releases information and/or documents to the Hospital in good faith.

AFFIRMATION

I represent that information provided in or attached to this application is accurate. I understand that a condition of this application is that any misrepresentation, misstatement, or omission from this application may be cause for automatic and immediate rejection of this application and may result in the denial of appointment/reappointment and clinical privileges. Upon subsequent discovery of such misrepresentation, misstatement, or omission, the Hospital may terminate my appointment and privileges in accordance with the Medical Staff Bylaws.

[redacted]

Applicant's Signature

[redacted]

Print Name

05/23/2023

Date

NewYork-Presbyterian

As indicated by the clinical leadership of the department you are applying to, your application for New York Presbyterian Medical Staff appointment and/or clinical privileges will be considered **only** for the following hospital site(s):

NewYork-Presbyterian / Weill Cornell

- ☐ NewYork-Presbyterian Weill Cornell Medical Center
- ☐ NewYork-Presbyterian Lower Manhattan Hospital
- ☐ NewYork-Presbyterian Brooklyn Methodist Hospital
- ☐ NewYork-Presbyterian Westchester Behavioral Health Center

NewYork-Presbyterian / Columbia

- ☒ NewYork-Presbyterian Columbia University Irving Medical Center
- ☐ NewYork-Presbyterian Allen Hospital
- ☐ NewYork-Presbyterian Morgan Stanley Children's Hospital
- ☐ NewYork-Presbyterian Westchester Hospital

☐ **NewYork-Presbyterian Queens**

☐ **NewYork-Presbyterian Hudson Valley Hospital**

☐ **NewYork-Presbyterian Gracie Square Hospital**

Please select whether you are applying as a:

Physician/Dentist:		*Advanced Practice Professional / Allied Health:*	✕

DEMOGRAPHIC AND PROFESSIONAL INFORMATION

Name: [redacted] [redacted] NP
Last First MI Degree

List other name by which you have been known: _____
Last First MI

List other name by which you have been known: _____
Last First MI

If you have been known by other names, please explain why your name changed:

Birth Date: [redacted] Place of Birth: United States
Country

Sex Assigned at Birth: ☐ Male ☒ Female ☐ Non-Binary Gender Identity: Female Pronouns: She/Her/Hers
Preferred Salutation: Ms.

U.S. Citizen? ☒ Yes ☐ No
If no, do you have legal authority to reside and work in the U.S.? ☐ Yes ☐ No

Home Address: [redacted] [redacted] [redacted] [redacted] [redacted]-
Street City State Zip

Cell Phone: [redacted] Home Phone: [redacted]

E-Mail Address: [redacted]

Please Notify the Medical Staff Administration at MSO@NYP.ORG of any changes to your home address within 30 Days

CONFIDENTIAL INFORMATION:

National Provider Identification Number (NPI): [redacted]

Social Security Number: [redacted]

Medicaid ID#: _____ Medicare ID #_____

Language(s) or Patient Preferred Language:

Hospital personnel and physicians can provide direct services in their patient's preferred language provided that they are fluent in said language (e.g. direct services are those that are within their clinical scope of practice).

Based on the below assessment, those appropriately proficient and fluent to provide direct services in their patient's preferred language are considered Linguist Clinical Communicators (LCC)

This is separate from interpreter services and should be documented accurately in the medical record during every patient encounter.

Please indicate any non-English language(s) you intend to speak to patients and their families in <u>about their care and treatment.</u>	Name of Language(s) 1. _____ 2. _____ 3. _____

If you indicated that you intend to speak a non-English language in the care of patients, it is <u>required</u> that you assess your proficiency below.

	Language 1		Language 2		Language 3	
I lived in a country where the language written above was spoken and served that community in a clinical role for a minimum of 2 years.	Yes	No	Yes	No	Yes	No
I completed my clinical degree in the language written above.	Yes	No	Yes	No	Yes	No
I can speak the language fluently and accurately within the range of my personal and professional experiences. I can communicate effectively with a variety of audiences, tasks and settings. I am comfortable speaking about healthcare. I can understand all forms and styles of speech. I can understand language tailored for different audiences and can infer meanings and implications.	Yes	No	Yes	No	Yes	No
I speak the language as well as a native speaker or I am a native speaker. I can converse with ease on all topics including health care. I can understand educated and academic speech. My comprehension of the language is equal to that of a well-educated native speaker.	Yes	No	Yes	No	Yes	No

<u>Linguists Clinical Communicators Attestation</u>

Should you answer "yes" to any one of the statements above, you are considered a Linguist Clinical Communicator and therefore able to communicate directly about care and treatment in that preferred language.

I meet the requirements to be a Linguist Clinical Communicator to communicate directly with patients in the language(s) detailed above about clinical matters that impact their health care decisions. I understand that at any time if I am not comfortable speaking the language(s) during any patient interaction, I will use hospital-approved interpreter services. In addition, at any point a patient or family member has the right to request interpreter services.

By signing my name below, I certify my responses stated above are true and correct to the best of my knowledge.

Name: _____ Date: _____

Otherwise, you must use a hospital-approved interpreter service to communicate clinical information with patients

I do not meet the requirements to be a Linguist Clinical Communicator. I understand that I must use a hospital-approved interpreter service to communicate clinical information with patients.

By signing my name below, I certify my responses stated above are true and correct to the best of my knowledge.

Name: [redacted] Date: 05/23/2023

Policy: I-160 Communication Access For Patients

NewYork-Presbyterian

Alternate/Collaborating/Supervising Physician:

Do you have a NewYork-Presbyterian Hospital covering physician to care for your patients in your absence? ☐ Yes ☐ No

For **Nurse Practitioners**: please indicate the name of your Collaborating Physician.

For **Physician Assistants**: please indicate the name of your Supervising Physician.

Name	Contact Phone Number	Specialty
Not sure at this time	(000) 000-0000 Ext	Obstetrics and Gynecology
	( ) - Ext	
	( ) - Ext	

Please select 'Copy Page' at the top of the screen to add additional information.

PROFESSIONAL INFORMATION

New York Professional License Number: [redacted] Type of Licensure: Nurse Pending ☐

Free from any restrictions or limits? Yes ☒ No ☐ → If no, please explain limitation:

New York RN License Number: [redacted]

Free from any restrictions or limits? Yes ☒ No ☐ → If no, please explain limitation:

Current and Previous Professional License(s) in Other States

State:_____ License #:_____ Type of Licensure:_____ Exp. Date: _____

Free from any restrictions or limits? Yes ☐ No ☐ → If no, please explain limitation:

State:_____ License #:_____ Type of Licensure:_____ Exp. Date:_____

Free from any restrictions or limits? Yes ☐ No ☐ → If no, please explain limitation:

State:_____ License #:_____ Type of Licensure:_____ Exp. Date:_____

Free from any restrictions or limits? Yes ☐ No ☐ → If no, please explain limitation:

Please select 'Copy Page' at the top of the screen to add additional information.

FEDERAL DEA LICENSE NUMBER

Please list the information for each DEA license. Please note that you must have a valid DEA address in New York State to be credentialed by NewYork-Presbyterian Hospital.

Current Federal DEA License Number:_____ State:_____ Status:_____

DEA Expiration Date:_____ Free from any restrictions or limits? Yes ☐ No ☐

If no, please explain limitation:

Pending

Current and Previous State Controlled Substance Number(s):

CONFIDENTIAL INFORMATION

State: _____ CS License #: _____ Expiration Date: _____

State: _____ CS License #: _____ Expiration Date: _____

Please identify all limitation related to the above Controlled Substances Number(s) and explain limitation.

PROFESSIONAL CERTIFICATION

Practice Specialties

Primary Practice Specialty: Obstetrics and Gynecology

Specialty Status: Primary

Secondary Practice Specialty: _____

Specialty Status: _____

Alternate Practice Specialty: _____

Specialty Status: _____

Board Certification ☒ Board Certified ☐ Board Qualified ☐ Not Board Certified/ Not Applicable

Board Certificate: NCC Women Health Care NP

Board Status: Board Certified

Certification Date: 10/22/2020 Expiration Date: 12/15/2026 Recertification Date: _____

Lifetime Certified ☐ Maintenance of Certification/Osteopathic Continuous Certification: _____

For Physician Assistant Only: NCCPA Number: _____

Board Certificate: _____

Board Status: _____

Certification Date: _____ Expiration Date: _____ Recertification Date: _____

Lifetime Certified ☐ Maintenance of Certification/Osteopathic Continuous Certification: _____

Board Certificate: _____

Board Status: _____

Certification Date: _____ Expiration Date: _____ Recertification Date: _____

Lifetime Certified ☐ Maintenance of Certification/Osteopathic Continuous Certification: _____

CURRENT AND PREVIOUS PROFESSIONAL LIABILITY INSURANCE

Please provide information on your current and previous professional liability insurance carriers. If there has been a break or gap in coverage please provide an explanation below.

FOR REAPPOINTMENT: Please list all active insurance carriers, or carriers which provided malpractice coverage for you in the last two years.

CONFIDENTIAL INFORMATION:

Carrier: [redacted]

Policy Number: [redacted] Retroactive Date: 07/01/2022 Expiration Date: _____

Policy Limits: Per Occurrence: $ [redacted] Aggregate: $ [redacted] Other: $ _____

What type of coverage do you have? Medical Professional Liability-Occurrence

If claims made policy, do you have tail coverage: ☒ Yes ☐ No

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?

☐ Yes ☒ No

CONFIDENTIAL INFORMATION:

Carrier: [redacted]

Policy Number: [redacted] Retroactive Date: 07/10/2021 Expiration Date: _____

Policy Limits: Per Occurrence: $ [redacted] Aggregate: $ [redacted] Other: $ _____

What type of coverage do you have? Medical Professional Liability-Occurrence

If claims made policy, do you have tail coverage: ☒ Yes ☐ No

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?

☐ Yes ☒ No

Have you ever had any gap in coverage? ☐ Yes ☐ No

From: _____ To: _____

Explanation:

Please select 'Copy Page' at the top of the screen to add additional information

EDUCATION AND TRAINING

All gaps of more than 60 days require an explanation in the gap history section. Additionally, any incomplete portions of your training programs also require an explanation.

MEDICAL/PROFESSIONAL SCHOOL

Institution Name: [redacted]

Address [redacted] [redacted] NY [redacted]- United States

Street City State Zip Country

Degree: MS Master of Year Graduated: 2018

Dates attended: From: 05/18/2016 To: 05/18/2018

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☒ No

Please select 'Copy Page' at the top of the screen to add additional information

If you are a graduate of a foreign medical school, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No

Date Issued:_____ Serial Number for ECFMG:_____

Are you registered with the Federation Credentials Verification Service (FCVS)? Yes ☐ No ☒

FCVS Packet #:_____

***If yes, please have a requested packet sent to your NewYork Presbyterian credentialing analyst.**

INTERNSHIP

Institution Name:_____

Program Director:_____ Email:_____

Address:_____ -

Street City State Zip Country

Dates attended: From:_____ To:_____

Type of internship: ☐ Rotating ☐ Straight → If straight, please list specialty: _____

Did you successfully complete this program? ☐ Yes ☐ No

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

If more than one internship, please check here and attach additional information that duplicates the information requested above:
☐

RESIDENCY

Institution Name:_____

Program Director:_____ Email:_____

Address:_____ - _____

Street City State Zip Country

Dates attended: From:_____ To:_____

Is/Was this program ACGME accredited? ☐ Yes ☐ No

Specialty:_____

Did you successfully complete this program? ☐ Yes ☐ No

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

RESIDENCY

Institution Name:_____

Program Director:_____ Email:_____

Address:_____ - _____

Street City State Zip Country

Dates attended: From:_____ To:_____

Is/Was this program ACGME accredited? ☐ Yes ☐ No

Specialty:_____

Did you successfully complete this program? ☐ Yes ☐ No

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

Please select 'Copy Page' at the top of the screen to add additional information

FELLOWSHIP

Institution Name:_____

Program Director:_____ Email:_____

Address:_____ - _____

Street City State Zip Country

Dates attended: From:_____ To:_____

Is/Was this program ACGME accredited? ☐ Yes ☐ No

Specialty:_____

Did you successfully complete this program? ☐ Yes ☐ No

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

FELLOWSHIP

Institution Name:_____

Program Director:_____ Email:_____

Address:_____ - _____

Street City State Zip Country

Dates attended: From:_____ To:_____

Is/Was this program ACGME accredited? ☐ Yes ☐ No

Specialty:_____

Did you successfully complete this program? ☐ Yes ☐ No

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

Please select 'Copy Page' at the top of the screen to add additional information

CURRENT AND PAST APPOINTMENTS AND AFFILIATIONS

Please list all other hospitals, nursing homes, clinics, other healthcare organizations, military assignments, government agencies, schools, locum tenens assignments, humanitarian and/or private practices where you have worked clinically since Professional/Medical School. Gaps of more than 60 days requires explanation in the gap history section.

FOR REAPPOINTMENTS: Please document any facilities where you hold active privileges, or facilities where you have held privileges and resigned in the last two years.

[redacted]

Name: [redacted]

Affiliation Type: Work History Membership Status: Active Wtih Privileges

Address [redacted] New York NY [redacted] United States

Street City State Zip Country

Medical Staff Office Phone: [redacted] From: 10/01/2022 To: 06/23/2023

Department/Division: GYNECOLOGY Specialty: Gynecology

Department Head/Supervisor Name: [redacted] Email [redacted]

Malpractice Carrier at this Institution: _____ Policy Number: _____

Any limitations in your area of specialty at this hospital?

[redacted]

Name: _____

Affiliation Type: _____ Membership Status: _____

Address: _____ -

Street City State Zip Country

Medical Staff Office Phone: ( ) - From: _____ To: _____

Department/Division: _____ Specialty: _____

Department Head/Supervisor Name: _____ Email: _____

Malpractice Carrier at this Institution: _____ Policy Number: _____

Any limitations in your area of specialty at this hospital?

Do you have any gap in your education, work history, and/or affiliations greater than sixty (60) days?

☐ Yes ☒ No

PROFESSIONAL REFERENCES

Please list at least (4) four individuals who have knowledge of your current clinical competence, ethics, health status and can provide specific written comments on these matters upon request from New York-Presbyterian Hospital. The named individuals must have acquired the requisite knowledge through recent observation of your professional practice over a reasonable period of time, and at least one must have had organizational responsibility for your professional performance and at least one must be in the same discipline as yourself. None of the individuals should be related to you by family or current or impending professional partnership. (Suggested sources: Chief of Training Program, Department Chairperson or practitioners in the same specialty).

CONFIDENTIAL INFORMATION

1. Name: [redacted] [redacted]
   First MI Last Degree
   Specialty: Gynecology
   Associated Organization: [redacted]
   Telephone: [redacted] Email Address: [redacted]
   Relationship: Colleague Years Known: [redacted]

2. Name: [redacted] [redacted]
   First MI Last Degree
   Specialty: Gynecology
   Associated Organization: [redacted]
   Telephone: [redacted] Email Address: [redacted]
   Relationship: Colleague Years Known: [redacted]

3. Name: [redacted] [redacted]
   First MI Last Degree
   Specialty: Gynecology
   Associated Organization: [redacted]
   Telephone: [redacted] Email Address: [redacted]
   Relationship: Colleague Years Known: [redacted]

4. Name: [redacted] [redacted]
   First MI Last Degree
   Specialty: Gynecology
   Associated Organization: [redacted]
   Telephone: [redacted] Email Address: [redacted]
   Relationship: Colleague Years Known: [redacted]

PROFESSIONAL HISTORY: CONFIDENTIAL

Applicants for initial appointment/reappointment must answer all questions below.

FOR REAPPOINTMENT, answer these questions with information since your last reappointment period. Please answer the following questions to the best of your knowledge with a "yes" or "no."

ADVERSE OR OTHER ACTIONS

If you answer "yes" to any question, please provide explanation within the comment box.

1.	Has your professional license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily?	☐ Yes	☒ No
2.	Have you ever withdrawn an application for a professional license to practice your profession?	☐ Yes	☒ No
3.	Have you ever been reprimanded and/or fined by any state or federal agency which licenses providers?	☐ Yes	☒ No
4.	Have you ever been the subject of a legal complaint by any state or federal agency which licenses providers?	☐ Yes	☒ No
5.	Have you ever been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licensed providers?	☐ Yes	☒ No
6.	Has your participation in any internship, residency, or other training program ever been suspended, restricted or terminated prior to completion?	☐ Yes	☒ No
7.	Have you ever been denied certification of completion of your internship, residency, or other training program?	☐ Yes	☒ No
8.	Have you ever voluntarily left any internship, residency, or other training program?	☐ Yes	☒ No
9.	Have you ever involuntarily relinquished participation in any internship, residency, or other training program?	☐ Yes	☒ No
10.	Have you been denied initial or recertification for any Boards or subspecialty Boards?	☐ Yes	☒ No
11.	If you are not currently Board certified, have you attempted to take your boards and failed to pass?	☐ Yes	☒ No
12.	Has any information pertaining to you, been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data banks including without limited to malpractice and/or disciplinary actions?	☐ Yes	☒ No
13.	Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntary or involuntary?	☐ Yes	☒ No
14.	Have you ever been notified in writing that you are being investigated as the possible subject of a criminal disciplinary action with respect to your DEA or controlled substance registration?	☐ Yes	☒ No

15.	Have your clinical privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed by any hospital or facility to where you've practiced?	☐ Yes	☒ No
16.	Have you ever voluntarily relinquished your clinical privilege and/or membership at a hospital or a facility where you've practiced while under investigation?	☐ Yes	☒ No
17.	Have you involuntarily relinquished or failed to seek renewal of your clinical privileges and/or membership for any reason?	☐ Yes	☒ No
18.	Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or facility where you've held privileges and/or your license?	☐ Yes	☒ No
19.	Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and/or any other governmental health-related programs?	☐ Yes	☒ No
20.	Have you ever been denied membership in or voluntarily or involuntarily been terminated by any professional organization?	☐ Yes	☒ No
21.	Have Medicare, Medicaid, CHAMPUS, Peer Review Organization (PRO) authorities and/or any other third party payers brought charges against you for alleged inappropriate fees and/or quality-of-care issues?	☐ Yes	☒ No
22.	Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action by any health care organization, e.g. hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO?	☐ Yes	☒ No
23.	Have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g. hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO?	☐ Yes	☒ No
24.	Have you withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision?	☐ Yes	☒ No
25.	Are you currently performing, or do you plan to perform, any procedures for which you have ever been refused or lost privileges?	☐ Yes	☒ No
26.	Have you ever been found guilty of violations of Patient's rights?	☐ Yes	☒ No

For INITIAL APPLICANTS, please provide full detail and disclosure.
FOR REAPPOINTMENT, answer these questions with updated/new information since your last reappointment period.

PROFESSIONAL LIABILITY ACTIONS

If you answer "yes" to any question, please complete Form A

1. Have you ever been named on any professional liability action (past or pending)? ☐ Yes ☒ No
2. Has any professional liability judgement ever been entered against you? ☐ Yes ☒ No
3. Has any professional liability claim settlement ever been paid by you and/or paid on your behalf? ☐ Yes ☒ No
4. Are there currently any pending professional liability suits, actions and/or claims filed against you? ☐ Yes ☒ No

LIABILITY INSURANCE

If you answer yes to this question please complete Form B

1. Has your professional liability insurance ever been denied, suspended, limited, not renewed or terminated? ☐ Yes ☒ No

CRIMINAL ACTIONS

If you answer "yes" to any question, please complete Form C

1. Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country? ☐ Yes ☒ No
2. Have you been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action including but not limited to any such actions regarding sexual misconduct, child abuse, domestic violence or elder abuse? ☐ Yes ☒ No

MEDICAL CONDITION

If you answer "yes" to any question, please complete Form D

1. Do you currently have any mental or physical conditions that would compromise your ability to perform any essential functions of your responsibilities? ☐ Yes ☒ No
2. Do you currently have any mental or physical conditions that would adversely affect your ability to perform the essential functions required by the participation status you are requesting? ☐ Yes ☒ No
3. Do you currently have any mental or physical conditions that would adversely affect your ability to perform the essential functions required by the clinical privileges you are requesting? ☐ Yes ☒ No

CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

If you answer "yes" to any question, please complete Form E

1. Are you currently engaged in illegal use of any legal or illegal substances? ☐ Yes ☒ No

2. If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine or to perform essential functions of your position with reasonable skill and safety? ☐ Yes ☒ No

3. Are you currently participating in a supervised rehabilitation program and/or professional assistance program which monitors you for alcohol and/or substance abuse? ☐ Yes ☒ No

CONTINUING EDUCATION SUMMARY

Physicians and Dentists: As per the NYPH Medical Staff By-laws, all members of the Medical Staff are required to obtain 100 CME credits over each appointment cycle. These 100 credits over 2 years must include a minimum of 70 credits of Category 1 activities and a minimum of 10 credits of risk management education which is satisfied by taking the NYPH Annual Hospital Training each year of a 2 year cycle. Please note these credits may not be recognized by a state medical licensing agency or professional society.

Members of the **Professional Associate Staff** appointed through the Medical Staff Office are required to complete the number for continuing education credits required by the NYPH Medical Staff By-laws, the applicable New York State licensing agency and/or professional society.

Physician Assistants: 100 CME credits every two years, based on the year of your NCCPA certification.
Podiatrist: 50 hours every three years as required by the New York State Board for Podiatry.
Audiologist: 30 hours every three years as required by the New York Education Law.
Optometrist: 36 hours every three years as required by the New York Education Law.
Psychologist, Physicist, Radiology Techs and Pathology Techs: 20 hours per year as required by NewYork-Prebyterian Hospital.
Certified Registered Nurse Anesthetist: 40 hours every two years, as per New York State.
Registered Nurse First Assist: 300 points every 5 years as required by CNOR.
Nurse Practitioner:
American Academy of Nurse Practitioners: 100 hours of CEs every 5 years.
National Certificate Corporation: 10 to 50 hours of CEs based on your education plan.
Midwives: 20 hours of CEs every 5 years as required by the American Midwifery Certification Board.

I attest that I am in compliance with the applicable continuing education requirements listed above.

☒ Yes ☐ No

CONFLICT OF INTEREST

If you answer "yes" to any question, please complete Form F

"NYP" means The New York and Presbyterian Hospital and each entity listed on Attachment I.

"Relative" means your spouse, domestic partner, ancestors, brothers and sisters (where by whole or half-blood), children (whether natural or adopted), grandchildren, great-grandchildren, and the spouses of brothers, sisters, children, grandchildren and great-grandchildren.

"Compensation" includes all forms of cash and non-cash payments or benefits provided in exchange for services, including but not limited to, salary and wages, bonuses, severance payments, deferred payments, retirement benefits, fringe benefits, and other financial arrangements or transactions such as personal vehicles, food and/or beverage, housing, personal and family educational benefits, below-market loans, payment of personal or family travel, entertainment, and personal use of property.

"Nominal Value" means not exceeding $100 in a calendar year.

1. **Financial Relationships:** Within the current or prior calendar year, do you or a **Relative** have a financial relationship with an entity that to your knowledge does or, is seeking to do business with **NYP**? (Any pharmaceutical and/or device manufacturers should be considered a vendor of **NYP.**) A Financial Relationship is defined for this question as an ownership, investment, partnership, financial or voting interest in the entity.
   For providers, please consider the Open Payments data published by CMS for inclusion on this survey available at https://openpaymentsdata.cms.gov/
   ☐ Yes ☒ NO

2. **Gifts and Entertainment:** Within the current or prior calendar year, did you or a **Relative** receive, directly or indirectly, any benefit of more than **Nominal Value** from any vendor with which **NYP** conducts business or, to your knowledge, is seeking to conduct business? Items of value include, but are not limited to payments, fees, gifts, food and/or beverage, gratuities, special discounts, services, loans, travel, education, entertainment, or other favors. (Any pharmaceutical and/or device manufacturers should be considered a vendor of **NYP**.)
   For providers, please consider the Open Payments data published by CMS for inclusion on this survey available at https://openpaymentsdata.cms.gov/
   ☐ Yes ☒ NO

3. **Competitor, Vendor or Other Outside Relationship:** Are you or a **Relative** a member of the governing board, an officer, director, trustee, employee, agent, or consultant of (i) an entity that to your knowledge does or is seeking to do business with **NYP** or; (ii) any healthcare entity other than **NYP** that competes or could compete directly with **NYP**? Healthcare entities include, but are not limited to healthcare providers, pharmaceutical or device manufacturers, or other entities that provide similar services. Any pharmaceutical and/or device manufacturers should be considered as doing or seeking to do business with **NYP.**
   For providers, please consider the Open Payments data published by CMS for inclusion on this survey available at https://openpaymentsdata.cms.gov/.
   ☐ Yes ☒ NO

4. **Outside Relationship**: For NYP employees, are you on the governing board of any entity? Please note all external board positions need to be approved pursuant to the Conflicts of Interest - Speaking Engagements, Honoraria and Outside Board Positions Policy.
   ☐ Yes ☒ NO

5. **Familial Relationships:** Do you have any **Relatives** employed by **NYP**?
   ☐ Yes ☒ NO

6. **Other Interests or Activities:** Do you or a **Relative** know of any interest or activity not listed above, which may possibly be regarded as constituting a conflict of interest as described in **NYP's** Conflict of Interest Policy or Code of Conduct?
   ☐ Yes ☒ NO

I certify that I:

- ☒ Have received a copy of the Conflict of Interest Policy Statement;
- ☒ Have read and understand the Policy;
- ☒ Have agreed to comply with the Policy, and to update the information provided in this questionnaire in the event of any changes;
- ☒ Understand NYP is a charitable organization and in order to maintain its federal tax exemption it must engage primarily in activities which accomplish one or more of its tax-exempt purposes.

The processing of employee and patient information is a key function of NewYork-Presbyterian ("NYP"). In order to ensure the confidentiality of this information, each employee, student or trainee, affiliate, contractor, vendor or volunteer must read, sign and be governed by the following statements:

- Employee and patient records contain confidential information including but not limited to salaries, disciplinary actions, patient health information and patient financial information; they are privileged business documents belonging to NYP. Records include paper, printed and electronic files and documents.
- Privileged information encountered through routine review functions, such as those performed by NYP personnel must not be compromised or divulged. Discussion, access and/or reading of employee or patient records for non-job related reasons are prohibited. Under no circumstances should employee or patient information be discussed casually, socially, or in public areas.
- Requests for employee information should be directed to Human Resources. Requests for patient information should be directed to Health Information Management (Medical Records).
- All personnel are warned to be alert to any attempts by unauthorized persons to obtain employee or patient information though unscrupulous, devious or illegal means that are in violation of established policies of NYP. This information is valuable and confidential; and is protected by law and by strict NYP policies.
- Proprietary information such as financial and statistical records, purchasing and internal reports must also be kept confidential and only disseminated on a need to know basis.

Specific to patient privacy and safeguarding protected health information ("PHI"), you hereby attest to comply with the standards and expectations outlined below; and to appropriately use, disclose and safeguard PHI and the systems that maintain it.

Patient Privacy:

- Adhere to privacy laws and regulations, and applicable NYP policies and procedures
- Handle and maintain patient information in a confidential and secure manner
- Safeguard PHI, in any format (verbal. paper. electronic), and the systems you have access to
- Only use or disclose PHI as permissible by law
- Only access, use or disclose PHI as required to fulfill job duties and only for legitimate business purposes
- Only access, use or disclose the *"minimum necessary"* PHI to satisfy the intended purpose
- Avoid discussing PHI in public areas (elevators, cafeteria, public hallways/ waiting areas, etc.)
- Obtain patient's permission prior to disclosing PHI in front of family or friends
- Seek guidance when uncertain about appropriate use or disclosure of PHI
- Avoid printing PHI, whenever possible, and appropriately secure when required for retention
- Shred or appropriately destroy all printed documentation and other media that contains PHI as required
- Avoid removing PHI from the facility (paper, on laptop, flash drive, etc.)
- Do not take pictures or videos of patients for personal use, or with a personal device
- Do not discuss patient information in social settings, with my family or friends; or post any patient information on social media
- Abide by special privacy protection provisions regarding "Sensitive Health Information" (Mental Health , Substance Abuse , HIV/Aids, Reproductive Health, Genetic information)

Information Security:

- Adhere to Information Security laws and regulations and applicable NYP policies and procedures
- Access systems containing employee and patient health information only as needed to perform your duties as defined by your relationship (faculty, employment, student, contract, etc.) with NYP.
    - You must not access employee or patient health information for which you have no legitimate business needs
    - You must not use, disclose, copy, release, alter, revise, or destroy any employee or patient health

information except as properly authorized within the scope of your relationship with NYP.

- Safeguard and protect your individual credentials (user ID and password) or any other user credentials that allow for access to employee or patient health information. You will be responsible for all activities undertaken using your credentials and other authorizations.
  - You must secure (lock or sign out) your system when not occupied;
  - You must sign off of computer systems after use;
  - You must not share or allow anyone access to systems containing employee or patient health information under your individual account; and
  - You must not use another user's individual account to access any systems
- Abide by NYP policies and procedures regarding use of any devices that may contain any employee and patient health information including the use of encryption or other equivalent method of protection when required.
- Upon termination of your relationship with NYP, you will return all institutional information and devices or dispose of them in accordance with hospital policies regarding the disposal of electronic equipment.
- Communication using the NYP network and systems is not private, and the institution may monitor the content of your communication to protect the confidentiality and security of NYP data.
- You have no right or ownership interest of any employee or patient health information. NYP may at any time revoke your employee account, other authorization, or access to employee and patient health information. At all times during your relationship with NYP, you will act in the best interests of NYP.
- You will be responsible for any misuse or wrongful disclosure of employee and patient health information and for any failure to safeguard your account credentials should they be used to access employee and patient health information.

Representations:

- I have had an opportunity to read a copy of the Hospital bylaws and such Hospital policies and directives as are applicable to members of the medical staff, including the Medical Staff Bylaws and Rules and Regulations. I specifically agree to abide by the bylaws, policies, rules and regulations, and directives that are in force during the time that I am a member of the medical staff.

- I have had an opportunity to read a copy of the Code of Conduct and such Hospital policies and directives as are applicable to members of the medical staff. I specifically agree to abide by the Code of Conduct, policies, rules and regulations, and directives that are in force during the time that I am a member of the medical staff.

Reporting Obligations:

You have an affirmative responsibility to report issues or concerns regarding employee and/or patient health information immediately to the Office of Corporate Compliance at (212) 746-16 44. As such, you agree to:

- Report any suspicion or knowledge of unauthorized access to systems
- Report any misuse or disclosure of employee or patient health information
- Report, in accordance with NYP policies, activities by any individual that you suspect may compromise the confidentiality of employee or patient health information.

NYP prohibits retaliation in any form for good faith reporting of suspect activities and will maintain reported incidents in confidence to the extent permitted by law.

By signing this document, you agree to the requirements set forth within and understand that compliance with these provisions is a condition of your employment or affiliation with NYP. In addition, you attest to understanding that failure to comply may result in disciplinary action up to and including loss of privileges and termination in accordance with the Medical Staff Bylaws.

AFFIRMATION

I represent that the information provided in or attached to this application is accurate and complete. I understand that a condition of this application is that any misrepresentation, misstatement, or omission from this application may be cause for automatic and immediate rejection of this application and may result in the denial of appointment/reappointment and clinical privileges. Upon subsequent discovery of such misrepresentation, misstatement, or omission, the Hospital may terminate my appointment and privileges in accordance with the Medical Staff Bylaws.

PLEASE NOTE: IF YOUR MALPRACTICE INSURANCE IS OBTAINED FROM MCIC, INFORMATION FROM THIS APPLICATION MAY BE SHARED WITH MCIC.

[redacted]

Practitioner's Signature

[redacted]	[redacted]	05/23/2023
Electronic Signature -Type full name	*Last 4 digits of SSN*	*Date*

NewYork-Presbyterian

NEW YORK STATE PHYSICIAN/PRACTITIONER

ACKNOWLEDGEMENT STATEMENT

In accordance with applicable Federal (Public Law 98-21) and New York State law (Section 405.3 of Chapter V of Title 10), please read the following statements:

NEW YORK STATE - NOTICE TO PHYSICIANS
"Payments to hospitals for inpatient services is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, and for neonates, upon birth weight or admission weight as well. This data must be documented by the patient's medical record. Anyone who misrepresents, falsifies or conceals this information may be subject to fine, imprisonment, or civil penalty under applicable Federal and New York State laws."

FEDERAL - NOTICE TO PHYSICIANS
"Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and 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, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws."

It is required that the Hospital maintain on file your written and signed acknowledgement that you have received this notice. This copy must be on file within the Hospital before a claim can be submitted. Please retain a copy for your records and sign and date this verification statement using your full legal signature for our records.

I acknowledge that I have read and received the notice of Physician Notification Statement and Physician Attestation Statement.

Verified and completed by: [redacted]

Print Name & Title

[redacted]

Signature

05/23/2023

Date Signed

III. PHYSICIAN CONSULTATION

The parties shall be available to each other for consultation either on site or by electronic access including but not limited to telephone, facsimile and email. Each party will cover for the other in the absence of one of them or _____ who are designated by [redacted], N.P.
(Names of Third Parties) (Name of Applicant)
and [redacted], M.D., as appropriate for coverage in the absence of both parties.
(Name of Physician)
In the event that there is an unforeseen lack of coverage, patients will be referred to the appropriate emergency room.

IV. RECORD REVIEW

A representative sample of patient records shall be reviewed by the collaborating physician every three months to evaluate that [redacted], N.P.'s practice is congruent with the above identified practice
(Name of Applicant)
protocol documents and texts. Summarized results of this review will be signed by both parties and shall be maintained in the nurse practitioner's practice site for possible regulatory agency review. Consent forms for such review will be obtained from any patient who primary physician is other than [redacted], M.D.
(Name of Collaborative Physician)

V. RESOLUTION OF DISAGREEMENTS

Disagreement between [redacted], N.P. and [redacted], M.D.
(Name of Applicant) (Name of Collaborative Physician)
regarding a patient's health management that falls within the scope of practice of both parties will be resolved by a consensus agreement in accordance with current medical and nursing peer and literature consultation. In case of disagreements that cannot be resolved in this manner, [redacted], M.D.'s
(Name of Collaborative Physician)
opinion will prevail.

VI. ALTERATION OF AGREEMENT

The Collaborative Practice Agreement shall be reviewed at least annually and may be amended only in writing in a document signed by both parties and attached to the Collaborative Practice Agreement.

VII. AGREEMENT

Having read and understood the full contents of this document, the parties hereto agree to be bound by its terms.

Nurse Practitioner:

Printed Name: [redacted]

Certification #: [redacted] RN License #: _____

Signature: [redacted] Date: 7/26/23

Collaborating Physician:

Printed Name: [redacted]

Certification #: [redacted] MD License #: [redacted]

Signature: [redacted] Date: 7/21/23

Collaborative Practice Agreement

This agreement sets forth the terms of the Collaborative Practice Agreement between

[redacted], N.P. in the Department of Obstetrics and Gynecology
(Name of Applicant) (Department)
and [redacted], M.D. a member of the Medical Staff at New York-Presbyterian Hospital.
(Name of Physician)
This agreement should take effect as of 07/10/23.
(Date: mm/dd/yyyy)

INSTRUCTION

[redacted], N.P., meets the qualifications and practice requirements as
(Name of Applicant)
stated in Chapter 257 of the Laws of 1988 and Article 139 of the Education Law of New York State, holds a New York State License and is currently registered as a Registered Professional Nurse in good standing, is certified as a Nurse Practitioner pursuant to Sec. 6910 of the Education Law and herein meets the requirement of maintaining a collaborative practice agreement with [redacted], M.D., a duly licensed and currently
(Name of Physician)
registered physician in good standing under Article 131 of the New York State Education Law.

I. SCOPE OF PRACTICE

The practice of a Registered Professional Nurse as a Nurse Practitioner may include the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures including prescribing medications for patients whose conditions fall within the authorized scope of the practice as identified on the college certificate. This privilege includes the prescribing of all controlled substances under a DEA number. The Nurse Practitioner, as a Registered Nurse may also diagnose and treat human responses to actual or potential health problems through such services as a case finding, health counseling, health teaching, and provision of care supportive to or restorative of life and well-being. This practice will take place at NewYork-Presbyterian Hospital. The following exceptions to the certified scope of practice have been agreed upon by the undersigned parties:

_____

_____

_____
(list exception to scope of practice here – such as OB/GYN adolescent patients above the age of in the ANP or selected patients above the age of 18 under the following conditions of the PNP etc.)

II. PRACTICE PROTOCOLS

The protocols used in this Hawkins, J. W., Roberto-Nichols, D. M., & Stanley-Haney, J. L. (2011)
(Identify specialty as listed on college certificate)
practice are contained in Guidelines for Nurse Practitioners In Gynecologic
(Name approved protocol text with all bibliography citations)
and in Settings (10th ed.) New York, NY: Springer Pub.
(Cite location of any other protocols which are germane to this particular practice)

Nurse Practitioner Form 4NP

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Department Use Only
Approved
Date

Verification of Collaborative Agreement and Practice Protocol

Applicant Instructions

1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for a Certificate (Form 1).
2. You and the initial collaborating physician with whom you have a practice agreement and practice protocol must complete Sections II and III and return both pages of the form to the Office of the Professions at the address at the end of the form.. Be sure to sign and date item 4 in Section III.

Note: Form 4NP is not required to obtain a certificate, but must be submitted to the Office of the Professions no later than 90 days after commencement of practice. This submission to the Department is only required **once**.

Section I: Applicant Information

1 **Social Security Number** [redacted]
(Leave this blank if you do not have a U.S. Social Security Number)

2 **Birth Date** Month [redacted] Day [redacted] Year [redacted]

3 **If Already Certified, New York State Nurse Practitioner Certificate Number**
[redacted]

4 **Print Name as It Appears on Your Application for a Certificate (Form 1)**

Last [redacted]
First
Middle

5 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1 [redacted]
Line 2
Line 3
City
State
Country/ Province

Section II: Collaborating Physician

1. Name of collaborating physician: [redacted] *Last* [redacted] *First* *Middle*
2. Address: [redacted]
3. Telephone: [redacted] Fax: [redacted]
4. E-mail address: [redacted]
5. New York State medical license number: [redacted]
6. Area of current practice: Obstetrics and Gynecology
7. Area of specialty practice: Gynecologic Surgery

Section III: Practice Protocol

Instructions: You must use an approved practice protocol text that is a standard publication. Please select a protocol text from the approved list (see application instructions, pages 8-9) and submit this form to the Department at the address at the end of the form, no later than 90 days after the commencement of practice.

1. List title, publisher, and date of publication of the approved protocol text.

Hawkins, J.W Roberto-Nicholes, D. M., & Stanley-Haney, J.L (2011) Guidelines for Nurse Practitioners in Gynecologic Settings (10th ed) New York, NY Springer Pub

2. Location and description of practice site(s): (clinic, private office, HMO, etc.)

Practice Site		
Name	**Address**	**Description**
Columbia Doctors Midtown	51 West 51st Street New York, NY 10019	Private Office, Clinic
Columbia Doctors -Herbert Irving Pavilion	161 ft Washington Avenue 4th floor New York, BY 10032	Clinic, Private Office

3. Description of practice including any mutually agreed upon exceptions:

Gynecologic Focused with emphasis on surgical evaluation of gyn conditions

4. We hereby verify that we have a written collaborative agreement and have selected a practice protocol(s).

Nurse Practitioner signature: [redacted] Date: 8 / 23 / 23 (mo. / day / yr.)

Collaborating Physician signature: [redacted] Date: 8 / 23 / 23 (mo. / day / yr.)

Return Directly to: **New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.**

NewYork-Presbyterian
The University Hospitals of Columbia and Cornell

Medical Staff Office
New York-Presbyterian Hospital
Weill Cornell Medical Center
Columbia University Medical Center
466 Lexington Ave
New York, NY 10017
TEL 212-585-6425 FAX 212-585-6843

October 17, 2023

MEMO TO MSO MANAGEMENT

TO: Susan Diaz, CPCS, CPMSM, Lauri Martin, CPMSM
FROM: Nicole Paterno, Credentialing Analyst, CPCS
RE: [redacted], NP, OB/GYN, Gynecological Surgery- NYP Columbia University
SUBJECT: Professional references

Dr. Gruenberg, supervising physician for [redacted], has added additional comments for current competency and noted [redacted] in Obstetrics.

Attachments:
Professional Reference- [redacted] MD- Supervising Physician- Morris Heights Health Center
Professional Reference- [redacted] WHNP
Professional Reference- [redacted] WHNP
Professional Reference- [redacted] NP
Chair letter-pending
Approved Delineation of Privileges-Gynecological Surgery
NPDB- no reports
CV
Initial Request

NewYork-Presbyterian

Medical Staff Office
466 Lexington Avenue

New York, New York 10017
TEL:
EMAIL: [redacted]

9/19/2023

To: [redacted] MD

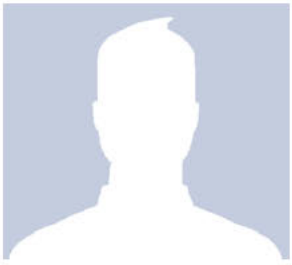
Re: [redacted] NP
OB/GYN
NA - 01/02/2023 through 09/09/2023

The above named practitioner has applied to NewYork-Presbyterian for initial appointment/reappointment and clinical privileges at NewYork-Presbyterian-New York, as indicated on the attached Delineation form(s) (if applicable). The applicant has indicated an affiliation with your institution, as identified above. The practitioner has signed consent; please provide us with an evaluation of the practitioner by commenting on the practitioner's professional knowledge, skills, and attitude by rating the following:

Click on View Applicant Consent button at top right of screen to view applicant's signed consent/release. Click on View Privileges button to view requested privileges (if applicable).

ALL QUESTIONS MUST BE ANSWERED TO ASSURE APPOINTMENTS.

PHOTO CONFIRMATION



Please confirm that the photo above is [redacted], NP:

- ○ Yes. I confirm that the photo matches the identity of the practitioner for whom I am completing the evaluation.
- ○ No. I am not able to confirm the photo matches the identity of the practitioner for whom I am completing the evaluation.
- ◉ N/A (Select this option if there is no photo.)

How well do you know the applicant?

- ○ Not Well
- ◉ Professional Acquaintance
- ○ Very Well

For ratings of Fair, Poor or Unable to Evaluate we ask that you please provide an explanation in the Comments area that follows.
Rating Scale: EX: Excellent, G: Good, F*: Fair, P*: Poor, U/E*: Unable to Evaluate

	EX	G	F*	P*	U/E*
Medical Knowledge – Knowledge of established and evolving biomedical, clinical, and cognate science and how to apply this knowledge to patient's care. This is evidenced by completion of education and the training requirements as well as on the job experience, in-service training and continuing education.	○	◉	○	○	○
Technical and Clinical Skills – The capacity to perform specific privilege/procedures. It is based on both knowledge and the ability to apply the knowledge.	◉	○	○	○	○
Clinical Judgment – The observation, perceptions, impressions, recollections, intuitions, beliefs, feelings and inference of judgments to reach decisions, individually or collectively with other providers, about a patient's diagnosis and treatment.	◉	○	○	○	○
Communication Skills – Ability to sustain a therapeutic and ethically sound relationship with other caregivers, patients and their families. Practitioner communicates effectively and demonstrates caring, compassionate and respectful behaviors. This also includes effective listening skills and the ability to elicit/provide information.	◉	○	○	○	○
Interpersonal Skills – Works effectively with other professionals, including those from other disciplines to provide patient-focused care as a member of the health care team.	◉	○	○	○	○
Professionalism – Demonstrates respect, compassion and integrity. Is responsive and accountable to the needs of the patient and the profession. Committed to providing high quality patient care and continuous professional development as well as being ethical in issues related to clinical care, patient confidentiality, and informed consent.	◉	○	○	○	○

Health Status – Are you aware of any health issues that may have a potential effect on the applicant's ability to perform the privileges being requested?

- ○ Yes*
- ◉ No

Relevant Training and Experience – In reviewing the attached request for privileges, do you feel that the applicant's training and experience are adequate to carry out these procedures?

- ◉ Yes
- ○ No*

Current Competence – In reviewing the attached request for privileges, do you feel that the applicant is currently competent to carry out these procedures?

- ◉ Yes
- ○ No*

Please provide any additional comments:

[redacted]

Overall Recommendation (check one):

- ○ I recommend privileges without reservation
- ◉ I recommend privileges with the following reservation(s):
- ○ I do not recommend this applicant for the following reason(s):

Reservations:

[redacted]

Your Name

[redacted]

Your Title

medical director

Your Phone Number

[redacted]

DocuSigned by:
[redacted]

9/26/2023 | 13:32:19 EDT

NewYork-Presbyterian

Medical Staff Office
466 Lexington Avenue

New York, New York 10017
TEL:
EMAIL: [redacted]

8/15/2023

To: [redacted] WHNP

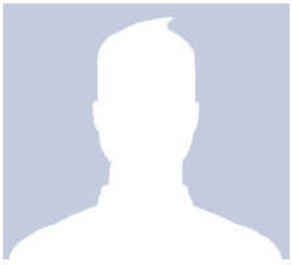
Re: [redacted], NP
Nursing
[redacted] - 12/03/2018 through 05/04/2020

The above named practitioner has applied to NewYork-Presbyterian for initial appointment/reappointment and clinical privileges at NewYork-Presbyterian-New York, as indicated on the attached Delineation form(s) (if applicable). The applicant has indicated an affiliation with your institution, as identified above. The practitioner has signed consent; please provide us with an evaluation of the practitioner by commenting on the practitioner's professional knowledge, skills, and attitude by rating the following:

Click on View Applicant Consent button at top right of screen to view applicant's signed consent/release. Click on View Privileges button to view requested privileges (if applicable).

ALL QUESTIONS MUST BE ANSWERED TO ASSURE APPOINTMENTS.

PHOTO CONFIRMATION



Please confirm that the photo above is [redacted], NP:

- ○ Yes. I confirm that the photo matches the identity of the practitioner for whom I am completing the evaluation.
- ○ No. I am not able to confirm the photo matches the identity of the practitioner for whom I am completing the evaluation.
- ◉ N/A (Select this option if there is no photo.)

How well do you know the applicant?

- ○ Not Well
- ○ Professional Acquaintance
- ◉ Very Well

For ratings of Fair, Poor or Unable to Evaluate we ask that you please provide an explanation in the Comments area that follows.
Rating Scale: EX: Excellent, G: Good, F*: Fair, P*: Poor, U/E*: Unable to Evaluate

	EX	G	F*	P*	U/E*
Medical Knowledge – Knowledge of established and evolving biomedical, clinical, and cognate science and how to apply this knowledge to patient's care. This is evidenced by completion of education and the training requirements as well as on the job experience, in-service training and continuing education.	◉	○	○	○	○
Technical and Clinical Skills – The capacity to perform specific privilege/procedures. It is based on both knowledge and the ability to apply the knowledge.	◉	○	○	○	○
Clinical Judgment – The observation, perceptions, impressions, recollections, intuitions, beliefs, feelings and inference of judgments to reach decisions, individually or collectively with other providers, about a patient's diagnosis and treatment.	◉	○	○	○	○
Communication Skills – Ability to sustain a therapeutic and ethically sound relationship with other caregivers, patients and their families. Practitioner communicates effectively and demonstrates caring, compassionate and respectful behaviors. This also includes effective listening skills and the ability to elicit/provide information.	◉	○	○	○	○
Interpersonal Skills – Works effectively with other professionals, including those from other disciplines to provide patient-focused care as a member of the health care team.	◉	○	○	○	○
Professionalism – Demonstrates respect, compassion and integrity. Is responsive and accountable to the needs of the patient and the profession. Committed to providing high quality patient care and continuous professional development as well as being ethical in issues related to clinical care, patient confidentiality, and informed consent.	◉	○	○	○	○

Health Status – Are you aware of any health issues that may have a potential effect on the applicant's ability to perform the privileges being requested?

- ○ Yes*
- ◉ No

Relevant Training and Experience – In reviewing the attached request for privileges, do you feel that the applicant's training and experience are adequate to carry out these procedures?

- ◉ Yes
- ○ No*

Current Competence – In reviewing the attached request for privileges, do you feel that the applicant is currently competent to carry out these procedures?

- ◉ Yes
- ○ No*

Please provide any additional comments:

Overall Recommendation (check one):

- ◉ I recommend privileges without reservation
- ○ I recommend privileges with the following reservation(s):
- ○ I do not recommend this applicant for the following reason(s):

Your Name

[redacted]

Your Title

WHNP-BC

Your Phone Number

[redacted]

DocuSigned by:
[redacted]

8/16/2023 | 09:54:14 EDT

NewYork-Presbyterian

Medical Staff Office
466 Lexington Avenue

New York, New York 10017
TEL:
EMAIL: [redacted]

8/16/2023

To: [redacted]WHNP

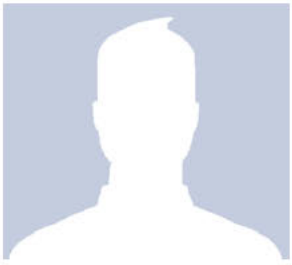
Re: [redacted], NP
Gynecology
[redacted] - 05/03/2021 through 10/03/2022

The above named practitioner has applied to NewYork-Presbyterian for initial appointment/reappointment and clinical privileges at NewYork-Presbyterian-New York, as indicated on the attached Delineation form(s) (if applicable). The applicant has indicated an affiliation with your institution, as identified above. The practitioner has signed consent; please provide us with an evaluation of the practitioner by commenting on the practitioner's professional knowledge, skills, and attitude by rating the following:

Click on View Applicant Consent button at top right of screen to view applicant's signed consent/release. Click on View Privileges button to view requested privileges (if applicable).

ALL QUESTIONS MUST BE ANSWERED TO ASSURE APPOINTMENTS.

PHOTO CONFIRMATION



Please confirm that the photo above is [redacted], NP:

- ○ Yes. I confirm that the photo matches the identity of the practitioner for whom I am completing the evaluation.
- ○ No. I am not able to confirm the photo matches the identity of the practitioner for whom I am completing the evaluation.
- ◉ N/A (Select this option if there is no photo.)

How well do you know the applicant?

- ○ Not Well
- ○ Professional Acquaintance
- ◉ Very Well

For ratings of Fair, Poor or Unable to Evaluate we ask that you please provide an explanation in the Comments area that follows.
Rating Scale: EX: Excellent, G: Good, F*: Fair, P*: Poor, U/E*: Unable to Evaluate

	EX	G	F*	P*	U/E*
Medical Knowledge – Knowledge of established and evolving biomedical, clinical, and cognate science and how to apply this knowledge to patient's care. This is evidenced by completion of education and the training requirements as well as on the job experience, in-service training and continuing education.	◉	○	○	○	○
Technical and Clinical Skills – The capacity to perform specific privilege/procedures. It is based on both knowledge and the ability to apply the knowledge.	◉	○	○	○	○
Clinical Judgment – The observation, perceptions, impressions, recollections, intuitions, beliefs, feelings and inference of judgments to reach decisions, individually or collectively with other providers, about a patient's diagnosis and treatment.	◉	○	○	○	○
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Interpersonal Skills – Works effectively with other professionals, including those from other disciplines to provide patient-focused care as a member of the health care team.	◉	○	○	○	○
Professionalism – Demonstrates respect, compassion and integrity. Is responsive and accountable to the needs of the patient and the profession. Committed to providing high quality patient care and continuous professional development as well as being ethical in issues related to clinical care, patient confidentiality, and informed consent.	◉	○	○	○	○

Health Status – Are you aware of any health issues that may have a potential effect on the applicant's ability to perform the privileges being requested?

- ○ Yes*
- ◉ No

Relevant Training and Experience – In reviewing the attached request for privileges, do you feel that the applicant's training and experience are adequate to carry out these procedures?

- ◉ Yes
- ○ No*

Current Competence – In reviewing the attached request for privileges, do you feel that the applicant is currently competent to carry out these procedures?

- ◉ Yes
- ○ No*

Please provide any additional comments:

Overall Recommendation (check one):

- ◉ I recommend privileges without reservation
- ○ I recommend privileges with the following reservation(s):
- ○ I do not recommend this applicant for the following reason(s):

Your Name

[redacted]

Your Title

Advanced Practice Clinician

Your Phone Number

[redacted]

DocuSigned by:
[redacted]

8/19/2023 | 09:48:49 EDT

NewYork-Presbyterian

Medical Staff Office
466 Lexington Avenue

New York, New York 10017
TEL:
EMAIL: [redacted]

8/16/2023

To: [redacted] NP

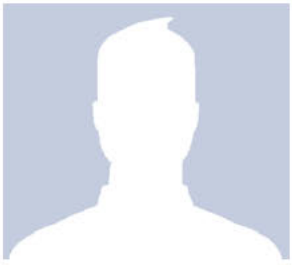
Re: [redacted], NP
Gynecology
Columbia NYP - 09/01/2019 through 09/01/2020

The above named practitioner has applied to NewYork-Presbyterian for initial appointment/reappointment and clinical privileges at NewYork-Presbyterian-New York, as indicated on the attached Delineation form(s) (if applicable). The applicant has indicated an affiliation with your institution, as identified above. The practitioner has signed consent; please provide us with an evaluation of the practitioner by commenting on the practitioner's professional knowledge, skills, and attitude by rating the following:

Click on View Applicant Consent button at top right of screen to view applicant's signed consent/release. Click on View Privileges button to view requested privileges (if applicable).

ALL QUESTIONS MUST BE ANSWERED TO ASSURE APPOINTMENTS.

PHOTO CONFIRMATION



Please confirm that the photo above is Elizabeth Tobin, NP:

- ○ Yes. I confirm that the photo matches the identity of the practitioner for whom I am completing the evaluation.
- ○ No. I am not able to confirm the photo matches the identity of the practitioner for whom I am completing the evaluation.
- ◉ N/A (Select this option if there is no photo.)

How well do you know the applicant?

- ○ Not Well
- ○ Professional Acquaintance
- ◉ Very Well

For ratings of Fair, Poor or Unable to Evaluate we ask that you please provide an explanation in the Comments area that follows.
Rating Scale: EX: Excellent, G: Good, F*: Fair, P*: Poor, U/E*: Unable to Evaluate

	EX	G	F*	P*	U/E*
Medical Knowledge – Knowledge of established and evolving biomedical, clinical, and cognate science and how to apply this knowledge to patient's care. This is evidenced by completion of education and the training requirements as well as on the job experience, in-service training and continuing education.	◉	○	○	○	○
Technical and Clinical Skills – The capacity to perform specific privilege/procedures. It is based on both knowledge and the ability to apply the knowledge.	◉	○	○	○	○
Clinical Judgment – The observation, perceptions, impressions, recollections, intuitions, beliefs, feelings and inference of judgments to reach decisions, individually or collectively with other providers, about a patient's diagnosis and treatment.	◉	○	○	○	○
Communication Skills – Ability to sustain a therapeutic and ethically sound relationship with other caregivers, patients and their families. Practitioner communicates effectively and demonstrates caring, compassionate and respectful behaviors. This also includes effective listening skills and the ability to elicit/provide information.	◉	○	○	○	○
Interpersonal Skills – Works effectively with other professionals, including those from other disciplines to provide patient-focused care as a member of the health care team.	◉	○	○	○	○
Professionalism – Demonstrates respect, compassion and integrity. Is responsive and accountable to the needs of the patient and the profession. Committed to providing high quality patient care and continuous professional development as well as being ethical in issues related to clinical care, patient confidentiality, and informed consent.	◉	○	○	○	○

Health Status – Are you aware of any health issues that may have a potential effect on the applicant's ability to perform the privileges being requested?

- ○ Yes*
- ◉ No

Relevant Training and Experience – In reviewing the attached request for privileges, do you feel that the applicant's training and experience are adequate to carry out these procedures?

- ◉ Yes
- ○ No*

Current Competence – In reviewing the attached request for privileges, do you feel that the applicant is currently competent to carry out these procedures?

- ◉ Yes
- ○ No*

Please provide any additional comments:

Overall Recommendation (check one):

- ◉ I recommend privileges without reservation
- ○ I recommend privileges with the following reservation(s):
- ○ I do not recommend this applicant for the following reason(s):

Your Name

[redacted]

Your Title

Nurse Practitioner

Your Phone Number

[redacted]

[redacted]

8/16/2023 | 18:57:42 EDT

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Nurse Practitioner - Gynecology

Delineation of Privileges

Applicant's Name: [redacted], NP

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Primary Privileges* or a Privilege Cluster.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Required Qualifications	
Certification/Licensure	The applicant shall be a currently Licensed Registered Nurse with a Nurse Practitioner Certification/Licensure in the relevant specialty area(s). **AND** Certification to issue prescriptions under Section 6902.3(b) of the Education Law.
Performance of Services	Services by a nurse practitioner are rendered in collaboration with a licensed physician qualified to collaborate in the specialty involved. **AND** All services rendered by a nurse practitioner are performed in accordance with a written collaborative practice agreement and practice protocol, which must be agreed to by the nurse practitioner and the collaborating physician. **AND** Clinical privileges assigned to registered professional nurses at NYP are as outlined in the New York State Nurse Practice Act and the Nursing By-Laws.
Additional Qualifications	A Nurse Practitioner who is granted admitting privileges by the Board of Trustees may admit patients to, and discharge patients from the Hospital and may follow such patients during hospitalization. **AND** Patients admitted by a Nurse Practitioner must be assigned an Attending Physician who is a member of the Medical Staff and will be designated as the attending of record.

Core Privileges - Nurse Practitioner - Gynecology

Request		*Request all privileges listed below.*
Weill Cornell	Columbia	Click shaded blue check box to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ - Currently granted privileges
		Provide direct care to patients through the following activities:
☑	☑	Take comprehensive history and perform physical examinations
☑	☑	Perform diagnostic testing and therapeutic procedures approved by the Clinical Service Chief
☑	☑	Evaluate and treat on the basis of history, physical examination, radiological, laboratory, and other diagnostic test results, pursuant to the practice protocols and collaborative practice agreement
☑	☑	Initiate referrals to other health care providers, and/or consult with the attending physician or the collaborating physician
☑	☑	Admitting and discharge privileges

Specialty Privileges - Nurse Practitioner - Gynecology

Request		*Request all privileges listed below.*
Weill Cornell	Columbia	Click shaded blue check box to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ - Currently granted privileges
		IUD [Minimum Visual Supervision 5 per procedure]
☑	☑	Insertion
☑	☑	Removal
		Contraceptive Implants [Minimum Visual Supervision 5 per procedure]
☐	☐	Insertion
☐	☐	Removal
		Skin [Minimum Visual Supervision 5 per procedure]
☑	☑	Application of Chemical Destructive
☑	☑	Punch Biopsy of Skin
☑	☑	Skin Tag Removal
		Additional Specialty Privileges [Minimum Visual Supervision 5 per procedure]
☑	☑	Performs Colposcopy
☑	☑	Performs Colposcopic Biopsy
☑	☑	Endometrial Biopsy
☑	☑	Foreign Body Removal

Qualifications

Education/Training Documentation of successful completion of an approved, recognized course or hands on experience.

Continuing Education	Applicant must complete continuing education and/or hands on experience to maintain competence as determined by the Chief of Service.
Certification for Contraceptive Implants	Certification of official training Program via Merck/Organon
Requirement at Initial	Must demonstrate competency as determined by at least 5 cases & Provide certification of official training program via Merck/Organon

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at New York-Presbyterian Hospital.

These clinical privileges are approved only for the New York Presbyterian hospital campus(es) and sites(s) specified in my Medical Staff application.

[redacted] 8/10/23

Practitioner's Signature Date

I have reviewed the above practitioner's application, education and training, requested clinical privileges, quality outcomes, and supporting documentation and make the following recommendations:

☐	Recommend all requested privileges
☐	Do not recommend any of the requested privileges
☐	

Privilege	

[redacted] MD

Signature Collaborating/Collaborative Relationship Physician — Date

[redacted] 8/23/23

Signature Service Chief/Designee — Mary D'Alton — Date

National Practitioner Data Bank
Health Resources and Services Administration
U.S. Department of Health and Human Services
P.O. Box 10832
Chantilly, VA 20153-0832
https://www.npdb.hrsa.gov

Continuous Query ID: [redacted]
DCN: [redacted]
Process Date: 07/25/2023 Page: 1 of 1
[redacted]
For authorized use by:
NEW YORK-PRESBYTERIAN HOSPITAL

TOBIN, ELIZABETH - CONTINUOUS QUERY RESPONSE

A. SUBJECT IDENTIFICATION INFORMATION (Recipients should verify that subject identified is, in fact, the subject of interest.)

Practitioner Name: [redacted]
Date of Birth: [redacted] **Gender:** FEMALE
Organization Name: NEW YORK-PRESBYTERIAN HOSPITAL
Work Address: 466 LEXINGTON AVE, BOX # 17, 9TH FLOOR, NEW YORK, NY 10017-3140
Home Address: [redacted]
Social Security Number: [redacted] **NPI:** [redacted]
License: [redacted]
Professional School(s): SUNY DOWNSTATE MEDICAL CENTER (2018)

B. CONTINUOUS QUERY ENROLLMENT INFORMATION

Enrollment Status: Enrolled - 07/25/2023 - 07/31/2024*
* Unless enrollment is canceled by the entity prior to this date
Statutes Queried: Title IV; Section 1921; Section 1128E
Entity Name: NEW YORK-PRESBYTERIAN HOSPITAL [redacted]
Authorized Submitter: DAISYMAY PARKS, MSO CONSULTANT, (646) 984-8595

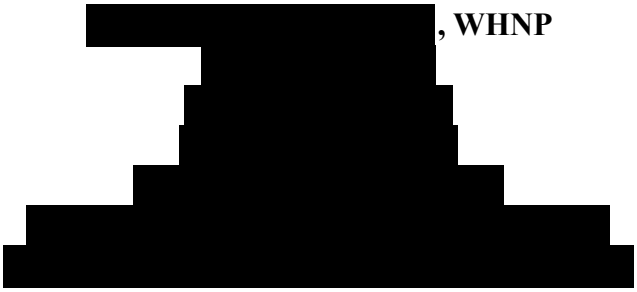
C. SUMMARY OF REPORTS ON FILE WITH THE NPDB AS OF 07/25/2023

The following report types have been searched:

Medical Malpractice Payment Report	No Reports	Health Plan Action(s):	No Reports
State Licensure or Certification Action	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

--------- No Reports Found Based on the Subject Information Submitted ---------

[redacted], WHNP



EMPLOYMENT

Clinical Coordinator III, Vagelos College of Physicians & Surgeons, NY, NY 07/2023 - present
- ·GYN care services at Gynecological Specialty Surgery
- ·Reports to Division Chief and Division Administrator
- ·Works with GYN Surgeons in a team approach to patient care

[redacted] Bronx, NY 10/2022 - 07/2023
- · Young Adult and Adolescents Health Unit
- · Routine gynecological examinations and pap tests
- · Order and provide STD testing, treatment and Counseling
- · IUD and Nexplanon placement
- · Male exams- sexual health and STD counseling

[redacted], multiple sites 05/2021- 10/2022
- · Medication Abortion Services

[redacted] Brooklyn, NY 04/2020 - 05/2021

Civilian RN Covid-19 Hospital/Javits Center Branch, NY, NY 03/2020 - 04/2020
- · Support Covid + patients transferred from local hospitals
- · 1500 bed Military Field hospital

WHNP, Maiden Lane Medical NY, NY 11/2019 - 03/2020
- · Routine gynecological examinations and pap test

WHNP, Public Health Solutions Brooklyn, NY 11/2018 - 11/2019
- · Title X funded Sexual and Reproductive Health Clinic

Nurse Manager RN, Parallax NY, NY 11/2017 - 11/2018
- · Education and Administration of MAT
  (Medication-Assisted Treatment of Opioid Use Disorder)

Perioperative RN/Pain Management, Mt. Sinai Beth Israel, NY,NY 07/2012- 07/2016
- · Procedure room admitting and monitoring patient care
- · Assisting with procedures requiring fluoroscopy

EDUCATION

SUNY Downstate Medical Center, MSN, WHNP , Brooklyn, NY 06/2016 - 06/2018
SUNY Downstate Medical Center, BSN, Nursing, Brooklyn, NY 08/2011- 06/2012
The Evergreen State College, BA, English, Olympia, WA 09/1996 - 06/1998

NewYork-Presbyterian

(Please note that all fields below are required. Any incomplete fields will be returned for completion for an application to be launched)

Initial Application Request Form

Request Type: Initial

Employed By: Employed by CU

Columbia Universiry Irving Medical Center

First Name: [redacted] **Gender:** Female

Middle Name: [redacted]

Last Name: [redacted] **Degree:** Select Degree

Email: [redacted]

Date of Birth: [redacted] **SSN:** [redacted] **NPI:**

Staff Category: NYPH - Nurse Practitioner

Department: Obstetrics & Gynecology **Secondary Department:** Secondary Department

Division: GSS **Secondary Division:**

Primary Campus: Select Primary Campus

Secondary Campus: Select Secondary Campus

Primary Office Address: *(Where the Practitioner will see NYP Patients)*

622 west 168th Broadway, PH16

Does the Practitioner currently hold a NYS License?: ☑ Yes ☐ No ☐ Application Submitted

Hospital Hire Only: Talent Acquisition Contact Name:

Nursing Only: Collaborating Physician Name:

Physician Assistant Only: Supervising Physician Name:

Does this Practitioner have a current appointment/privileges at any NYP Facility: Select Yes/No

Has this Practitioner held an appointment/privileges at NYP previously?: Select Yes/No

---

Application Requested by: Rashaun White **Request Date:** 09/21/2023

Credentialing Contact Name: Rashaun White

Credentialing Contact Email: [redacted]

Medical Staff Credentialing Target Date: 11/01/2023

(Please allow 12 weeks for application processing)

If Target Date is **less than 12 weeks**, please document reason(s):

Please see existing initial request

Comments/Notes for MSO:

NP OBGYN Gynecology - DOP

Submit request form and CV to MSOInitialRequests@nyp.org

Revised 9/25/2023

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Nurse Practitioner - Gynecology

Delineation of Privileges

Applicant's Name: [redacted]

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Primary Privileges* or a Privilege Cluster.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

Required Qualifications

Certification/Licensure

The applicant shall be a currently Licensed Registered Nurse with a Nurse Practitioner Certification/Licensure in the relevant specialty area(s).

AND

Certification to issue prescriptions under Section 6902.3(b) of the Education Law.

Performance of Services

Services by a nurse practitioner are rendered in collaboration with a licensed physician qualified to collaborate in the specialty involved.

AND

All services rendered by a nurse practitioner are performed in accordance with a written collaborative practice agreement and practice protocol, which must be agreed to by the nurse practitioner and the collaborating physician.

AND

Clinical privileges assigned to registered professional nurses at NYP are as outlined in the New York State Nurse Practice Act and the Nursing By-Laws.

Additional Qualifications

A Nurse Practitioner who is granted admitting privileges by the Board of Trustees may admit patients to, and discharge patients from the Hospital and may follow such patients during hospitalization.

AND

Patients admitted by a Nurse Practitioner must be assigned an Attending Physician who is a member of the Medical Staff and will be designated as the attending of record.

Core Privileges - Nurse Practitioner - Gynecology

Request		*Request all privileges listed below.*
Weill Cornell	Columbia	Click shaded blue check box to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ - Currently granted privileges
		Provide direct care to patients through the following activities:
☑	☑	Take comprehensive history and perform physical examinations
☑	☑	Perform diagnostic testing and therapeutic procedures approved by the Clinical Service Chief
☑	☑	Evaluate and treat on the basis of history, physical examination, radiological, laboratory, and other diagnostic test results, pursuant to the practice protocols and collaborative practice agreement
☑	☑	Initiate referrals to other health care providers, and/or consult with the attending physician or the collaborating physician
☑	☑	Admitting and discharge privileges

Specialty Privileges - Nurse Practitioner - Gynecology

Request		*Request all privileges listed below.*
Weill Cornell	Columbia	Click shaded blue check box to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ - Currently granted privileges
		IUD [Minimum Visual Supervision 5 per procedure]
☑	☑	Insertion
☑	☑	Removal
		Contraceptive Implants [Minimum Visual Supervision 5 per procedure]
☐	☐	Insertion
☐	☐	Removal
		Skin [Minimum Visual Supervision 5 per procedure]
☑	☑	Application of Chemical Destructive
☑	☑	Punch Biopsy of Skin
☑	☑	Skin Tag Removal
		Additional Specialty Privileges [Minimum Visual Supervision 5 per procedure]
☑	☑	Performs Colposcopy
☑	☑	Performs Colposcopic Biopsy
☑	☑	Endometrial Biopsy
☑	☑	Foreign Body Removal

Qualifications

Education/Training Documentation of successful completion of an approved, recognized course or hands on experience.

Continuing Education	Applicant must complete continuing education and/or hands on experience to maintain competence as determined by the Chief of Service.
Certification for Contraceptive Implants	Certification of official training Program via Merck/Organon
Requirement at Initial	Must demonstrate competency as determined by at least 5 cases & Provide certification of official training program via Merck/Organon

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at New York-Presbyterian Hospital.

These clinical privileges are approved only for the New York Presbyterian hospital campus(es) and sites(s) specified in my Medical Staff application.

[redacted] 8/10/23

Practitioner's Signature Date

I have reviewed the above practitioner's application, education and training, requested clinical privileges, quality outcomes, and supporting documentation and make the following recommendations:

☐	Recommend all requested privileges
☐	Do not recommend any of the requested privileges
☐	

Privilege	

[redacted] MD

Signature Collaborating/Collaborative Relationship Physician — Date

[redacted] 8/23/23

Signature Service Chief/Designee — Mary D'Alton — Date

BASIC LIFE SUPPORT

BLS Provider

American Heart Association.

[redacted]

has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Basic Life Support (CPR and AED) Program.

Issue Date
10/18/2023

Training Center Name
Vitali Partners, LLC

Training Center ID
TN20925

Training Center City, State
Knoxville, TN

Training Center Phone Number
(800) 991-6511

Training Site Name
CPR Certified Trainer

Renew By
10/2025

Instructor Name
Leslie Durbin

Instructor ID
02221028505

eCard Code
[redacted]

QR Code

To view or verify authenticity, students and employers should scan this QR code with their mobile device or go to www.heart.org/cpr/mycards.

[redacted] **WHNP**

EMPLOYMENT

WHNP, Morris Heights Health Center, Bronx, NY 10/2022 - present
- · Young Adult and Adolescents Health Unit
- · Routine gynecological examinations and pap tests
- · Order and provide STD testing, treatment and Counseling
- · IUD and Nexplanon placement
- · Male exams- sexual health and STD counseling

APC, Planned Parenthood of Greater New York, multiple sites 05/2022 - present
- · Medication Abortion Services

Clinical NP, HHC Covid Testing Site Brooklyn, NY 4/2020 - 05/2022

Civilian RN Covid-19 Hospital/Javits Center Branch, NY, NY 3/2020 - 4/2020
- · Support Covid + patients transferred from local hospitals
- · 1500 bed Military Field hospital

WHNP, Maiden Lane Medical NY, NY 11/2019 - Covid furlough
- · Routine gynecological examinations and pap tests
- · Order and provide STD testing, treatment and Counseling
- · IUD and Nexplanon placement

WHNP, Public Health Solutions Brooklyn, NY 11/2018 - 11/2019
- · Title X funded Sexual and Reproductive Health Clinic

Nurse Manager RN, Parallax NY, NY 11/2017 - 11/2018
- · Education and Administration of MAT
  (Medication-Assisted Treatment of Opioid Use Disorder)

Perioperative RN/Pain Management, Mt. Sinai Beth Israel, NY,NY 7/2011- 7/2016
- · Procedure room admitting and monitoring patient care
- · Assisting with procedures requiring fluoroscopy

EDUCATION

SUNY Downstate Medical Center, MSN, WHNP Brooklyn, NY
SUNY Downstate Medical Center, BSN, Nursing Brooklyn, NY
The Evergreen State College, BA, English Olympia, WA

National Student Clearinghouse®
2300 Dulles Station Blvd., Suite 220, Herndon, VA 20171
PH (703) 742-4200 FX (703) 318-4058
www.studentclearinghouse.org

DegreeVerify Certificate

Transaction ID#: [redacted]
Requested By: NYP CREDENTIALING
Date Requested: 10/03/2023 09:43 EDT
Date Notified: 10/03/2023 09:43 EDT

Status: Confirmed
Fee: $14.95

INFORMATION YOU PROVIDED

Subject Name: [redacted] (First Name) (Middle Name) [redacted] (Last Name)
Date of Birth: [redacted] (mm/dd/yyyy)
School Name: SUNY DOWNSTATE MEDICAL CENTER
Attempt To: Verify a degree

INFORMATION VERIFIED

Name On School's Records: [redacted]
Date Awarded: 05/31/2018
Degree Title: MASTER
Official Name of School: SUNY DOWNSTATE MEDICAL CENTER
Major Course(s) of Study: WOMEN'S HEALTH
(and NCES CIP Code, if available): [redacted]
Dates of Attendance: 09/01/2016 to 05/31/2018
Major Course(s) of Study: WOMEN'S HEALTH
(and NCES CIP Code, if available): [redacted]

Name On School's Records: [redacted]
Date Awarded: 08/31/2011
Degree Title: BACHELOR OF SCIENCE
Official Name of School: SUNY DOWNSTATE MEDICAL CENTER

National Student Clearinghouse®
2300 Dulles Station Blvd., Suite 220, Herndon, VA 20171
PH (703) 742-4200 FX (703) 318-4058
www.studentclearinghouse.org

DegreeVerify Certificate

School Division:	**COLLEGE OF NURSING**
Major Course(s) of Study:	**ACCELERATED NURSING**
(and NCES CIP Code, if available):	[redacted]
Dates of Attendance:	**06/01/2010 to 08/31/2011**
Major Course(s) of Study:	**ACCELERATED NURSING**
(and NCES CIP Code, if available):	[redacted]

[redacted], WHNP-BC®

[redacted]

has earned the following certification from the National Certification Corporation:

Women's Health Care Nurse Practitioner

Earned October 22, 2020 and due December 15, 2026

NCC ID: [redacted] Verified on 9/19/2023 ([redacted])

NATIONAL CERTIFICATION CORPORATION CORPORATE SEAL 1975 Official Seal ILLINOIS

Carol M. Wallman, DNP, APRN, NNP-BC
NCC President

National Practitioner Data Bank
Health Resources and Services Administration
U.S. Department of Health and Human Services
P.O. Box 10832
Chantilly, VA 20153-0832
https://www.npdb.hrsa.gov

Continuous Query ID: [redacted]
DCN: [redacted]
Process Date: 07/25/2023 Page: 1 of 1
[redacted]
For authorized use by:
NEW YORK-PRESBYTERIAN HOSPITAL

[redacted] - CONTINUOUS QUERY RESPONSE

A. SUBJECT IDENTIFICATION INFORMATION (Recipients should verify that subject identified is, in fact, the subject of interest.)

Practitioner Name: [redacted]
Date of Birth: [redacted] **Gender:** FEMALE
Organization Name: NEW YORK-PRESBYTERIAN HOSPITAL
Work Address: 466 LEXINGTON AVE, BOX # 17, 9TH FLOOR, NEW YORK, NY 10017-3140
Home Address: [redacted]
Social Security Number: [redacted]
License: NURSE PRACTITIONER, [redacted], NY
REGISTERED NURSE, [redacted] NY
Professional School(s): SUNY DOWNSTATE MEDICAL CENTER (2018)

B. CONTINUOUS QUERY ENROLLMENT INFORMATION

Enrollment Status: Enrolled - 07/25/2023 - 07/31/2024*
* Unless enrollment is canceled by the entity prior to this date
Statutes Queried: Title IV; Section 1921; Section 1128E
Entity Name: NEW YORK-PRESBYTERIAN HOSPITAL (DBID ending in ...59)
Authorized Submitter: DAISYMAY PARKS, MSO CONSULTANT, (646) 984-8595

C. SUMMARY OF REPORTS ON FILE WITH THE NPDB AS OF 07/25/2023

The following report types have been searched:

Medical Malpractice Payment Report	No Reports	Health Plan Action(s):	No Reports
State Licensure or Certification Action	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

--------- No Reports Found Based on the Subject Information Submitted ---------

NPPES NPI Registry

NPPES

Downloads

API

Help

view all the data associated with the NPI.

Home / Back To Results / NPI View

Please Note: Issuance of an NPI does not ensure or validate that the Health Care Provider is Licensed or Credentialed. For more information please refer to NPI: What You Need to Know

[redacted] WHNP

Gender: Female

NPI: [redacted]

Last Updated: 2018-10-30

Certification Date:

Details

Name	Value
NPI	[redacted]
Enumeration Date	2018-10-30
NPI Type	NPI-1 Individual
Sole Proprietor	YES
Status	Active
Mailing Address	[redacted] [redacted] United States Phone: [redacted] | Fax: View Map

[redacted]

NPPES NPI Registry

NPPES

Downloads

API

Help

	View Map
Secondary Practice Address(es)	
Health Information Exchange	**Endpoint Type** / **Endpoint** / **Endpoint Description** / **Use** / **Content Type** / **Affiliation** / **Endpoint Location**
Other Identifiers	**Issuer** / **State** / **Number**
Taxonomy	**Primary Taxonomy** / **Selected Taxonomy** / **State** / **License Number** Yes / [redacted] - Nurse Practitioner - Women's Health / NY / [redacted]

A federal government website managed by the
U.S. Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244

[redacted]

Registrant Verification For

[redacted]

DEA Number:	[redacted]
Expiration Date:	11/30/2026
Additional Company Info:	COLUMBIA DOCTORS
Registered Address:	[redacted]
City:	NEW YORK
State:	NY
Zip Code:	[redacted]
Business Activity:	MLP-NURSE PRACTITIONER
DEA Schedules:	[redacted]
Payment Indicator:	Paid
Registration Status:	ACTIVE
Date of Verification:	10/03/2023

This Primary Source Verification was obtained from the Drug Enforcement Administration's Controlled Substance Act Registrant Database.

[redacted]

X

LICENSEE INFO

Address	[redacted]
Profession	Nurse Practitioner In Women's Health (042)
License Number	[redacted]
Date of Licensure	October 25, 2018
Status	Registered
Registered through Date	June 30, 2024
Additional Qualifications	• F - Certified with prescriptive privilege
Additional Licenses	• Registered Professional Nursing (022) license # [redacted]

July 27, 2023 10:18 AM (ET)

[redacted]

[redacted]

[redacted]

LICENSEE INFO

Address	[redacted]
Profession	Registered Professional Nursing (022)
License Number	[redacted]
Date of Licensure	January 17, 2012
Status	Registered
Registered through Date	June 30, 2026
Additional Qualifications	• None
Additional Licenses	• Nurse Practitioner In Women's Health (042) [redacted]

November 1, 2023 08:49 AM (ET)

[redacted]

An official website of the United States government
Here's how you know

You have 2 new alerts
Show / Hide Alerts

SAM.GOV®

Search

All Words

e.g. 1606N020Q02

Select Domain
Entity Information

All Entity Information

Entities

Disaster Response Registry

Responsibility / Qualification

Exclusions

Filter By

Keyword Search

For more information on how to use our keyword search, visit our help guide

- Any Words
- All Words
- Exact Phrase

e.g. 123456789, Smith Corp

Classification

Excluded Individual

First Name

Middle Name

Last Name

SSN / TIN

Add Individual

[redacted] ×

Excluded Entity

Federal Organizations

Exclusion Type

Exclusion Program

Location

Dates

Reset

No matches found

We couldn't find a match for your search criteria.

Please try another search or go back to previous results.

Go Back

Feedback

- Our Website
- Our Partners
- Policies
- Customer Service

General Services Administration

This look-up tool is a searchable database that allows you to look up providers who do not wish to enroll in the Medicare program and have "opted out" of Medicare, by their National Provider Identifier (NPI), or by first name and last name.

Find a Provider:

Provider name

[redacted]

[redacted]

NPI number

[redacted]

Specialty

Select speciality

ZIP code

ZIP code

Clear All Find Provider

[redacted]

Displaying **0 - 0** of **0** records Records per page: 10

Sorry, no matches found.

Here are some search tips:

- Make sure all words are spelled correctly.
- Try one or two fewer filters.
- For NPI search, enter the full 10-digit ID
- For CCN search, enter the full 6-character ID

Resources

Resources

Datasets

Information about the tool

This look-up tool is a searchable database that allows you to look up providers who do not wish to enroll in the Medicare program and have “opted out” of Medicare, by their National Provider Identifier (NPI), or by first name and last name.

This data is populated from the Provider Enrollment, Chain, and Ownership System (PECOS) and is updated monthly. It also includes data until the last day of the previous month.

Resources (2)

Featured Resource

Opt Out Affidavits Methodology

View Methodology

Featured Resource

Opt Out Affidavits Data Dictionary

View Data Dictionary

Information about associated datasets

The Opt-Out Affidavits dataset provides information on providers who have decided not to participate in Medicare. It contains provider's NPI, specialty, address, and effective dates.

Related Datasets

Dataset

Opt Out Affidavits

Page last modified
July 19, 2023

Contact us

Didn't find the answer you were looking for?

Email Support

Visit our tips page to learn how to best use the Exclusions Database. If you experience technical difficulties, please email the webmaster at webmaster@oig.hhs.gov.

Exclusions Search Results: Individuals

No Results were found for

[redacted]

If no results are found, this individual or entity (if it is an entity search) is not currently excluded. Print this Web page for your documentation

Search Again

Search conducted 7/27/2023 10:39:48 AM EST on OIG LEIE Exclusions database.
Source data updated on 7/10/2023 9:00:00 AM EST

Return to Search

Office of the Medicaid Inspector General

Medicaid Exclusions ▸ *Search Medicaid Exclusions Results*

Export to PDF

Export to Excel

Search Again

You searched for: [redacted]
List Execution Date: 7/27/2023 10:40:05 AM.
Records returned: 0.
Data was last updated: 07/27/2023 12:01:09 AM.

No records were found matching your search criteria.

[redacted]

X

LICENSEE INFO

Profession: Registered Professional Nursing (022)

License Number: [redacted]

No Enforcement Actions Found

July 27, 2023 10:18 AM (ET)

[redacted]

[redacted]

[redacted]

X

LICENSEE INFO

Profession: Nurse Practitioner In Women's Health (042)

License Number: [redacted]

No Enforcement Actions Found

July 27, 2023 10:18 AM (ET)

[redacted]

[redacted]

ADVICE OF INSURANCE – LIMITED COVERAGE

Date: 11/13/2023

FROM: The New York and Presbyterian Hospital / Columbia University
Medical Center
622 West 168th St
New York, NY 10032

To: [redacted]

For claims history or other required insurance forms, please contact:
Marjorie Moran
Finance, Insurance
466 Lexington Ave, 15th Floor
New York, NY 10017
212-297-5581

Insurance described below has been bound in the name of the following Named Insureds:

- **-THE NEW YORK AND PRESBYTERIAN HOSPITAL**
- **-UNIVERSITY OF ROCHESTER**
- **-THE JOHNS HOPKINS HOSPITAL**
- **-THE JOHNS HOPKINS UNIVERSITY**
- **-YALE NEW HAVEN HOSPITAL, INC.**
- **-YALE UNIVERSITY**
- **-CORNELL UNIVERSITY**
- **-THE TRUSTEES OF COLUMBIA UNIVERSITY IN THE CITY OF NEW YORK**

ADDITIONAL INSURED: [redacted], NP
FORM OF COVERAGE: Hospital, Physicians and Surgeons Professional Liability and Commercial Liability
LIMITS OF LIABILITY:
Professional Liability (Part 1): [redacted]
Commercial General Liability (Part 2):
INSURANCE CARRIER: MCIC Vermont (A Reciprocal Risk Retention Group)
POLICY NUMBER: [redacted]
POLICY AND COVERAGE TERM: 11/01/2023 - 12/31/2023
RETROACTIVE DATE (if applicable): 11/01/2023 **DEPARTMENT:** OB/GYN

PROVISIONS APPLICABLE:

This is a "claims-made" policy and defined terms have the meanings set forth in the policy.

Professional Liability coverage provided to the Additional Insured applies only while such Additional Insured is named on the schedule entitled 'Limited Coverage' submitted by a Named Insured or an Endorsement No. 1 Insured. In addition, such coverage applies only while acting within the scope or course of his or her professional employment if he or she is employed by a Named Insured or an Endorsement No.1 Insured, but if not so employed, such coverage applies only while (i) acting within the scope or course of his or her professional duties within the limitations prescribed by a Named Insured or an Endorsement No. 1 Insured or (ii) acting within the scope or course of a program of approved medical instruction by a Named Insured or an Endorsement No. 1 Insured.

Commercial General Liability coverage provided to the Additional Insured applies while such Additional Insured is : (1) acting within the scope of his or her or its duties for a Named Insured or an Endorsement No. 1 Insured or (2) engaged in the conduct of his or her or its professional business which is located on premises owned or leased by a Named Insured or an Endorsement No. 1 Insured.

The above coverages will automatically terminate upon : (1) the Additional Insured no longer meeting MCIC Vermont eligibility criteria or (2) the termination of such Additional Insured's affiliation with a Named Insured or Endorsement No. 1 Insured.

Tail Coverage is included for a new policy year provided the affiliated Named Insured continues to purchase the above referenced forms of coverage from MCIC Vermont for future Medical Incidents and Occurrences.

Additional terms and conditions of coverage are set forth in the policy corresponding to the policy number noted above (a copy of which may be obtained by contacting the entity noted above as the contact to obtain a claims history and other required insurance forms).

NOTE: The Additional Insured is required to cooperate with the Insurer and its agents at all times in connection with any claims. Insurance coverage may be terminated as a result of breach of this obligation and as otherwise set forth in the policy.

NOTE: The inception of the coverage evidenced herein for the Additional Insured is predicated upon the Additional Insured's (i) successful completion of Credentialing and Privileging (if one or both of the foregoing are applicable) as required by the affiliated Named Insured of such Additional Insured and, if required by the affiliated Named Insured of such Additional Insured, (ii) commencement of (a) employment by a Named Insured, Endorsement No. 1 Insured or Professional Corporation insured by MCIC Vermont (A Reciprocal Risk Retention Group) or (b) a Professional Services Agreement or similar agreement between the Additional Insured and a Named Insured or Endorsement No. 1 Insured (if either of the preceding clause (a) or (b) are applicable).

NOTICE: This policy is issued by your reciprocal risk retention group. Your reciprocal risk retention group may not be subject to all of the insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for your reciprocal risk retention group.

[redacted]

MCIC Vermont (A Reciprocal Risk Retention Group), by its attorney-in-fact MCIC Vermont LLC
76 St. Paul Street, Suite # 500
Burlington, Vermont 05402-1530

ADVICE OF INSURANCE – LIMITED COVERAGE

Date: 12/04/2023

FROM: The New York and Presbyterian Hospital / Columbia University Medical Center
622 West 168th St
New York, NY 10032

To: [redacted]

For claims history or other required insurance forms, please contact:
Marjorie Moran
Finance, Insurance
466 Lexington Ave, 15th Floor
New York, NY 10017
212-297-5581

Insurance described below has been bound in the name of the following Named Insureds:

- **-THE NEW YORK AND PRESBYTERIAN HOSPITAL**
- **-UNIVERSITY OF ROCHESTER**
- **-THE JOHNS HOPKINS HOSPITAL**
- **-THE JOHNS HOPKINS UNIVERSITY**
- **-YALE NEW HAVEN HOSPITAL, INC.**
- **-YALE UNIVERSITY**
- **-CORNELL UNIVERSITY**
- **-THE TRUSTEES OF COLUMBIA UNIVERSITY IN THE CITY OF NEW YORK**

ADDITIONAL INSURED: [redacted], NP
FORM OF COVERAGE: Hospital, Physicians and Surgeons Professional Liability and Commercial Liability
LIMITS OF LIABILITY:
Professional Liability (Part 1): [redacted]
Commercial General Liability (Part 2):
INSURANCE CARRIER: MCIC Vermont (A Reciprocal Risk Retention Group)
POLICY NUMBER: [redacted]
POLICY AND COVERAGE TERM: 01/01/2024 - 12/31/2024

DEPARTMENT: OB/GYN

PROVISIONS APPLICABLE:

This is a "claims-made" policy and defined terms have the meanings set forth in the policy.

Professional Liability coverage provided to the Additional Insured applies only while such Additional Insured is named on the schedule entitled 'Limited Coverage' submitted by a Named Insured or an Endorsement No. 1 Insured. In addition, such coverage applies only while acting within the scope or course of his or her professional employment if he or she is employed by a Named Insured or an Endorsement No.1 Insured, but if not so employed, such coverage applies only while (i) acting within the scope or course of his or her professional duties within the limitations prescribed by a Named Insured or an Endorsement No. 1 Insured or (ii) acting within the scope or course of a program of approved medical instruction by a Named Insured or an Endorsement No. 1 Insured.

Commercial General Liability coverage provided to the Additional Insured applies while such Additional Insured is : (1) acting within the scope of his or her or its duties for a Named Insured or an Endorsement No. 1 Insured or (2) engaged in the conduct of his or her or its professional business which is located on premises owned or leased by a Named Insured or an Endorsement No. 1 Insured.

The above coverages will automatically terminate upon : (1) the Additional Insured no longer meeting MCIC Vermont eligibility criteria or (2) the termination of such Additional Insured's affiliation with a Named Insured or Endorsement No. 1 Insured.

Tail Coverage is included for a new policy year provided the affiliated Named Insured continues to purchase the above referenced forms of coverage from MCIC Vermont for future Medical Incidents and Occurrences.

Additional terms and conditions of coverage are set forth in the policy corresponding to the policy number noted above (a copy of which may be obtained by contacting the entity noted above as the contact to obtain a claims history and other required insurance forms).

NOTE: The Additional Insured is required to cooperate with the Insurer and its agents at all times in connection with any claims. Insurance coverage may be terminated as a result of breach of this obligation and as otherwise set forth in the policy.

NOTE: The inception of the coverage evidenced herein for the Additional Insured is predicated upon the Additional Insured's (i) successful completion of Credentialing and Privileging (if one or both of the foregoing are applicable) as required by the affiliated Named Insured of such Additional Insured and, if required by the affiliated Named Insured of such Additional Insured, (ii) commencement of (a) employment by a Named Insured, Endorsement No. 1 Insured or Professional Corporation insured by MCIC Vermont (A Reciprocal Risk Retention Group) or (b) a Professional Services Agreement or similar agreement between the Additional Insured and a Named Insured or Endorsement No. 1 Insured (if either of the preceding clause (a) or (b) are applicable).

NOTICE: This policy is issued by your reciprocal risk retention group. Your reciprocal risk retention group may not be subject to all of the insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for your reciprocal risk retention group.

[redacted]

MCIC Vermont (A Reciprocal Risk Retention Group), by its attorney-in-fact MCIC Vermont LLC
76 St. Paul Street, Suite # 500
Burlington, Vermont 05402-1530

NewYork-Presbyterian

Medical Staff Office
New York-Presbyterian Hospital
Weill Cornell Medical Center
Columbia University Medical Center
466 Lexington Avenue
New York, NY 10017

June 30, 2021

[redacted]

Dear Ms. [redacted]

We are pleased to inform you that you have been reappointed to the Medical Staff of New York-Presbyterian Hospital from 7/1/2021 to 10/31/2022 in the Department of Surgery.

Your appointment will need to be renewed again prior to 10/31/2022.

The Medical Staff Office will contact you via the email address we have on file, on or about 90 days prior to the start of your next reappointment date to begin your re-credentialing process.

If you have any questions or need further information, please call the Medical Staff Office at 212-585-6410.

Sincerely,

Steven Kaplan, MD
Associate Chief Medical Officer (CUMC)
Stk2002@nyp.org

CC: Chair, Department of Surgery

NewYork-Presbyterian

Medical Staff Office
New York-Presbyterian Hospital
Weill Cornell Medical Center
Columbia University Medical Center
466 Lexington Avenue
New York, NY 10017

November 17, 2022

[redacted]

Dear Ms. [redacted]

We are pleased to inform you that you have been reappointed to the Medical Staff of New York-Presbyterian Hospital at **NYP Columbia University** as a(n) **Nurse Practitioner** from **11/1/2022** to **10/31/2024** in the Department of **Surgery** / **Surgery**.

Your appointment will need to be renewed again prior to **10/31/2024**.

The Medical Staff Office will contact you via the email address we have on file, on or about 90 days prior to the start of your next reappointment date to begin your re-credentialing process.

If you have any questions or need further information, please contact the Medical Staff Office at MSO@nyp.org.

Sincerely,

Steven Kaplan, MD
System Vice President and Chief Medical Officer for Medical and Professional Affairs (CUMC)
Stk2002@nyp.org

CC: Chair, Department of Surgery

NewYork-Presbyterian

Medical Staff
Credentialing Application

The following guidelines apply throughout the Application:

- Fields displayed in **RED** are mandatory and must be answered for the Application to be successfully submitted.

  Note: A completed Application can be forwarded for processing by clicking **Submit** (located at both the top and the bottom of the Application).

- **Attachments, where applicable, can be added while completing the Application by selecting**
  - Add Attachment from the Menu drop-down
  - Examples of requested attachments include the following:
    - Personal Photo
    - Signature
    - Proof of Insurance
    - Copies of credentials (Degree, Diplomas, and Licenses)

The following guidelines apply to specific forms/sections of the Application:

Part/Section	Notes
Attestation Questions	**Responding "yes" to any of the Attestation Questions will open a comment box or Explanations Form where further details must be provided.**
Application Attestation	**An Electronic Signature must be entered together with the last four digits of your SSN and date.**
Additional Records	Copy page **For areas of your application requiring more space: Select the "Check here" box or click on the copy page towards the top of the page to create a duplicate page.**
Reappointment Application	**For your assistance, information is pre-populated where possible. Please review all this information, making changes where appropriate. Please provide updated information since your LAST NYP Appointment (2 year period)**

Practitioner Rights

As NewYork-Presbyterian Hospital's Medical Staff Administration proceeds with the credentialing process required by regulatory and accreditation standards, we want you to be aware of your rights and responsibilities as an applicant.

Action on your application for initial appointment or reappointment will be withheld until all required documentation is available. The credentialing process will begin no later than five business days following receipt of the completed application. The credentialing process will be terminated on any application which remains incomplete for more than thirty days.

In the event information is obtained during our credentialing and verification process that varies substantially from the information you have provided, you will be given an opportunity to clarify the discrepancy.

Deliberate omission or falsification of critical information on your application (i.e., disciplinary actions taken by other State licensing boards, malpractice claims history, board certification decisions) may be reportable to the Office of Professional Medical Conduct.

You have a right to review information obtained by NewYork-Presbyterian Hospital's Medical Staff Administration to evaluate your application. This will include information from organizations such as malpractice insurance carriers and state licensing boards. Peer review/reference or quality assurance information will not be available for review. You may contact the Medical Staff Administration at any time to request information regarding the status of your application for initial appointment or reappointment.

You will receive notification from NewYork-Presbyterian Hospital within fifteen days of the final decision regarding your membership to the Medical Staff and your clinical privileges.

All Medical Staff and Affiliate Staff credentials files are maintained by the Medical Staff Administration and treated as confidential information. Any disclosure of information is regulated and must be requested in writing.

I certify I am aware of my rights as stated above and it is my intent to be fully credentialed by the NewYork-Presbyterian Hospital's Medical Staff Administration. In order for verification of credentials and clinical competence to be obtained on my behalf, I acknowledge consent via my signed attestation.

I acknowledge I have reviewed the Practitioner rights ☒

MEDICAL STAFF CONSENT AND IMMUNITY

REPRESENTATIONS

I have had an opportunity to read a copy of the Hospital bylaws and such Hospital policies and directives as are applicable to members of the medical staff, including the Medical Staff Bylaws and Rules and Regulations. I specifically agree to abide by the bylaws, policies, rules and regulations, and directives that are in force during the time that I am a member of the medical staff.

NOTICE OF IMMUNITY

I understand that the Hospital and its authorized representatives are entitled to seek immunity under New York State Public Health Law §2805-m(3), New York State Education Law §6527(5) and the Health Care Quality Improvement Act (42 USC §11101 *et seq*) (HCQI) and all remedies thereunder in the event that I sue the Hospital or its authorized representatives for good faith actions, recommendations, reports, statements, communications, or disclosures involving me and related to- my professional qualifications (credentials), clinical competence, character, physical and mental condition, ethics, behavior, or any other matter bearing on my qualifications for membership to the medical staff.

RELEASE, IMMUNITY AND CONSENT

Regardless of whether I am appointed/reappointed to the medical staff of the Hospital I agree to the following:

1. I authorize the Hospital and its authorized representatives to consult with any third party who may have information bearing on my professional qualifications (credentials), clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter bearing on my qualifications for membership to the medical staff. I also authorize said third parties to release to the Hospital and its authorized representatives upon request, any documents, recommendations, reports, statements, or disclosures relating to my professional qualifications (credentials), clinical competence, character, physical and mental condition, ethics, behavior, or any other matter bearing on my qualifications for membership to the medical staff.

2. In accordance with HCQI and the aforementioned State laws, I release from liability and agree not to sue any third party who releases information and/or documents to the Hospital in good faith.

AFFIRMATION

I represent that information provided in or attached to this application is accurate. I understand that a condition of this application is that any misrepresentation, misstatement, or omission from this application may be cause for automatic and immediate rejection of this application and may result in the denial of appointment/reappointment and clinical privileges. Upon subsequent discovery of such misrepresentation, misstatement, or omission, the Hospital may terminate my appointment and privileges in accordance with the Medical Staff Bylaws.

[redacted]

Applicant's Signature

[redacted]

Print Name

06/10/2022

Date

NewYork-Presbyterian

Please check the box next to the entity or entities to which you are applying.

NewYork-Presbyterian / Weill Cornell

- ☐ NewYork-Presbyterian Weill Cornell Medical Center
- ☐ NewYork-Presbyterian Lower Manhattan Hospital
- ☐ NewYork-Presbyterian Westchester Behavioral Health Center

NewYork-Presbyterian / Columbia

- ☒ NewYork-Presbyterian Columbia University Irving Medical Center
- ☐ NewYork-Presbyterian Allen Hospital
- ☐ NewYork-Presbyterian Morgan Stanley Children's Hospital
- ☐ NewYork-Presbyterian Lawrence Hospital

☐ **NewYork-Presbyterian Queens**

☐ **NewYork-Presbyterian Hudson Valley Hospital**

☐ **NewYork-Presbyterian Brooklyn Methodist Hospital**

☐ **NewYork-Presbyterian Gracie Square Hospital**

Please select whether you are applying as a:

Physician/Dentist:		*Advanced Practice Professional / Allied Health:*	X

DEMOGRAPHIC AND PROFESSIONAL INFORMATION

Name: [redacted] [redacted] [redacted] NP
Last First MI Degree

List other name by which you have been known: [redacted] [redacted] [redacted]
Last First MI

List other name by which you have been known: _____
Last First MI

If you have been known by other names, please explain why your name changed:

Birth Date: [redacted] Place of Birth: United States
Country

Sex Assigned at Birth: ☐ Male ☒ Female ☐ Non-Binary Gender Identity: Female Pronouns: She/Her/Hers

Preferred Salutation: _____

U.S. Citizen? ☒ Yes ☐ No

If no, do you have legal authority to reside and work in the U.S.? ☐ Yes ☐ No

Home Address: [redacted] [redacted] [redacted] [redacted]
Street City State Zip

Cell Phone: [redacted] Home Phone: [redacted]

E-Mail Address: [redacted]

Please Notify the Medical Staff Administration at MSO@NYP.ORG of any changes to your home address within 30 Days

CONFIDENTIAL INFORMATION:

National Provider Identification Number (NPI): [redacted]

Social Security Number: [redacted]

Medicaid ID#: _____ Medicare ID #_____

Language(s) or Patient Preferred Language:

Hospital personnel and physicians can provide direct services in their patient's preferred language provided that they are fluent in said language (e.g. direct services are those that are within their clinical scope of practice).

Based on the below assessment, those appropriately proficient and fluent to provide direct services in their patient's preferred language are considered Linguist Clinical Communicators (LCC)

This is separate from interpreter services and should be documented accurately in the medical record during every patient encounter.

Please indicate any non-English language(s) you intend to speak to patients and their families in <u>about their care and treatment.</u>	Name of Language(s) 1. Spanish 2. _____ 3. _____

If you indicated that you intend to speak a non-English language in the care of patients, it is <u>required</u> that you assess your proficiency below.

	Language 1		Language 2		Language 3	
I lived in a country where the language written above was spoken and served that community in a clinical role for a minimum of 2 years.	Yes	× No	Yes	No	Yes	No
I completed my clinical degree in the language written above.	Yes	× No	Yes	No	Yes	No
I can speak the language fluently and accurately within the range of my personal and professional experiences. I can communicate effectively with a variety of audiences, tasks and settings. I am comfortable speaking about healthcare. I can understand all forms and styles of speech. I can understand language tailored for different audiences and can infer meanings and implications.	× Yes	No	Yes	No	Yes	No
I speak the language as well as a native speaker or I am a native speaker. I can converse with ease on all topics including health care. I can understand educated and academic speech. My comprehension of the language is equal to that of a well-educated native speaker.	× Yes	No	Yes	No	Yes	No

<u>Linguists Clinical Communicators Attestation</u>

Should you answer "yes" to any one of the statements above, you are considered a Linguist Clinical Communicator and therefore able to communicate directly about care and treatment in that preferred language.

I meet the requirements to be a Linguist Clinical Communicator to communicate directly with patients in the language(s) detailed above about clinical matters that impact their health care decisions. I understand that at any time if I am not comfortable speaking the language(s) during any patient interaction, I will use hospital-approved interpreter services. In addition, at any point a patient or family member has the right to request interpreter services.

By signing my name below, I certify my responses stated above are true and correct to the best of my knowledge.

Name: [redacted] _____ Date: 06/10/2022

Otherwise, you must use a hospital-approved interpreter service to communicate clinical information with patients

I do not meet the requirements to be a Linguist Clinical Communicator. I understand that I must use a hospital-approved interpreter service to communicate clinical information with patients.

By signing my name below, I certify my responses stated above are true and correct to the best of my knowledge.

Name: _____ Date: _____

Policy: I-160 Communication Access For Patients

NewYork-Presbyterian

Alternate/Collaborating/Supervising Physician:

Do you have a NewYork-Presbyterian Hospital covering physician to care for your patients in your absence? ☒ Yes ☐ No

For **Nurse Practitioners**: please indicate the name of your Collaborating Physician.

For **Physician Assistants**: please indicate the name of your Supervising Physician.

Name	Contact Phone Number	Specialty
[redacted]	[redacted]	[redacted]
	( ) - Ext	
	( ) - Ext	

Please select 'Copy Page' at the top of the screen to add additional information.

PROFESSIONAL INFORMATION

New York Professional License Number [redacted] Type of Licensure: Nurse Pending ☐

Free from any restrictions or limits? Yes ☒ No ☐ → If no, please explain limitation:

New York RN License Number: [redacted]

Free from any restrictions or limits? Yes ☒ No ☐ → If no, please explain limitation:

Current and Previous Professional License(s) in Other States

State: License #: Type of Licensure: Exp. Date:

Free from any restrictions or limits? Yes ☐ No ☐ → If no, please explain limitation:

State: License #: Type of Licensure: Exp. Date:

Free from any restrictions or limits? Yes ☐ No ☐ → If no, please explain limitation:

State: License #: Type of Licensure: Exp. Date:

Free from any restrictions or limits? Yes ☐ No ☐ → If no, please explain limitation:

Please select 'Copy Page' at the top of the screen to add additional information.

FEDERAL DEA LICENSE NUMBER

Please list the information for each DEA license. Please note that you must have a valid DEA address in New York State to be credentialed by NewYork-Presbyterian Hospital.

Current Federal DEA License Number: [redacted] State: NY Status: Active

DEA Expiration Date: [redacted] Free from any restrictions or limits? Yes ☒ No ☐

If no, please explain limitation:

Current and Previous State Controlled Substance Number(s):

CONFIDENTIAL INFORMATION

State: _____ CS License #: _____ Expiration Date: _____

State: _____ CS License #: _____ Expiration Date: _____

Please identify all limitation related to the above Controlled Substances Number(s) and explain limitation.

CURRENT AND PREVIOUS PROFESSIONAL LIABILITY INSURANCE

Please provide information on your current and previous professional liability insurance carriers. If there has been a break or gap in coverage please provide an explanation below.

FOR REAPPOINTMENT: Please list all active insurance carriers, or carriers which provided malpractice coverage for you in the last two years.

CONFIDENTIAL INFORMATION:

Carrier: [redacted]

Policy Number: [redacted] Retroactive Date: [redacted] Expiration Date: [redacted]

Policy Limits: Per Occurrence: $_____ Aggregate: $_____ Other: $ _____

What type of coverage do you have? [redacted]

If claims made policy, do you have tail coverage: ☐ Yes ☐ No

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?

☐ Yes ☐ No

CONFIDENTIAL INFORMATION:

Carrier: _____

Policy Number: _____ Retroactive Date: _____ Expiration Date: _____

Policy Limits: Per Occurrence: $_____ Aggregate: $_____ Other: $ _____

What type of coverage do you have? _____

If claims made policy, do you have tail coverage: ☐ Yes ☐ No

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?

☐ Yes ☐ No

Have you ever had any gap in coverage? ☐ Yes ☐ No

From: _____ To: _____

Explanation:

Please select 'Copy Page' at the top of the screen to add additional information

CURRENT AND PAST APPOINTMENTS AND AFFILIATIONS

Please list all other hospitals, nursing homes, clinics, other healthcare organizations, military assignments, government agencies, schools, locum tenens assignments, humanitarian and/or private practices where you have worked clinically since Professional/Medical School. Gaps of more than 60 days requires explanation in the gap history section.

FOR REAPPOINTMENTS: Please document any facilities where you hold active privileges, or facilities where you have held privileges and resigned in the last two years.

[redacted]

Name: [redacted]

Affiliation Type: [redacted] Membership Status: [redacted]

Address: [redacted]
Street City State Zip Country

Medical Staff Office Phone: [redacted] From: [redacted] To: [redacted]

Department/Division: [redacted] Specialty: [redacted]

Department Head/Supervisor Name: [redacted] Email:

Malpractice Carrier at this Institution: Policy Number:

Any limitations in your area of specialty at this hospital?

[redacted]

Name: [redacted]

Affiliation Type: Work History Membership Status: [redacted]

Address: [redacted]es
Street City State Country

Medical Staff Office Phone: [redacted] From: [redacted] To [redacted]

Department/Division: [redacted] Specialty: [redacted]

Department Head/Supervisor Name: [redacted] Email:

Malpractice Carrier at this Institution: Policy Number:

Any limitations in your area of specialty at this hospital?

Do you have any gap in your education, work history, and/or affiliations greater than sixty (60) days?

☐ Yes ☒ No

PROFESSIONAL HISTORY: CONFIDENTIAL

Applicants for initial appointment/reappointment must answer all questions below.

FOR REAPPOINTMENT, answer these questions with information since your last reappointment period.

Please answer the following questions to the best of your knowledge with a "yes" or "no."

ADVERSE OR OTHER ACTIONS

If you answer "yes" to any question, please provide explanation within the comment box.

1.	Has your professional license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily?	☐ Yes	☒ No
2.	Have you ever withdrawn an application for a professional license to practice your profession?	☐ Yes	☒ No
3.	Have you ever been reprimanded and/or fined by any state or federal agency which licenses providers?	☐ Yes	☒ No
4.	Have you ever been the subject of a legal complaint by any state or federal agency which licenses providers?	☐ Yes	☒ No
5.	Have you ever been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licensed providers?	☐ Yes	☒ No
6.	Has your participation in any internship, residency, or other training program ever been suspended, restricted or terminated prior to completion?	☐ Yes	☒ No
7.	Have you ever been denied certification of completion of your internship, residency, or other training program?	☐ Yes	☒ No
8.	Have you ever voluntarily left any internship, residency, or other training program?	☐ Yes	☒ No
9.	Have you ever involuntarily relinquished participation in any internship, residency, or other training program?	☐ Yes	☒ No
10.	Have you been denied initial or recertification for any Boards or subspecialty Boards?	☐ Yes	☒ No
11.	If you are not currently Board certified, have you attempted to take your boards and failed to pass?	☐ Yes	☒ No
12.	Has any information pertaining to you, been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data banks including without limited to malpractice and/or disciplinary actions?	☐ Yes	☒ No
13.	Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntary or involuntary?	☐ Yes	☒ No
14.	Have you ever been notified in writing that you are being investigated as the possible subject of a criminal disciplinary action with respect to your DEA or controlled substance registration?	☐ Yes	☒ No

15. Have your clinical privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed by any hospital or facility to where you've practiced? ☐ Yes ☒ No

16. Have you ever voluntarily relinquished your clinical privilege and/or membership at a hospital or a facility where you've practiced while under investigation? ☐ Yes ☒ No

17. Have you involuntarily relinquished or failed to seek renewal of your clinical privileges and/or membership for any reason? ☐ Yes ☒ No

18. Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or facility where you've held privileges and/or your license? ☐ Yes ☒ No

19. Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and/or any other governmental health-related programs? ☐ Yes ☒ No

20. Have you ever been denied membership in or voluntarily or involuntarily been terminated by any professional organization? ☐ Yes ☒ No

21. Have Medicare, Medicaid, CHAMPUS, Peer Review Organization (PRO) authorities and/or any other third party payers brought charges against you for alleged inappropriate fees and/or quality-of-care issues? ☐ Yes ☒ No

22. Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action by any health care organization, e.g. hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO? ☐ Yes ☒ No

23. Have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g. hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO? ☐ Yes ☒ No

24. Have you withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision? ☐ Yes ☒ No

25. Are you currently performing, or do you plan to perform, any procedures for which you have ever been refused or lost privileges? ☐ Yes ☒ No

26. Have you ever been found guilty of violations of Patient's rights? ☐ Yes ☒ No

For INITIAL APPLICANTS, please provide full detail and disclosure.
FOR REAPPOINTMENT, answer these questions with updated/new information since your last reappointment period.

PROFESSIONAL LIABILITY ACTIONS

If you answer "yes" to any question, please complete Form A

1.	Have you ever been named on any professional liability action (past or pending)?	☐ Yes	☒ No
2.	Has any professional liability judgement ever been entered against you?	☐ Yes	☒ No
3.	Has any professional liability claim settlement ever been paid by you and/or paid on your behalf?	☐ Yes	☒ No
4.	Are there currently any pending professional liability suits, actions and/or claims filed against you?	☐ Yes	☒ No

LIABILITY INSURANCE

If you answer yes to this question please complete Form B

1.	Has your professional liability insurance ever been denied, suspended, limited, not renewed or terminated?	☐ Yes	☒ No

CRIMINAL ACTIONS

If you answer "yes" to any question, please complete Form C

1.	Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country?	☐ Yes	☒ No
2.	Have you been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action including but not limited to any such actions regarding sexual misconduct, child abuse, domestic violence or elder abuse?	☐ Yes	☒ No

MEDICAL CONDITION

If you answer "yes" to any question, please complete Form D

1.	Do you currently have any mental or physical conditions that would compromise your ability to perform any essential functions of your responsibilities?	☐ Yes	☒ No
2.	Do you currently have any mental or physical conditions that would adversely affect your ability to perform the essential functions required by the participation status you are requesting?	☐ Yes	☒ No
3.	Do you currently have any mental or physical conditions that would adversely affect your ability to perform the essential functions required by the clinical privileges you are requesting?	☐ Yes	☒ No

CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

If you answer "yes" to any question, please complete Form E

1. Are you currently engaged in illegal use of any legal or illegal substances? ☐ Yes ☒ No

2. If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine or to perform essential functions of your position with reasonable skill and safety? ☐ Yes ☒ No

3. Are you currently participating in a supervised rehabilitation program and/or professional assistance program which monitors you for alcohol and/or substance abuse? ☐ Yes ☒ No

CONTINUING EDUCATION SUMMARY

Physicians and Dentists: As per the NYPH Medical Staff By-laws, all members of the Medical Staff are required to obtain 100 CME credits over each appointment cycle. These 100 credits over 2 years must include a minimum of 70 credits of Category 1 activities and a minimum of 10 credits of risk management education which is satisfied by taking the NYPH Annual Hospital Training each year of a 2 year cycle. Please note these credits may not be recognized by a state medical licensing agency or professional society.

Members of the **Professional Associate Staff** appointed through the Medical Staff Office are required to complete the number for continuing education credits required by the NYPH Medical Staff By-laws, the applicable New York State licensing agency and/or professional society.

Physician Assistants: 100 CME credits every two years, based on the year of your NCCPA certification.
Podiatrist: 50 hours every three years as required by the New York State Board for Podiatry.
Audiologist: 30 hours every three years as required by the New York Education Law.
Optometrist: 36 hours every three years as required by the New York Education Law.
Psychologist, Physicist, Radiology Techs and Pathology Techs: 20 hours per year as required by NewYork-Prebyterian Hospital.
Certified Registered Nurse Anesthetist: 40 hours every two years, as per New York State.
Registered Nurse First Assist: 300 points every 5 years as required by CNOR.
Nurse Practitioner:
American Academy of Nurse Practitioners: 100 hours of CEs every 5 years.
National Certificate Corporation: 10 to 50 hours of CEs based on your education plan.
Midwives: 20 hours of CEs every 5 years as required by the American Midwifery Certification Board.

I attest that I am in compliance with the applicable continuing education requirements listed above.

☒ Yes ☐ No

CONFLICT OF INTEREST

If you answer "yes" to any question, please complete Form F

1. Do you or a relative have any of the following relationships with an entity that does or, to your knowledge, is seeking to do business with NYP?
   a. As an officer, director, trustee, employee, agent or consultant of the entity; OR
   b. Have an ownership, partnership, financial or voting interest in the entity (you need not report any financial interest in less than 5% of the outstanding publicly traded shares of a supplier or purchaser of goods or services unless the financial interest is substantial in relation to your assets or the assets of your relative); OR
   c. Receive any compensation or income from the entity

   ☐ Yes ☒ No

2. Within the last year, did you or a relative receive any gifts, entertainment, reward or other benefit of more than nominal value or hold any loans from any source with which NYP conducts business or, to your knowledge, is seeking to conduct business? (You do not need to report any benefit received from NYP.)

   ☐ Yes ☒ No

3. Within the last year, did you or a relative engage in any transaction with NYP? *"Transaction" is defined as the purchase, sale, license or lease of assets by or to NYP, the rendering of services in any capacity for compensation to or from NYP, or any salary, wages or bonuses, any benefit received under any NYP written employee benefit plans or arrangements, any reimbursement of expenses made in conformity with any NYP reimbursement procedures, any healthcare services received from NYP, or any residential leases from NYP, on customary terms.)*

   ☐ Yes ☒ No

4. Are you a member of the governing board, an officer or other employee of any healthcare institution other than NYP?

   ☐ Yes ☒ No

5. Do you have any relatives employed by NYP?

   ☐ Yes ☒ No

6. Do you or a relative know of any interest or activity not listed above, which may possibly be regarded as constituting a conflict of interest as described in NYP's Conflict of Interest Policy or Code of Conduct?

   ☐ Yes ☒ No

I certify that I:

☒ Have received a copy of the Conflict of Interest Policy Statement;

☒ Have read and understand the Policy;

☒ Have agreed to comply with the Policy, and to update the information provided in this questionnaire in the event of any changes;

☒ Understand NYP is a charitable organization and in order to maintain its federal tax exemption it must engage primarily in activities which accomplish one or more of its tax-exempt purposes.

NewYork-Presbyterian Confidentiality, Privacy and Information Security Agreement

The processing of employee and patient information is a key function of NewYork-Presbyterian ("NYP"). In order to ensure the confidentiality of this information, each employee, student or trainee, affiliate, contractor, vendor or volunteer must read, sign and be governed by the following statements:

- Employee and patient records contain confidential information including but not limited to salaries, disciplinary actions, patient health information and patient financial information; they are privileged business documents belonging to NYP. Records include paper, printed and electronic files and documents.
- Privileged information encountered through routine review functions, such as those performed by NYP personnel must not be compromised or divulged. Discussion, access and/or reading of employee or patient records for non-job related reasons are prohibited. Under no circumstances should employee or patient information be discussed casually, socially, or in public areas.
- Requests for employee information should be directed to Human Resources. Requests for patient information should be directed to Health Information Management (Medical Records).
- All personnel are warned to be alert to any attempts by unauthorized persons to obtain employee or patient information though unscrupulous, devious or illegal means that are in violation of established policies of NYP. This information is valuable and confidential; and is protected by law and by strict NYP policies.
- Proprietary information such as financial and statistical records, purchasing and internal reports must also be kept confidential and only disseminated on a need to know basis.

Specific to patient privacy and safeguarding protected health information ("PHI"), you here by attest to comply with the standards and expectations outlined below; and to appropriately use, disclose and safeguard PHI and the systems that maintain it.

Patient Privacy:

- Adhere to privacy laws and regulations, and applicable NYP policies and procedures
- Handle and maintain patient information in a confidential and secure manner
- Safeguard PHI, in any format (verbal. paper. electronic), and the systems you have access to
- Only use or disclose PHI as permissible by law
- Only access, use or disclose PHI as required to fulfill job duties and only for legitimate business purposes
- Only access, use or disclose the *"minimum necessary"* PHI to satisfy the intended purpose
- Avoid discussing PHI in public areas (elevators, cafeteria, public hallways/ waiting areas, etc.)
- Obtain patient's permission prior to disclosing PHI in front of family or friends
- Seek guidance when uncertain about appropriate use or disclosure of PHI
- Avoid printing PHI, whenever possible, and appropriately secure when required for retention
- Shred or appropriately destroy all printed documentation and other media that contains PHI as required
- Avoid removing PHI from the facility (paper, on laptop, flash drive, etc.)
- Do not take pictures or videos of patients for personal use, or with a personal device
- Do not discuss patient information in social settings, with my family or friends; or post any patient information on social media
- Abide by special privacy protection provisions regarding "Sensitive Health Information" (Mental Health , Substance Abuse , HIV/Aids, Reproductive Health, Genetic information)

Information Security:

- Adhere to Information Security laws and regulations and applicable NYP policies and procedures
- Access systems containing employee and patient health information only as needed to perform your duties as defined by your relationship (faculty, employment, student, contract, etc.) with NYP.

- You must not access employee or patient health information for which you have no legitimate business needs
- You must not use, disclose, copy, release, alter, revise, or destroy any employee or patient health information except as properly authorized within the scope of your relationship with NYP.

- Safeguard and protect your individual credentials (user ID and password) or any other user credentials that allow for access to employee or patient health information. You will be responsible for all activities undertaken using your credentials and other authorizations.
  - You must secure (lock or sign out) your system when not occupied;
  - You must sign off of computer systems after use;
  - You must not share or allow anyone access to systems containing employee or patient health in formation under your individual account; and
  - You must not use another user's individual account to access any systems
- Abide by NYP policies and procedures regarding use of any devices that may contain any employee and patient health information including the use of encryption or other equivalent method of protection when required.
- Upon termination of your relationship with NYP, you will return all institutional information and devices or dispose of them in accordance with hospital policies regarding the disposal of electronic equipment.
- Communication using the NYP network and systems is not private, and the institution may monitor the content of your communication to protect the confidentiality and security of NYP data.
- You have no right or ownership interest of any employee or patient health information. NYP may at any time revoke your employee account, other authorization, or access to employee and patient health information. At all times during your relationship with NYP, you will act in the best interests of NYP.
- You will be responsible for any misuse or wrongful disclosure of employee and patient health information and for any failure to safeguard your account credentials should they be used to access employee and patient health information.

Representations:

- I have had an opportunity to read a copy of the Hospital bylaws and such Hospital policies and directives as are applicable to members of the medical staff, including the Medical Staff Bylaws and Rules and Regulations. I specifically agree to abide by the bylaws, policies, rules and regulations, and directives that are in force during the time that I am a member of the medical staff.

- I have had an opportunity to read a copy of the Code of Conduct and such Hospital policies and directives as are applicable to members of the medical staff. I specifically agree to abide by the Code of Conduct, policies, rules and regulations, and directives that are in force during the time that I am a member of the medical staff.

Reporting Obligations:

You have an affirmative responsibility to report issues or concerns regarding employee and/or patient health information immediately to the Office of Corporate Compliance at (212) 746-16 44. As such, you agree to:

- Report any suspicion or knowledge of unauthorized access to systems
- Report any misuse or disclosure of employee or patient health information
- Report, in accordance with NYP policies, activities by any individual that you suspect may compromise the confidentiality of employee or patient health information.

NYP prohibits retaliation in any form for good faith reporting of suspect activities and will maintain reported incidents in confidence to the extent permitted by law.

By signing this document, you agree to the requirements set forth within and understand that compliance with these provisions is a condition of your employment or affiliation with NYP. In addition, you attest to understanding that failure to comply may result in disciplinary action up to and including loss of privileges and termination in accordance with the Medical Staff Bylaws.

AFFIRMATION

I represent that the information provided in or attached to this application is accurate and complete. I understand that a condition of this application is that any misrepresentation, misstatement, or omission from this application may be cause for automatic and immediate rejection of this application and may result in the denial of appointment/reappointment and clinical privileges. Upon subsequent discovery of such misrepresentation, misstatement, or omission, the Hospital may terminate my appointment and privileges in accordance with the Medical Staff Bylaws.

PLEASE NOTE: IF YOUR MALPRACTICE INSURANCE IS OBTAINED FROM MCIC, INFORMATION FROM THIS APPLICATION MAY BE SHARED WITH MCIC.

[redacted]

Practitioner's Signature

[redacted]	[redacted]	06/10/2022
Electronic Signature -Type full name	*Last 4 digits of SSN*	*Date*

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Nurse Practitioner - Surgery RNFA

Delineation of Privileges

Applicant's Name: [redacted]

Instructions:

1. Click the **Request** checkbox to request a group of privileges such as *Primary Privileges* or a Privilege Cluster.
2. Uncheck any privileges you do not want to request in that group.
3. Check off any special privileges you want to request.
4. Sign form electronically and submit with any required documentation.

[redacted] Required Qualifications	
Education and Training	Documentation of successful completion of an approved, recognized course or hands on experience.
Certification/Licensure	The applicant shall be a currently Licensed Registered Nurse with a Nurse Practitioner Certification/Licensure in the relevant specialty area(s). **AND** Certification to issue prescriptions under Section 6902.3(b) of the Education Law.
Performance of Services	Services by a nurse practitioner are rendered in collaboration with a licensed physician qualified to collaborate in the specialty involved. **AND** All services rendered by a nurse practitioner are performed in accordance with a written collaborative practice agreement and practice protocol, which must be agreed to by the nurse practitioner and the collaborating physician. **AND** Clinical privileges assigned to registered professional nurses at NYP are as outlined in the New Your State Nurse Practice Act and the Nursing By-Laws.
Additional Qualifications	A Nurse Practitioner who is granted admitting privileges by the Board of Trustees may admit patients to, and discharge patients from the Hospital and may follow such patients during hospitalization. **AND** Patients admitted by a Nurse Practitioner must be assigned an Attending Physician who is a member of the Medical Staff and will be designated as the attending of record.

[redacted]

Qualifications	
Continuing Education	Applicant must complete continuing education and/or hands on experience to maintain competence as determined by the Chief of Service.

NP Registered Nurse First Assistant (RNFA) Delineation of Privileges

Request		*Request all privileges listed below.*
Weill Cornell	Columbia	Click shaded blue check box to Request all privileges. Uncheck any privileges you do not want to request.
☐	☑	☑ - Currently granted privileges
		Core Privileges for NP Registerd Nurse First Assistant (RNFA)
☐	☐	Procedures of the kidney; ureters; bladder; prostate; scrotum including testicles and vagina and such other procedures that are extensions of the same techniques and skills.
☐	☑	Preoperative evaluation; positioning, prepping and draping the patient; providing exposure through the use of instruments, retractors, suctioning and sponging techniques.
		Extended Privileges as Approved by Service Chief
☐	☑	Provides homeostasis by clamping blood vessels, coagulating bleeding, ligating vessels and by other means as directed by the surgeon
☐	☑	Performs wound closure as directed by the surgeon; sutures the peritoneum, fascia, subcutaneous tissue and skin
☐	☑	Assist as directed by the surgeon during laparoscopic procedures
☐	☐	Provide laser assistance as directed by surgeon [Requires Completion of Annual Laser Safety Training for Registered Nurses]
☐	☑	Handles and/or cuts tissue as directed

Qualifications	
Education/Training	Applicant must have graduated from a Nurse Practitioner Program related to their specialty. **AND** Completion of a course that meets the Association of Operating Room Nurses' Standards for RNFA Education Programs.
Additional Qualifications	Applicant must have a current RNFA Certification. **AND** Applicant must meet requirements of status and regulations.

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at New York-Presbyterian Hospital.

[redacted] _____ Date 6/10/2022

[redacted]

Core Privileges - Nurse Practitioner - Surgery RNFA

Request: Weill Cornell	Request: Columbia	Request all privileges listed below. Click shaded blue check box to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ - Currently granted privileges
		Provide direct care to patients through the following activities:
☐	☑	Take comprehensive history and perform physical examinations
☐	☑	Perform diagnostic testing and therapeutic procedures approved by the Clinical Service Chief
☐	☑	Evaluate and treat on the basis of history, physical examination, radiological, laboratory, and other diagnostic test results, pursuant to the practice protocols and collaborative practice agreement
☐	☑	Initiate referrals to other health care providers, and/or consult with the attending physician or the collaborating physician
☐	☑	Admitting and discharge privileges

Specialty Privileges - Nurse Practitioner - Surgery RNFA

Request: Weill Cornell	Request: Columbia	Request all privileges listed below. Click shaded blue check box to Request all privileges. Uncheck any privileges you do not want to request.
☐	☐	☐ - Currently granted privileges
		Arterial Catheters [Minimum Visual Supervision 3 per procedure]
☐	☐	Insertion
☐	☑	Removal
		Skin [Minimum Visual Supervision 2 per procedure]
☐	☐	Delayed Hypersensitivity Skin Test
☐	☐	Punch Biopsy of Skin
☐	☐	Scraping
☐	☐	Skin Tag Removal
☐	☐	Subungual Hematoma Evacuation
		Additional Specialty Privileges
☐	☐	Anoscopy [Minimum Visual Supervision 3]
☐	☑	Arterial Puncture for Blood Gas [Minimum Visual Supervision 2]
☐	☐	Performing Abdominal Ultrasound [Minimum Visual Supervision 20]
☐	☑	Suture Wounds and Lacerations [Minimum Visual Supervision 3]
☐	☑	Remove Sutures [Minimum Visual Supervision 3]
☐	☑	Nasogastric Tube Placement [Minimum Visual Supervision 3]
☐	☑	Drain Removal [Minimum Visual Supervision 3]
☐	☑	Staple Removal [Minimum Visual Supervision 3]
☐	☑	Incision and Drainage of Subcutaneous Abscess [Minimum Visual Supervision 3]

[redacted]

I have reviewed the above practitioner's application, education and training, requested clinical privileges, quality outcomes, and supporting documentation and make the following recommendations:

☒	Recommend all requested privileges
☐	Do not recommend any of the requested privileges

Privilege	

[redacted]

Signature Collaborating/Collaborative Relationship Physician — Date: 6/14/22

[redacted]

Signature of Service Chief/Designee — Date: 06/17/2022

ADVANCED CARDIOVASCULAR LIFE SUPPORT

ACLS Provider

American Heart Association.

[redacted]

has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Advanced Cardiovascular Life Support (ACLS) Program.

Issue Date

[redacted]

Training Center Name

[redacted]

Training Center ID

[redacted]

Training Center City, State

New York, NY

Training Center Phone Number

[redacted]

Renew By

01/2024

Instructor Name

[redacted]

Instructor ID

[redacted]

eCard Code

[redacted]

QR Code

[redacted]

To view or verify authenticity, students and employers should scan this QR code with their mobile device or go to www.heart.org/cpr/mycards.

BASIC LIFE SUPPORT

BLS Provider

American Heart Association.

[redacted]

has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Basic Life Support (CPR and AED) Program.

Issue Date
[redacted]

Training Center Name
[redacted]

Training Center ID
[redacted]

Training Center City, State
New York, NY

Training Center Phone Number
[redacted]

Renew By
07/2024

Instructor Name
[redacted]

Instructor ID
[redacted]

eCard Code
[redacted]

QR Code
[redacted]

To view or verify authenticity, students and employers should scan this QR code with their mobile device or go to www.heart.org/cpr/mycards.

ANCC
AMERICAN NURSES CREDENTIALING CENTER
CERTIFICATION

The Commission on Certification grants

[redacted]

the credential of

FAMILY NURSE PRACTITIONER
FNP-BC

valid from August 7, 2021 to August 6, 2026

Certification Number: [redacted]

COMMISSION ON CERTIFICATION
BOARD CERTIFIED
AMERICAN NURSES CREDENTIALING CENTER
ANCC

Heidi McNeely

Heidi McNeely, MSN, RN, PCNS-BC
Chair, Commission on Certification

Rhonda Anderson DNSc(h), MPA, RN, FAAN

Rhonda Anderson, DNSC(h), MPA, RN, FAAN
President, American Nurses Credentialing Center

NCCA
ABSNC Accreditation Board for Specialty Nursing Certification
Formerly the ABNS Accreditation Council

This ANCC certification is accredited by the National Commission for Certifying Agencies and the Accreditation Board for Specialty Nursing Certification.

National Practitioner Data Bank
Health Resources and Services Administration
U.S. Department of Health and Human Services
P.O. Box 10832
Chantilly, VA 20153-0832
https://www.npdb.hrsa.gov

[redacted] 1

For authorized use by:
NEW YORK PRESBYTERIAN HOSPITAL

[redacted]- CONTINUOUS QUERY RESPONSE

A. SUBJECT IDENTIFICATION INFORMATION (Recipients should verify that subject identified is, in fact, the subject of interest.)

Practitioner Name: [redacted]
Date of Birth: [redacted] **Gender:** FEMALE
Other Name(s) Used: [redacted]
Organization Name: NEW YORK PRESBYTERIAN HOSPITAL
Organization Type: [redacted]
Work Address: [redacted]
Home Address: [redacted]
Social Security Number: [redacted] **DEA:** [redacted]
NPI: [redacted]
License: REGISTERED NURSE, [redacted]
NURSE PRACTITIONER, [redacted]
Professional School(s): [redacted]

B. CONTINUOUS QUERY ENROLLMENT INFORMATION

Enrollment Status: Enrolled - 03/25/2013 - 03/31/2023*
* Unless enrollment is canceled by the entity prior to this date
Statutes Queried: Title IV; Section 1921; Section 1128E
Entity Name: NEW YORK PRESBYTERIAN HOSPITAL [redacted]
Authorized Submitter: SUSANA CLARKE, CREDENTIALING ANALYST, (212) 585-6416

C. SUMMARY OF REPORTS ON FILE WITH THE NPDB AS OF 06/10/2022

The following report types have been searched:

Medical Malpractice Payment Report	No Reports	Health Plan Action(s):	No Reports
State Licensure or Certification Action	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

---------- No Reports Found Based on the Subject Information Submitted ----------

Provider Information for [redacted]

Search (/registry/) / Back to Results / NPI View

Please Note: Issuance of an NPI does not ensure or validate that the Health Care Provider is Licensed or Credentialed. For more information please refer to NPI: What You Need to Know (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/NPI-What-You-Need-To-Know.pdf)

[redacted]

[redacted]

Gender: FEMALE

NPI: [redacted]

Last Updated: 2007-11-28
Certification Date:

Details

Name	Value
NPI	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Name	Value
Mailing Address	[redacted] [redacted] [redacted] Phone: [redacted] | Fax: View Map (/registry/map-view?q=4[redacted]United States)
Primary Practice Address	[redacted] [redacted] [redacted] Phone: [redacted] | Fax: [redacted] View Map (/registry/map-view?q=[redacted]United States)

Health Information Exchange

Endpoint Type	Endpoint	Endpoint Description	Use	Content Type	Affiliation	Endpoint Location

Other Identifiers

Issuer	State	Number

Taxonomy

Primary Taxonomy	Selected Taxonomy	State	License Number
Yes	[redacted] - Nurse Practitioner Family	NY	[redacted]

Data Provided by:
DEA
U.S. Department of Justice, Drug Enforcement Administration, Diversion Control Division

Current Date: 6/26/2022 **Data File Release Date:** 6/26/2022

Drug Enforcement Administration (DEA) Datafiles

Registrant Profile

for

[redacted] **NP**

Address: [redacted]

State and Zip: [redacted]

DEA Number: [redacted]

Drug Schedule: [redacted]

Expiration Date: 6/30/2024

Status: ACTIVE

Business Activity: MLP-Nurse Practitioner

Payment Indicator: **P**aid

Data Provided by:

NYSED Office of Professions

Data made available by weekly file download

Current Date: 11/2/2022 **Data File Published Date:** 10/30/2022

License Information

Name:	[redacted]
Address:	[redacted]
Profession:	NURSE PRACTITIONER IN FAMILY HEALTH
License No:	[redacted]
Date of Licensure	[redacted]
Additional Qualification:	F - Certified with prescriptive privilege
Status:	Registered
Discipline Indicated:	No
Registration End Date:	12/31/2025

Online Services

Verifications

- Licensees, by name
- Licensees, by license number
- Permits, by name
- Pharmacy Establishments
- Professional Business Entities (other than pharmacies)
- Help with Searches
- Terms of Use

Registration Renewal

- Renewal Information

NYSED / OP / Online Services

Verification Searches

The information furnished at this web site is from the Office of Professions' official database and is updated daily, Monday through Friday. The Office of Professions considers this information to be a secure, primary source for license verification.

License Information *

08/11/2022

Name : [redacted]
Address : NEW YORK NY
Profession : NURSE PRACTITIONER IN FAMILY HEALTH
License No: [redacted]
Date of Licensure : [redacted]5
Additional Qualification : F - Certified with prescriptive privilege
Status : REGISTERED
Registered through last day of : 12/22

* Use of this online verification service signifies that you have read and agree to the terms and conditions of use. See HELP glossary for further explanations of terms used on this page.

- Use your browser's back key to return to licensee list.
- You may search to see if there has been recent disciplinary action against this licensee.
- Note: The Board of Regents does not discipline *physicians(medicine), physician assistants,* or *specialist assistants.* The status of individuals in these professions may be impacted by information provided by the NYS Department of Health. To search for the latest discipline actions against individuals in these professions, please check the New York State Department of Health's Office of Professional Medical Conduct homepage.

Online Services

Verifications

- Licensees, by name
- Licensees, by license number
- Permits, by name
- Pharmacy Establishments
- Professional Business Entities (other than pharmacies)
- Help with Searches
- Terms of Use

Registration Renewal

- Renewal Information

NYSED / OP / Online Services

Verification Searches

The information furnished at this web site is from the Office of Professions' official database and is updated daily, Monday through Friday. The Office of Professions considers this information to be a secure, primary source for license verification.

License Information *

08/12/2022

Name : [redacted]
Address : [redacted]
Profession : REGISTERED PROFESSIONAL NURSING
License No: [redacted]
Date of Licensure : [redacted]
Additional Qualification :
Status : REGISTERED
Registered through last day of : 12/23

* Use of this online verification service signifies that you have read and agree to the terms and conditions of use. See HELP glossary for further explanations of terms used on this page.

- Use your browser's back key to return to licensee list.
- You may search to see if there has been recent disciplinary action against this licensee.
- Note: The Board of Regents does not discipline *physicians(medicine), physician assistants,* or *specialist assistants.* The status of individuals in these professions may be impacted by information provided by the NYS Department of Health. To search for the latest discipline actions against individuals in these professions, please check the New York State Department of Health's Office of Professional Medical Conduct homepage.

An official website of the United States government Here's how you know

Entity Validation Delays Show Details
Jun 27, 2022

Planned Maintenance Schedule Show Details
Apr 3, 2022

See All Alerts

SAM.GOV

Sign In

Home Search Data Bank Data Services Help

Search All Words e.g. 1606N020Q02

Select Domain
Entity Information

All Entity Information

Entities

Disaster Response Registry

Exclusions

Filter By

Keyword Search

For more information on how to use our keyword search, visit our help guide

Any Words

All Words

Exact Phrase

e.g. 123456789, Smith Corp

Classification

Excluded Individual

First Name

Middle Name

Last Name

SSN / TIN

Add Individual

No matches found

We couldn't find a match for your search criteria.

Please try another search or go back to previous results.

Go Back

[redacted] ×

Excluded Entity

Federal Organizations

Exclusion Type

Exclusion Program

Location

Dates

Reset

Feedback

Our Website

About This Site

Our Community

Release Notes

System Alerts

Our Partners

Acquisition.gov

USASpending.gov

Grants.gov

More Partners

Policies

Privacy Policy

Disclaimers

Freedom of Information Act

Accessibility

Customer Service

Help

Check Registration

Federal Service Desk

External Resources

Contact

GSA General Services Administration

This is a U.S. General Services Administration Federal Government computer system that is **"FOR OFFICIAL USE ONLY."** This system is subject to monitoring. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

Data.CMS.gov

All Interactive Tools

Provider Opt-Out Affidavits Look-up Tool

This look-up tool is a searchable database that allows you to look up providers who do not wish to enroll in the Medicare program and have "opted out" of Medicare, by their National Provider Identifier (NPI), or by first name and last name.

Find a Provider:

Provider name

[redacted]

[redacted]

NPI number

Enter 10-digit NPI numbe[redacted]

Back to Top

Data.CMS.gov

ZIP code

ZIP code

Clear All Fin

Displaying 0 - 0 of 0 records Records per page: 10

Sorry, no matches found.

Here are some search tips:

- Make sure all words are spelled correctly.
- Try one or two fewer filters.
- For NPI search, enter the full 10-digit ID
- For CCN search, enter the full 6-character ID

Back to Top

Information about the tool

This look-up tool is a searchable database that allows you to look up providers who do not wish to enroll in the Medicare program and have "opted out" of Medicare, by their National Provider Identifier (NPI), or by first name and last name.

This data is populated from the Provider Enrollment, Chain, and Ownership System (PECOS) and is updated monthly. It also includes data until the last day of the previous month.

Resources (2)

Featured Resource

Opt Out Affidavits Methodology

View Methodology

Featured Resource

Opt Out Affidavits Data Dictionary

View Data Dictionary

Information about associated datasets

[redacted]

Data.CMS.gov

Related Datasets

Dataset

Opt Out Affidavits

Page last modified
June 17, 2022

Contact us

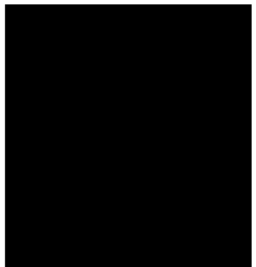
Didn't find the answer you were looking for?

Email Support

[redacted]

Back to Top

Data.CMS.gov



Visit our tips page to learn how to best use the Exclusions Database. If you experience technical difficulties, please email the webmaster at webmaster@oig.hhs.gov.

Exclusions Search Results: Individuals

No Results were found for

[redacted]

If no results are found, this individual or entity (if it is an entity search) is not currently excluded. Print this Web page for your documentation

Search Again

Search conducted 6/15/2022 10:01:53 AM EST on OIG LEIE Exclusions database.
Source data updated on 6/10/2022 8:00:00 AM EST

Return to Search

Office of the Medicaid Inspector General

Medicaid Exclusions ▸ *Search Medicaid Exclusions Results*

Export to PDF

Export to Excel

Search Again

You searched for: [redacted]
List Execution Date: 6/18/2022 8:06:24 AM.
Records returned: 0.
Data was last updated: 06/18/2022 12:01:12 AM.

No records were found matching your search criteria.

ADVICE OF INSURANCE – LIMITED COVERAGE

Date: 11/30/2022

FROM: The New York and Presbyterian Hospital / Columbia University Medical Center
622 West 168th St
New York, NY 10032

MCIC VERMONT
A Reciprocal Risk Retention Group

To: [redacted]

For claims history or other required insurance forms, please contact:
Marjorie Moran
Finance, Insurance
466 Lexington Ave, 16th Floor
New York, NY 10017
212-297-5581

Insurance described below has been bound in the name of the following Named Insureds:

- **-THE NEW YORK AND PRESBYTERIAN HOSPITAL**
- **-UNIVERSITY OF ROCHESTER**
- **-THE JOHNS HOPKINS HOSPITAL**
- **-THE JOHNS HOPKINS UNIVERSITY**
- **-YALE NEW HAVEN HOSPITAL, INC.**
- **-YALE UNIVERSITY**
- **-CORNELL UNIVERSITY**
- **-THE TRUSTEES OF COLUMBIA UNIVERSITY IN THE CITY OF NEW YORK**

ADDITIONAL INSURED:	[redacted]
FORM OF COVERAGE:	Hospital, Physicians and Surgeons Professional Liability and Commercial Liability
LIMITS OF LIABILITY:	
Professional Liability (Part 1):	$5,000,000 each claim, no annual aggregate
Commercial General Liability (Part 2):	$2,500,000 each claim, no annual aggregate
INSURANCE CARRIER:	MCIC Vermont (A Reciprocal Risk Retention Group)
POLICY NUMBER:	[redacted]
POLICY AND COVERAGE TERM:	01/01/2023 - 12/31/2023

DEPARTMENT: [redacted]

PROVISIONS APPLICABLE:

This is a "claims-made" policy and defined terms have the meanings set forth in the policy.

Professional Liability coverage provided to the Additional Insured applies only while such Additional Insured is named on the schedule entitled 'Limited Coverage' submitted by a Named Insured or an Endorsement No. 1 Insured. In addition, such coverage applies only while acting within the scope or course of his or her professional employment if he or she is employed by a Named Insured or an Endorsement No.1 Insured, but if not so employed, such coverage applies only while (i) acting within the scope or course of his or her professional duties within the limitations prescribed by a Named Insured or an Endorsement No. 1 Insured or (ii) acting within the scope or course of a program of approved medical instruction by a Named Insured or an Endorsement No. 1 Insured.

Commercial General Liability coverage provided to the Additional Insured applies while such Additional Insured is : (1) acting within the scope of his or her or its duties for a Named Insured or an Endorsement No. 1 Insured or (2) engaged in the conduct of his or her or its professional business which is located on premises owned or leased by a Named Insured or an Endorsement No. 1 Insured.

The above coverages will automatically terminate upon : (1) the Additional Insured no longer meeting MCIC Vermont eligibility criteria or (2) the termination of such Additional Insured's affiliation with a Named Insured or Endorsement No. 1 Insured.

Tail Coverage is included for a new policy year provided the affiliated Named Insured continues to purchase the above referenced forms of coverage from MCIC Vermont for future Medical Incidents and Occurrences.

Additional terms and conditions of coverage are set forth in the policy corresponding to the policy number noted above (a copy of which may be obtained by contacting the entity noted above as the contact to obtain a claims history and other required insurance forms).

NOTE: The Additional Insured is required to cooperate with the Insurer and its agents at all times in connection with any claims. Insurance coverage may be terminated as a result of breach of this obligation and as otherwise set forth in the policy.

NOTE: The inception of the coverage evidenced herein for the Additional Insured is predicated upon the Additional Insured's (i) successful completion of Credentialing and Privileging (if one or both of the foregoing are applicable) as required by the affiliated Named Insured of such Additional Insured and, if required by the affiliated Named Insured of such Additional Insured, (ii) commencement of (a) employment by a Named Insured, Endorsement No. 1 Insured or Professional Corporation insured by MCIC Vermont (A Reciprocal Risk Retention Group) or (b) a Professional Services Agreement or similar agreement between the Additional Insured and a Named Insured or Endorsement No. 1 Insured (if either of the preceding clause (a) or (b) are applicable).

NOTICE: This policy is issued by your reciprocal risk retention group. Your reciprocal risk retention group may not be subject to all of the insurance laws and regulations of your State. State insurance insolvency guaranty funds are not available for your reciprocal risk retention group.

[redacted]

MCIC Vermont (A Reciprocal Risk Retention Group), by its attorney-in-fact MCIC Vermont LLC
76 St. Paul Street, Suite # 500
Burlington, Vermont 05402-1530

NewYork-Presbyterian

[redacted] NP

General Profile

Enhanced Credentialing Activity

Primary Office Address

[redacted]

Other Provider Information

ID#: [redacted]
SSN: [redacted]
Date of Birth: [redacted]
Provider Specialties: Nurse Practitioner

NPI: [redacted]
UPIN:
Medicare#:
Medicaid#:

Credentialing Activity

Application

Application Sent Date: 05/31/2022
Attestation Date: 07/29/2022
Received Date: 07/29/2022

Most Recent Query

Query Type:
Query Date:
Issues: ☐

Credentialing Completed: ☑
Completed Date: 10/25/2022

NYP Columbia University Irving Medical Center

From 11/01/2022 To 10/31/2024

Information Upon Credentialing Completion

Status: Active
Category: Nurse Practitioner
Category Applied For: Nurse Practitioner
Network:
Cred Activity Notes:

Committee Progress

Started:
Status: Board of Trustees
Issues: ☐

Activity Completed: ☑
Completed Date: 10/25/2022

Licenses

[redacted], NP

Verified: ☐

License Type: State License
State: NY
License Number: [redacted]
Status: Active
Expiration Date: 12/31/2025

Verified: ☐

License Type: DEA Certificate
State: NY
License Number: [redacted]
Status: Active
Expiration Date: 06/30/2024

Verified: ☐

License Type: Infection Control Certificate
State: NY
License Number:
Status: Active
Expiration Date: 09/26/2026

Verified: ☐

License Type: State License
State: NY
License Number: [redacted]
Status: Active
Expiration Date: 12/31/2023

Verified: ☐

License Type: GSA/SAM
State:
License Number:
Status: Active
Expiration Date:

Verified: ☐

License Type: Medicare Opt-out
State:
License Number:
Status:
Expiration Date:

Verified: ☐

License Type: OIG
State:
License Number:
Status:
Expiration Date:

Verified: ☐

License Type: OMIG
State:
License Number:
Status:
Expiration Date:

Verified: ☐

License Type: OPMC or OPD
State:
License Number:
Status:
Expiration Date:

[redacted] NP

Insurance

NewYork-Presbyterian | Columbia University Irving Medical Center Verified: ☐

Policy Number: [redacted]
Coverage Type: Risk Retention Group - Claims Made Policy
Expiration Date: 12/31/2021

MCIC Vermont Inc. (A Risk Retention Group) Verified: ☐

Policy Number: [redacted]
Coverage Type: Risk Retention Group - Claims Made Policy
Expiration Date: 12/31/2022

MCIC Vermont Inc. (A Risk Retention Group) Verified: ☐

Policy Number: [redacted]
Coverage Type: Risk Retention Group - Claims Made Policy
Expiration Date: 12/31/2022

Affiliations

[redacted] Verified: ☐

Affiliation Type: [redacted]
Category:
Dept./Specialty:
Start Date:
End Date:

[redacted] Verified: ☐

Affiliation Type: [redacted]
Category:
Dept./Specialty:
Start Date:
End Date:

NewYork-Presbyterian

NEW YORK STATE PHYSICIAN/PRACTITIONER

ACKNOWLEDGEMENT STATEMENT

In accordance with applicable Federal (Public Law 98-21) and New York State law (Section 405.3 of Chapter V of Title 10), please read the following statements:

NEW YORK STATE - NOTICE TO PHYSICIANS
"Payments to hospitals for inpatient services is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, and for neonates, upon birth weight or admission weight as well. This data must be documented by the patient's medical record. Anyone who misrepresents, falsifies or conceals this information may be subject to fine, imprisonment, or civil penalty under applicable Federal and New York State laws."

FEDERAL - NOTICE TO PHYSICIANS
"Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and 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, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws."

It is required that the Hospital maintain on file your written and signed acknowledgement that you have received this notice. This copy must be on file within the Hospital before a claim can be submitted. Please retain a copy for your records and sign and date this verification statement using your full legal signature for our records.

I acknowledge that I have read and received the notice of Physician Notification Statement and Physician Attestation Statement.

Verified and completed by: [redacted]

Print Name & Title

[redacted]

Signature

05/23/2023

Date Signed

III. PHYSICIAN CONSULTATION

The parties shall be available to each other for consultation either on site or by electronic access including but not limited to telephone, facsimile and email. Each party will cover for the other in the absence of one of them or _____ who are designated by [redacted], N.P.
(Names of Third Parties) (Name of Applicant)
and [redacted], M.D., as appropriate for coverage in the absence of both parties.
(Name of Physician)
In the event that there is an unforeseen lack of coverage, patients will be referred to the appropriate emergency room.

IV. RECORD REVIEW

A representative sample of patient records shall be reviewed by the collaborating physician every three months to evaluate that [redacted], N.P.'s practice is congruent with the above identified practice
(Name of Applicant)
protocol documents and texts. Summarized results of this review will be signed by both parties and shall be maintained in the nurse practitioner's practice site for possible regulatory agency review. Consent forms for such review will be obtained from any patient who primary physician is other than [redacted], M.D.
(Name of Collaborative Physician)

V. RESOLUTION OF DISAGREEMENTS

Disagreement between [redacted], N.P. and [redacted], M.D.
(Name of Applicant) (Name of Collaborative Physician)
regarding a patient's health management that falls within the scope of practice of both parties will be resolved by a consensus agreement in accordance with current medical and nursing peer and literature consultation. In case of disagreements that cannot be resolved in this manner, [redacted], M.D.'s
(Name of Collaborative Physician)
opinion will prevail.

VI. ALTERATION OF AGREEMENT

The Collaborative Practice Agreement shall be reviewed at least annually and may be amended only in writing in a document signed by both parties and attached to the Collaborative Practice Agreement.

VII. AGREEMENT

Having read and understood the full contents of this document, the parties hereto agree to be bound by its terms.

Nurse Practitioner:

Printed Name: [redacted]

Certification #: [redacted] RN License #: _____

Signature: [redacted] Date: 7/26/23

Collaborating Physician:

Printed Name: [redacted]

Certification #: [redacted] MD License #: [redacted]

Signature: [redacted] Date: 7/21/23

Collaborative Practice Agreement

This agreement sets forth the terms of the Collaborative Practice Agreement between

[redacted], N.P. in the Department of Obstetrics and Gynecology
(Name of Applicant) (Department)
and [redacted], M.D. a member of the Medical Staff at New York-Presbyterian Hospital.
(Name of Physician)
This agreement should take effect as of 07/10/23.
(Date: mm/dd/yyyy)

INSTRUCTION

[redacted], N.P., meets the qualifications and practice requirements as
(Name of Applicant)
stated in Chapter 257 of the Laws of 1988 and Article 139 of the Education Law of New York State, holds a New York State License and is currently registered as a Registered Professional Nurse in good standing, is certified as a Nurse Practitioner pursuant to Sec. 6910 of the Education Law and herein meets the requirement of maintaining a collaborative practice agreement with [redacted], M.D., a duly licensed and currently
(Name of Physician)
registered physician in good standing under Article 131 of the New York State Education Law.

I. SCOPE OF PRACTICE

The practice of a Registered Professional Nurse as a Nurse Practitioner may include the diagnosis of illness and physical conditions and the performance of therapeutic and corrective measures including prescribing medications for patients whose conditions fall within the authorized scope of the practice as identified on the college certificate. This privilege includes the prescribing of all controlled substances under a DEA number. The Nurse Practitioner, as a Registered Nurse may also diagnose and treat human responses to actual or potential health problems through such services as a case finding, health counseling, health teaching, and provision of care supportive to or restorative of life and well-being. This practice will take place at NewYork-Presbyterian Hospital. The following exceptions to the certified scope of practice have been agreed upon by the undersigned parties:

_____

_____

_____
(list exception to scope of practice here – such as OB/GYN adolescent patients above the age of in the ANP or selected patients above the age of 18 under the following conditions of the PNP etc.)

II. PRACTICE PROTOCOLS

The protocols used in this Hawkins, J. W., Roberto-Nichols, D. M., & Stanley-Haney, J. L. (2011)
(Identify specialty as listed on college certificate)
practice are contained in Guidelines for Nurse Practitioners In Gynecologic
(Name approved protocol text with all bibliography citations)
and in Settings (10th ed.) New York, NY: Springer Pub.
(Cite location of any other protocols which are germane to this particular practice)

Nurse Practitioner Form 4NP

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Department Use Only
Approved
Date

Verification of Collaborative Agreement and Practice Protocol

Applicant Instructions

1. Complete Section I. In item 4, enter your name exactly as it appears on your Application for a Certificate (Form 1).
2. You and the initial collaborating physician with whom you have a practice agreement and practice protocol must complete Sections II and III and return both pages of the form to the Office of the Professions at the address at the end of the form.. Be sure to sign and date item 4 in Section III.

Note: Form 4NP is not required to obtain a certificate, but must be submitted to the Office of the Professions no later than 90 days after commencement of practice. This submission to the Department is only required **once**.

Section I: Applicant Information

1 **Social Security Number** [redacted]
(Leave this blank if you do not have a U.S. Social Security Number)

2 **Birth Date** Month [redacted] Day [redacted] Year [redacted]

3 **If Already Certified, New York State Nurse Practitioner Certificate Number**
[redacted]

4 **Print Name as It Appears on Your Application for a Certificate (Form 1)**

Last [redacted]
First
Middle

5 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1 [redacted]
Line 2
Line 3
City
State
Country/ Province

Section II: Collaborating Physician

1. Name of collaborating physician: [redacted] *Last* [redacted] *First* *Middle*
2. Address: [redacted]
3. Telephone: [redacted] Fax: [redacted]
4. E-mail address: [redacted]
5. New York State medical license number: [redacted]
6. Area of current practice: Obstetrics and Gynecology
7. Area of specialty practice: Gynecologic Surgery

Section III: Practice Protocol

Instructions: You must use an approved practice protocol text that is a standard publication. Please select a protocol text from the approved list (see application instructions, pages 8-9) and submit this form to the Department at the address at the end of the form, no later than 90 days after the commencement of practice.

1. List title, publisher, and date of publication of the approved protocol text.

Hawkins, J.W Roberto-Nicholes, D. M., & Stanley-Haney, J.L (2011) Guidelines for Nurse Practitioners in Gynecologic Settings (10th ed) New York, NY Springer Pub

2. Location and description of practice site(s): (clinic, private office, HMO, etc.)

Practice Site		
Name	**Address**	**Description**
Columbia Doctors Midtown	51 West 51st Street New York, NY 10019	Private Office, Clinic
Columbia Doctors -Herbert Irving Pavilion	161 ft Washington Avenue 4th floor New York, BY 10032	Clinic, Private Office

3. Description of practice including any mutually agreed upon exceptions:

Gynecologic Focused with emphasis on surgical evaluation of gyn conditions

4. We hereby verify that we have a written collaborative agreement and have selected a practice protocol(s).

Nurse Practitioner signature: [redacted] Date: 8 / 23 / 23 (mo. / day / yr.)

Collaborating Physician signature: [redacted] Date: 8 / 23 / 23 (mo. / day / yr.)

Return Directly to: **New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Nurse Practitioner Unit, 89 Washington Avenue, Albany, NY 12234-1000.**

NEW YORK-PRESBYTERIAN HOSPITAL

FPPE - Focused Professional Practice Evaluation for Nurse Practitioners

Name of Nurse Practitioner: [redacted] MS, APRN, FNP-BC **Staff ID #:** [redacted]

Clinical Service: Neurology **Date:** 11/13/2020

A Focused Professional Practice Evaluation (FPPE) will be initiated for all initial appointments and must be completed within the first three months of hire. Extension approved due to high priority administrative responsibilities

Evaluation from 5/15/2020 **to** 11/13/2020

SUMMARY PERFORMANCE EVALUATION				
A. HEALTH ASSESSMENT	**SATISFACTORY**	**NEEDS IMPROVEMENT**	**UNSATISFACTORY**	**DOES NOT APPLY**
1. Demonstrates skillful interviewing of patients.	x			
2. Elicits an age-appropriate comprehensive health history.	x			
3. Elicits and records information specific to patient's complaints (e.g., onset, timing, duration, location, associated symptoms, alleviating factors, quantity/intensity, etc)	X			
4. Performs a complete physician examination.	x			
5. Demonstrates use of appropriate techniques of inspection, palpation, percussion, and auscultation throughout the examination.	X			
6. Prepares patient's charts for review according to the facilities schedule.	X			
7. Differentiates normal from abnormal findings.	x			
8. Uses appropriate equipment accurately & efficiently when performing a physical examination.	X			
9. Adapts the history and physical to meet the needs of individual patients.	X			
10. Selects appropriate diagnostic tests to gather information necessary to evaluate the health status of a patient.	X			
11. Records information in a well-organized, concise manner.	x			
12. Analyzes all data in order to formulate an assessment of the patient's status and establish a plan of care.	X			
13. Identifies specific health promotion/maintenance needs of patients and families.	X			
14. Describe etiology, developmental considerations, pathogenesis and clinical manifestations of specific disease processes.	X			
15. Correlates pathophysiology with patient's signs & systems.	x			
16. Correlates pathophysiology with laboratory data.	x			
17. Demonstrates knowledge of pathophysiology of acute and chronic diseases of conditions commonly encountered in the practice setting.	X			
B. TECHNICAL SKILLS				
1. Performs and interprets selected laboratory tests.	x			
2. Performs technical skills specific to practice settings.	x			
3. Performs therapeutic maneuvers skillfully.	x			
C. MANAGEMENT OF ACUTE AND CHRONIC ILLNESSESS				
1. Assesses and manages most common acute illnesses accordingly of areas of preparation, age of patient, legal parameters and current standards of practice.	X			
2. Assesses and manages stable chronic illnesses according to areas of preparation, age of patient, legal parameters and current standards of practice.	X			
3. Identifies and manages emergency or crisis situations.	x			
4. Collaborates with health team members and makes appropriate referrals.	X			
5. Demonstrates diagnostic reasoning ability in formulating assessments.	X			
D. MEDICAL RECORD REVIEW 1. NP new hires with > 3600 hours practice must complete three months of medical record reviews. At least three patient record per month must be evaluated by MD collaborator.	X			

Please comment on the applicant's overall competence. (Attach additional sheets if necessary)

Clinic is 4-6 hours weekly depending on need. Visits and medical record discussed, reviewed, and co-signed by Attending.

Collaborating Physician OR

Collaborative Relationship Physician (Print Name): Joshua Willey, MD Chief of Service (Print Name): Joshua Willey MD

Signature/Date 11/13/20 Chief of Service Signature/Date: 11/13/2020

Nurse Practitioner Signature/Date: [redacted] 11/13/20

Rev. 9/1/2015

NewYork-Presbyterian Hospital

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)
Nurse Practitioner (NP)

NAME of NP: [redacted], MS, APRN, FNP-BC DEPARTMENT: Neurology

INDICATORS	BENCHMARK	JANUARY - JUNE Year: 2023
Patient Care		
#Quality of Care Referrals for Review	0	0
# Sentinel Events	0	0
Practice Based Learning		
# Departmental Meetings Attended	1 month	1/23, 2/3, 2/23 - no other meetings due to survey sched and other meetings for it
Professional Development		
# CME Credits Obtained	30 hrs/year	41.5 hrs
Interpersonal Skills		
# Patient Complaints	0	0

The above mentioned criteria have been adopted for OPPE for the NP.

As Service Chief, I review the data at least twice a year in order to determine if there are any issues or trends related to competencies required to perform delineated privileges or related to the quality of care provided by every NP involved in the care within the service. A FPPE will be initiated if any of the following will occur:

a. A sentinel event to be the result of NP error.
b. More than two significant adverse events or near misses related to NP error during the review period.
c. A trend noted in the performance over two months period demonstrating unexplained outcomes or from similarly privileged clinicians within the service.
d. Any other evidence that suggests a potential issue with the quality of care provided by a clinician.

Collaborating/Collaborative Relationship Physician:	Joshua Willey, MD		05/30/2023
	Print	Signature	Date
Chief of Service:	Joshua Willey, MD		05/30/2023
	Print	Signature	Date
NP Signature:	[redacted]	5/22/2023	
	Signature	Date	

Revised: 3-11, 9-15

NewYork-Presbyterian Hospital

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)
Nurse Practitioner (NP)

NAME of NP: [redacted] MS, APRN, FNP-BC DEPARTMENT: Neurology

INDICATORS	BENCHMARK	JULY - DECEMBER Year: 2023
Patient Care		
#Quality of Care Referrals for Review	0	0
# Sentinel Events	0	0
Practice Based Learning		
# Departmental Meetings Attended	1 month	8/4, 8/18, 9/1, 10/20, 10/27, 11/3, 11/17, and 12/1/2023
Professional Development		
# CME Credits Obtained	30 hrs/year	41.5 hrs
Interpersonal Skills		
# Patient Complaints	0	0

The above mentioned criteria have been adopted for OPPE for the NP.

As Service Chief, I review the data at least twice a year in order to determine if there are any issues or trends related to competencies required to perform delineated privileges or related to the quality of care provided by every NP involved in the care within the service. A FPPE will be initiated if any of the following will occur:

a. A sentinel event to be the result of NP error.
b. More than two significant adverse events or near misses related to NP error during the review period.
c. A trend noted in the performance over two months period demonstrating unexplained outcomes or from similarly privileged clinicians within the service.
d. Any other evidence that suggests a potential issue with the quality of care provided by a clinician.

	Print	Signature	Date
Collaborating/Collaborative Relationship Physician:	Joshua Willey, MD		12/22/2023
Chief of Service:	Joshua Willey, MD		12/22/2023
NP Signature:		12/5/2023	
	Signature	Date	

Revised: 3-11, 9-15

MSOW VerityStream

Practitioner: [redacted]

Privilege Manager Privilege Inquiry

Prod01 Server

◉ Search by Facility ○ Search by Practitioner

Find Facility: CPMCMSO: Columbia Medical Staff Office

Find Specialty:

Find Practitioner: [redacted]

View Options

◉ Privileges ○ Offices ○ General Information

Privilege Search Options Facility Enterprise

Search Current Practitioner: Enter ICD or Privilege Text

Nurse Practitioner - Neurology

Core Privileges - Nurse Practitioner - Neurology

Provide direct care to patients through the following activities:

- Take comprehensive history and perform physical examinations (5/1/2022 - 4/30/2024)
- Perform diagnostic testing and therapeutic procedures approved by the Clinical Service Chief (5/1/2022 - 4/30/2024)
- Evaluate and treat on the basis of history, physical examination, radiological, laboratory, and other diagnostic test results, pursuant to the practice protocols and collaborative practice agreement (5/1/2022 - 4/30/2024)
- Initiate referrals to other health care providers, and/or consult with the attending physician or the collaborating physician (5/1/2022 - 4/30/2024)

Specialty Privileges - Nurse Practitioner - Neurology

Additional Specialty Privileges

- Nasogastric Tube Placement [Minimum Visual Supervision 1] (5/1/2022 - 4/30/2024)