



CAROLINAS HEALTHCARE SYSTEM
PHYSICIAN/DENTIST SUPPORT STAFF
CLINICAL SITE AUTHORIZATION NOTIFICATION

Thank you for your interest in applying for membership and privileges at one or more facilities of Carolinas HealthCare System.

In keeping with the requirements set forth by The Joint Commission, regarding physician/dentist support staff (HR standard HR.1.20, E.P.11), which specifically requires “that prior to the provision of care, the qualifications and competence of a non-employee brought into the hospital by a licensed independent practitioner to provide care, treatment or services ... are assessed by the hospital and determined to be commensurate with the qualifications and competence required if the individual were to be employed by the hospital to perform the same or similar services” CHS has developed a process to accomplish this assessment. Support Staff to which this pertains include not only rounding nurses, scribes and therapists but anyone who may accompany you. Allied Health Professionals; such as Physician Assistants, Nurse Practitioners, Certified Nurse Mid-Wives, and R.N. First Assists, go through the Medical Staff Office.

If you anticipate having your support staff assist you in one or more facilities of Carolinas HealthCare System, you must contact the CHS Placement Center at (704) 444-3151. The CHS Placement Center will then forward you all necessary documents that will need to be completed and processed prior to your support staff assisting you in the hospital.

Please note that by having your Support Staff assist you at any Carolinas HealthCare System facility you assume full responsibility for their acts or omissions and hereby indemnify, defend and hold harmless Carolinas HealthCare System and the facility against any claims, actions, or liability caused by, arising out of, or resulting from any act or omission of the Support Staff involved.

Should you have any questions, please feel free to contact the CHS Placement Center directly at the number listed above.

Thank you and we look forward to working with you.

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I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED THIS NOTICE AND PROVIDE THE FOLLOWING:

_____ I **do not** anticipate having any Support Staff with me at any of the applicable Carolinas HealthCare System facilities listed below.

_____ I **do** anticipate having Support Staff with me at one or more of the applicable Carolinas HealthCare System facilities listed below and provide the following information regarding the staff that will be accompanying me:

_____	_____
Name and Title	Phone

Position	

Applicable Facilities: _____ CMC _____ Carolinas Rehabilitation _____ CMC-University
 _____ CMC-Mercy _____ CMC-Pineville _____ CMC-Lincoln

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I understand that I am responsible for the acts or omissions of my Support Staff while at Carolinas HealthCare System facilities and I possess evidence of liability insurance in an amount of not less than \$1,000,000 per occurrence and \$3,000,000 in the aggregate to cover such Staff.

_____	_____
Physician/Dentist Signature	Date

Print Name