



## ANNUAL PSHP WORKSHEET

Re-credentialing for a Physician Sponsored Healthcare Professional (PSHP)

**Submit completed forms and required documents to CHRISTUS Spohn HR Department.  
All documentation must be submitted together for processing.**

<b>Name:</b>		<b>Job Title:</b>	
<b>Point of Contact:</b>		<b>Point of Contact Email address:</b>	
<b>Re-credentialing Checklist</b> <i>As you complete each task, initial and date the boxes below.</i>		<b>HR USE ONLY</b>	
		Date Completed	Expiration Date
	Competencies (Includes Age Specific)		
	Sponsorship Agreement		
	Job Description		
	PSHP Evaluation		
	Confidentiality Agreement		
	Personal Data Form		
	Review of Orientation documents (Pages 2 – 187) General Orientation Checklist (Submit Pages 1)		
<b>Certifications</b>			
	CPR (American Heart Association)		
	Professional License		
	Liability Insurance (100K,300K)		
	Flu		
	TB & Survey, X-Ray (if applicable)		
	N-95 Respirator Fit Test		
<b>Facility:</b> (Circle)      Alice              Beeville              Kleberg              Corpus Christi			
I certify that I have completed and attached all required forms and documents. I understand that only complete applications will be reviewed by HR and failure to <b>submit a complete application will result in delays in processing.</b>			
<b>Signed:</b>		<b>Date:</b>	
Submit complete application to Email: <b>HR_SPN@CHRISTUSHEALTH.ORG</b>		<b>Mail: CHRISTUS Spohn Employment Center 716 Ayers Street Corpus Christi, TX 78404 ATTN: PSHP HR</b>	
<b>Phone:</b> 361.881.6434 <b>Fax:</b> 361.881.6428			
<b>FOR HR USE ONLY</b>			
	Validate/update in Echo		
	Approval letter		
	Scan docs to Medical Staff		
	Scan docs to Airvault		
	PSHP employer re-credentialing validation (if applicable)		
	Processing Fee (\$50)		

## INITIAL COMPETENCY/SKILLS CHECKLIST Sleep Study Coordinator

**Associate Name:** \_\_\_\_\_

**Hire Date:** \_\_\_\_\_

High School graduate or equivalent, familiar with hospital procedures, able to collect and record study data, have excellent verbal communication skills, and strong customer service skills. Competency will be assessed by a Spohn Staff preceptor or physician sponsor.

**Self Assessment: 1= Not Familiar      2= Need Further Development      3= Proficient**

**Validation Method: V=verbal      O=Observation      T= Test      D= Demonstration/Lab**

Self Assessment	Performance Criteria	Method of Evaluation	Date Completed Initials/Coach	Comments
	The sleep study coordinator should have excellent communication skills.	V=verbal O=Observation T= Test D= Demonstration/Lab		
	Demonstrate attention to detail skills and be computer proficient.	V=verbal O=Observation T= Test D= Demonstration/Lab		
	Evaluate and enroll stroke patients into a sleep apnea study .	V=verbal O=Observation T= Test D= Demonstration/Lab		
	Accurately collect and record study data (directly into laptop computers)	V=verbal O=Observation T= Test D= Demonstration/Lab		

Comments: \_\_\_\_\_

\_\_\_\_\_

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Associate Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Coach/Preceptor Signature / Credentials: \_\_\_\_\_ Date: \_\_\_\_\_

Coach/Preceptor Printed Name: \_\_\_\_\_

Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Manager's Printed Name \_\_\_\_\_

**CHRISTUS Spohn Health System**  
Age Specific Performance Appraisal

<b>NAME:</b> <hr/>	<b>ASSOCIATE NUMBER:</b> <hr/>
<b>POSITION TITLE:</b> <hr/>	<b>DATE:</b> <hr/>

The above staff member must be able to demonstrate the **knowledge** and **skills** necessary to provide care based on physical, motor and sensory adaptation, cognitive and psychosocial appropriate to the age of the patients served in his/her assigned area.

**Age Specific Checklist:**

The assessment of competence for each applicable category on the checklist below is based on one or more of the following:

- 1 – Review of a sample of medical records.
- 2 - Observation of interaction with patient, family, significant other.
- 3 - Observation of participation in development of age appropriate treatment plan.
- 4 - Other \_\_\_\_\_.

N/A – Not Applicable

*From the list above, place the appropriate response in each box below.  
Mark N/A if the staff member has NOT had any contact with a particular age category.*

<b>Competency</b>	Neonate	Infant	Toddler	Pre-School	School Age	Adolescent	Adult	Geriatric
	0-1mo	1mo-1 yr	1-3y	3-6 y	6-12y	12-17y	18-64y	65 +
Verbalizes knowledge of growth and development								
Demonstrates ability to obtain age-specific data								
Applies age-specific data to treatment plan								
Performs care appropriate to age category (i.e., medication, equipment)								
Utilizes age-appropriate communication skills								
Incorporates knowledge of age-specific community resources								
Involves family and/or significant other in plan of care								

I have reviewed and completed the annual competency checklist for my department.

\_\_\_\_\_ Date

Signature, Associate

\_\_\_\_\_ Date

Signature, Validator

**Comments:**

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**CHRISTUS SPOHN HEALTH SYSTEM**  
**Physician Sponsored Health Professional**

***POSITION DESCRIPTION***

**Title: Sleep Study Coordinator**

**Description:**

The primary role of the sleep study coordinator is to enroll stroke patients into a sleep apnea study. Limited physical contact with stroke patients will be necessary. Additionally, they will be responsible for collecting and recording study data (directly into laptop computers) and interviewing patients. The sleep study coordinator should have excellent communication skills, be very detail oriented and computer proficient.

**Qualifications:**

- High School graduate or equivalent
- Familiarity with hospital procedures
- Ability to collect and record study data
- Excellent verbal communication skills
- Strong Customer Service skills that will enhance the interaction with the patient care team, patient and family

**Signature of Sleep Study Coordinator** \_\_\_\_\_

**Date** \_\_\_\_\_

**Printed Name of Sleep Study Coordinator** \_\_\_\_\_

**Date** \_\_\_\_\_

**CHRISTUS Spohn Health System**  
**Physician Sponsored Healthcare Professional Contracted by Physician**  
**Supervising Physician's Agreement**

As a member of a Medical Staff of CHRISTUS Spohn Health System, I request permission to have the Physician Sponsored Healthcare Professional (PSHP) identified below assist me in connection with my practice in accordance with the Medical Staff Bylaws, Credentials Policy and Procedure Manual and Rules and Regulations.

Name of PSHP: \_\_\_\_\_ Job Title: \_\_\_\_\_

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This Supervising Physician Agreement is to be signed by physicians supervising a PSHP assisting in physician practice within CHRISTUS Spohn Health System. As supervising physician I agree to:

- Accept responsibility for the individual's performance of the practice prerogatives authorized for him or her while under my supervision
- Accept responsibility for the proper conduct of the individual within the hospital and for the correction and resolution of any problems that may arise
- Complete periodic evaluations of the quality of the individual's practice, and immediately report any concerns I may have related to such quality
- Immediately notify the Medical Staff Office in the event any of the following occur:
  - a. The employment status of the individual changes
  - b. The individual's authorized scope of practice changes, or the individual is under investigation by a relevant licensing board, and/or any other certifying board or healthcare or licensing entity
  - c. My professional liability insurance coverage is changed insofar as coverage of the acts of the individual is concerned

\_\_\_\_\_  
Supervising Physician Signature                      Printed Name                      Date

\_\_\_\_\_  
Supervising Physician Signature                      Printed Name                      Date

\_\_\_\_\_  
Supervising Physician Signature                      Printed Name                      Date

\_\_\_\_\_  
Supervising Physician Signature                      Printed Name                      Date

\_\_\_\_\_  
Supervising Physician Signature                      Printed Name                      Date

\_\_\_\_\_  
Supervising Physician Signature                      Printed Name                      Date

CHRISTUS Spohn Health System  
 Evaluation of Physician Sponsored Healthcare  
 Professional

Name \_\_\_\_\_ Job Title \_\_\_\_\_

Hospital \_\_\_\_\_ Date \_\_\_\_\_

	<b>Satisfactory</b>	<b>Unsatisfactory</b>	<b>No Information</b>
<b>Teamwork/Communication:</b> Effectively uses verbal, non-verbal, Written and interpersonal Communication skills in a clear And concise manner to ensure Appropriate understanding and Response.	_____	_____	_____
Cooperates with others	_____	_____	_____
Relationship with professional staff	_____	_____	_____
<b>Quality of Work:</b>			
Takes ownership for work	_____	_____	_____
Level of independence and Accountability	_____	_____	_____
Assessment of patient needs	_____	_____	_____
Reports change in condition promptly	_____	_____	_____
Seeks help when unfamiliar with Procedures or routines	_____	_____	_____
Aware of safety practices	_____	_____	_____

Comments:  
 \_\_\_\_\_  
 \_\_\_\_\_

Evaluator's name \_\_\_\_\_ Date \_\_\_\_\_



## CONFIDENTIALITY AND COMPUTER RESOURCES AGREEMENT FOR HEALTH CARE PARTNERS

**APPLICABILITY:** CHRISTUS Health affords its' Health Care Partners (ie: Individuals other than employed Associates who are involved with CHRISTUS Health in the provision of healthcare and healthcare operations such as Physicians, Physician's staff, Residents, Fellows, Students, Other health professionals, Volunteers, Vendors, and those with contractual relationships). with access, electronically or otherwise, to all types of confidential and proprietary information including information regarding patients, Associates, and the financial, administrative or health care operations of CHRISTUS Health ("CHRISTUS Health Information). CHRISTUS Health may also provide access to CHRISTUS Health computing equipment, information networks, systems or data ("CHRISTUS Health Information Systems"). CHRISTUS Health Information, obtained or disseminated by any method, including limited data sets, is a valued and sensitive asset and must be treated as such by Health Care Partners.

**PURPOSE:** This agreement must be signed by Health Care Partners who are given access to CHRISTUS Health Information, evidencing their agreement to abide by the terms set forth herein. CHRISTUS Health may amend the terms herein or the policies referenced herein. This Agreement will be retained as a permanent record in an area specified by appropriate CHRISTUS Health Management. **Violations of the terms herein, or refusal to sign, will result in disciplinary action that may include loss of association with CHRISTUS Health, loss of clinical privileges, medical or allied health staff membership, and/or legal action.**

**CHRISTUS Health INFORMATION:** CHRISTUS Health Information is not only a valuable and sensitive asset of CHRISTUS but is also protected by law and by CHRISTUS Health policies, management directives, and guidelines. CHRISTUS Health Information is confidential to the extent required by law and the policies of CHRISTUS Health and it will only be used as necessary to care and treat the patients of CHRISTUS Health or to otherwise accomplish the mission and business objectives of CHRISTUS Health.

CHRISTUS Health Information includes, but is not limited to:

- Patient/member information (records of conversation, admitting information, financial information, clinical information of any kind, etc.)
- Associate/physician/volunteer information (salary, employment records, personnel, health, disciplinary actions, etc.)
- Business and financial information (financial and statistical records, strategic business plans, internal reports, memos, contracts, peer review information, communications, etc.)
- Other information relating to CHRISTUS Health and information proprietary to other companies or persons that CHRISTUS has and/or uses in connection with the operations of CHRISTUS Health (computer programs, client and vendor proprietary information, source code, or technology, etc.) in any type of relationship to CHRISTUS Health.
- Other information relating to CHRISTUS Health and its operations.





## **CONFIDENTIALITY AND COMPUTER RESOURCES AGREEMENT FOR HEALTH CARE PARTNERS**

### **TERMS FOR ACCESS TO AND USE OF CHRISTUS HEALTH INFORMATION AND INFORMATION SYSTEMS**

#### **I. Confidentiality and Information Access.**

- A. I understand that CHRISTUS Health Information is an important asset of CHRISTUS Health and that I have an obligation to protect it from misuse or unauthorized disclosure.
- B. I shall handle CHRISTUS Health Information and utilize the documents, images, equipment software, etc. which allows me to access such Information only as needed to perform my responsibilities as a CHRISTUS Health Affiliate consistent with HIPAA Privacy and Security guidelines and procedures. This means, among other things, that:
  1. I understand that any information to which I may have access relating to such things as a patient's stay, diagnosis, financial situation, or medical record and any information relating to an Associate, such as salary, performance review, or disciplinary action is confidential and protected under the law and applicable regulation;
  2. I will only access CHRISTUS Health Information for which I have a legitimate need to know; and I will not in any way use, divulge, copy, release, sell, loan, review, alter or destroy any Confidential Information except as duly authorized and within the scope of my responsibilities at CHRISTUS Health; and
  3. I will not misuse or carelessly handle CHRISTUS Health Information. This includes information obtained through daily activities, documents, computer systems and any other information I encounter during my affiliation. Should CHRISTUS Health Information be accidentally revealed as a result of my action or inaction, I will take immediate steps with the management of CHRISTUS Health to mitigate the disclosure.
- C. I will report to CHRISTUS Health Management, any activities by any individual or entity that I suspect may compromise the confidentiality of or constitute misuse of CHRISTUS Health Information. The identity of the person making a report made in good faith about suspect activities will be held in confidence to the extent permitted by law, including the name of the person making the report.
- D. I will safeguard and will not disclose my facility security or computer security access code(s), sign-on ID(s) or password(s) or any other authorization I have that allows me to access and use CHRISTUS Health Information. I will also update my security access code(s) on a regular basis, as required by CHRISTUS Health guidelines and procedures. Should my access code(s) be accidentally revealed, I will take immediate steps to request a new one or have my password(s) reset.
- E. I understand that I have no right or ownership interest in any CHRISTUS Health Information. CHRISTUS Health may at any time revoke my access code(s) or sign-on ID(s), other authorization or access to CHRISTUS Health Information.
- F. I will attend training programs provided by or on behalf of CHRISTUS Health relating to policies and procedures for the handling of CHRISTUS Health Information related to my function, and will sign statements certifying my attendance to such training.



## **CONFIDENTIALITY AND COMPUTER RESOURCES AGREEMENT FOR HEALTH CARE PARTNERS**

**If granted access to CHRISTUS Health Information Systems, I agree to the following sections:**

### **II. Information System Use.**

- A. I accept responsibility for all activities undertaken using my access code or other authorization and understand that I am directly responsible for the accuracy and completeness of data entries that are made into any computerized record under my security access code.
- B. I understand that an information system may electronically assign my name to data entry sessions through my security access code. Therefore, I understand the importance of logging off after I have completed each data entry session and not allowing someone else to use my security access code.
- C. I will not demonstrate the operation of any CHRISTUS Health Information System to anyone without appropriate authorization. I understand that I must establish and maintain my competence in accordance with organizational guidelines in order to retain my access rights.
- D. I will not disclose information about CHRISTUS Health Information Systems to unauthorized individuals. I understand this includes, but is not limited to the design, programming techniques, flow charts, source code, screens, and documentation of systems.

**III. Use of the CHRISTUS Health Electronic Mail and Internet E-mail Systems.** If I have use of the CHRISTUS Health Electronic Mail and Instant Messaging systems (E-mail) and Internet E-mail systems:

- A. I understand that CHRISTUS Health E-mail is the sole property of CHRISTUS Health and is subject to inspection at any time.
- B. My use of those systems must be limited to CHRISTUS Health related business in compliance with applicable policies and guidelines and in a manner consistent with the values of CHRISTUS Health. Distribution of electronic chain mail, disseminating pornography, violence, racial or gender slurs, or other inappropriate or other offensive language or information is prohibited.
- C. I will make every possible effort to protect the privacy and confidentiality of E-mail. I understand that standard E-mail messages are an insecure method of data transmission and should not be utilized to transmit confidential or individually identifiable health information without appropriate safeguards and technical controls to secure the transmission.
- D. I understand that E-mail messages may be monitored by CHRISTUS Health and that management has a right to review these communications.
- E. CHRISTUS Health may monitor, filter or block Internet E-mail activity occurring on CHRISTUS Health equipment or CHRISTUS Health Information Systems to ensure compliance with applicable laws, management directives, or guidelines.
- F. I understand that E-mail messages may be characterized as legal documents that may be used as such in legal proceedings.



## CONFIDENTIALITY AND COMPUTER RESOURCES AGREEMENT FOR HEALTH CARE PARTNERS

IV. **Internet Use Agreement.** If I have Internet Use through CHRISTUS Health, I understand the failure of CHRISTUS Health to prevent unauthorized use of the Internet does not relieve an individual of the responsibility for obtaining authorization prior to his or her use of the Internet. These terms apply to all CHRISTUS Health's Health Care Partners and their personnel and agents who are granted Internet access by CHRISTUS Health Information Management. If I have been granted such access to the CHRISTUS Internet System, I understand that:

- A. CHRISTUS Health may monitor, filter or block Internet activity occurring on CHRISTUS Health equipment or CHRISTUS Health Information System to ensure compliance with applicable laws, management directives, or guidelines. If CHRISTUS Health discovers or suspects activities that are not in compliance, records may be retrieved and used to document wrongful use. Violations may result in a revocation of Internet access privileges and/or legal action by CHRISTUS Health.
- B. CHRISTUS Health assumes no liability for any direct or indirect damages arising from the user's connection to or use of the Internet. CHRISTUS Health is not responsible for the accuracy of information found on the Internet and only facilitates the access and dissemination of information through its systems. Users are solely responsible for any material they access or disseminate through the Internet.
- C. CHRISTUS Health assumes no liability for copyright infringement resulting from the user's receipt or dissemination of works through the Internet. It shall be the user's responsibility to ascertain and respect the copyright status of any work viewed, downloaded, uploaded or otherwise accessed through the Internet.
- D. I must make every effort to protect the privacy and confidentiality of any information posted to the Internet within business to business transactions. Internet data transmissions of individually identifiable health information must be performed with appropriate safeguards and technical controls to secure the transmission.
- E. Subscribers to electronic mailing lists are responsible for determining the purpose of the list before subscribing. Persons subscribing to an electronic mailing list will be viewed as having solicited materials delivered by the list.
- F. Persons sending materials to national E-mail networks or posting material to the Internet using CHRISTUS Health Information Systems should state that such material represents personal opinion and does not necessarily represent policies or opinions of CHRISTUS Health.
- G. The following activities involving the use of the Internet are strictly prohibited
  - 1. Use of the Internet (including Internet E-mail) in a manner inconsistent with the beliefs and values of CHRISTUS Health. This includes the access or dissemination of pornography, violence, racial or gender slurs, or other inappropriate information.
  - 2. Communicating information concerning any password, identifying code, personal identification number, or other confidential information (patient, Associate, business, or otherwise) without the permission of its owner or the controlling authority to which it belongs.



## **CONFIDENTIALITY AND COMPUTER RESOURCES AGREEMENT FOR HEALTH CARE PARTNERS**

3. Creating, modifying, executing, or retransmitting any computer program or instructions intended to gain unauthorized access to, or make unauthorized use of, a computer facility, software, or licensed software.
4. Creating, modifying, executing, or retransmitting any computer program or instructions intended to obscure the identity of the sender of electronic mail or electronic messages.
5. Making unauthorized copies of licensed software.
6. Effecting or receiving unauthorized electronic transfer of funds or any unapproved commercial purpose.
7. Allowing unauthorized access by non-associates to CHRISTUS Health computer resources or network facilities.
8. Any communication which violates applicable state and/or Federal laws and regulations.
9. Intentionally sending viruses or any other communication designed to bring down or otherwise disrupt a computer or related system's operation.



**CONFIDENTIALITY AND COMPUTER RESOURCES AGREEMENT FOR  
HEALTH CARE PARTNERS**

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**ACKNOWLEDGMENT AND AGREEMENT**

I have read and understand this CHRISTUS Health Confidentiality and Computer Use Agreement. I agree to abide by the terms hereof and the Directives, Guidelines and Procedures of CHRISTUS Health, as they relate to CHRISTUS Health Information and CHRISTUS Health Information Systems. I understand that this Agreement is but a summary of CHRISTUS Health Management Directives, Policies, Guidelines and Procedures related CHRISTUS Health Information. I understand that any Management Directive, Policy, Guideline or Procedure of CHRISTUS Health may be amended or revised by CHRISTUS Health at any time, at its discretion. Any failure on my part to abide by this Agreement or CHRISTUS Health Management Directives, Policies, Guidelines and Procedures may result in the termination of my authorization access to and/or use of CHRISTUS Health Information or appropriate legal action to enforce the terms of this Agreement.

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This Agreement is entered into this the \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

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HEALTH CARE PARTNER SIGNATURE

PRINTED NAME

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HEALTH CARE PARTNER COMPANY/GROUP

HEALTH CARE PARTNER ADDRESS / LOCATION



**Physician Sponsored Health Care Professional  
PERSONAL DATA FORM**

**Name:** \_\_\_\_\_  
Last                      First                      Middle Name (As shown on Social Security Card)

**Mailing Address:** \_\_\_\_\_  
Number                      Street                      Apt#                      City/State                      Zip

**Email Address:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Other:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Male:** \_\_\_\_ **Female:** \_\_\_\_

**EEOC:** White \_\_\_\_ Black \_\_\_\_ Hispanic \_\_\_\_ Asian \_\_\_\_ Other \_\_\_\_

**Job Title:** \_\_\_\_\_

**Have you ever been employed by CHRISTUS Spohn Health System?** \_\_\_\_ Yes \_\_\_\_ No

**If so, what dates were you employed?** \_\_\_\_\_

**In Case of Emergency notify:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Work:** \_\_\_\_\_

*Revised: 02.2019*