HÔPITAL
NOTRE-DAME
HOSPITAL (HEARST)

Hello Doctor:

Following your recent correspondence with Mrs. Mélanie Goulet, our Recruiting Coordinator, please find enclosed the following application package for medical staff privileges at our hospital:

- Application for Appointment
- Standard List of Medical Staff Privileges (indicate procedures you want to perform)
- Confidentiality Agreement (read enclosed policy and return signed agreement only)
- Authentication of Verbal/Telephone Orders (read enclosed policy and return signed agreement only)
- Authentication of Dictated Reports (read enclosed policy and return signed agreement only)
- Application of Temporary Medical Staff Privileges (signature required)
- Applicant's Vulnerable Sector Screening Process (complete form and bring to your local OPP with two identification documents)

Also include a copy of the following:

- CPSO Certificate
- CMPA Certificate
- ACLS Certificate
- ATLS Certificate
- Recent headshot picture

Please return documentation to my attention either by fax or email as soon as possible.
Fax: 705-372-2923
E-mail: pouliotm@ndh.on.ca

If you have any questions, do not hesitate to contact me.

Yours in health care,

Melissa Pouliot
Executive Assistant to the CEO
pouliotm@ndh.on.ca
Tel: 705-372-2955

HÔPITAL NOTRE-DAME HOSPITAL (HEARST)

Application for Appointment to the Professional Staff

INITIAL APPOINTMENT

PART A: IDENTIFYING INFORMATION

Last Name	Given Name(s)		For the purpose of identification, please attach a recent photograph.
Date of birth : (Year – month – date)	Home Telephone		
HOME ADDRESS			
City	Prov.	Postal Code	

OFFICE Address ☐ CHECK THIS BOX IF SAME AS HOME ADDRESS			Business Telephone
City	Prov.	Postal Code	Cellular
Email address			Fax

BUSINESS/BILLING

Please specify which address you would like to use for payment purposes : ✱ PLEASE NOTE: If you use your home address for payment purposes it will be visible in our electronic record regional system.✱

☐ Home ☐ Business

Physician Billing Number		**Physician WSIB Billing Number**	Mask Fitting # : _____
ATLS Certification Year:	ACLS Certification Year:	ALARM Certification Year:	Date of last fitting: _____ **(Please include a copy of your card)**

PART B: QUALIFICATIONS

Ontario Licence (Please attach a copy of your CPSO Membership Card)

Licensed to Practice in Ontario?	Type	Date First Issued //yy //mm //dd
CPSO Registration Number		Expiry Date //yy //mm //dd

Other Licences:

Other/Previous Practice Licenses(s)?	Province	Country	Type
Licence/Registration number	Date First Issued //yy //mm //dd		Expiry Date //yy //mm //dd

CMPA number	Class
Other Coverage: Name of Company	Policy Number

Malpractice Insurance Information (Please attach a copy of your CMPA membership card)

PART C: EDUCATION AND TRAINING (Enclose copy of up-to-date curriculum vitae, including record of professional education, post-graduate training, and chronology of academic and professional career, organizational positions and committee membership)

Pre-Medical/Dental/Midwifery/Nursing Education

Name of University, College, Medical, Dental School	Diploma/Degree	Dates	
		From	To

Medical/Dental/Midwifery/Nursing Education – (Please attach copy of certificate)

Name of University, College, Medical, Dental School	Diploma/Degree	Dates	
		From	To

Post Graduate Medical/Dental Trainin (Internships/Residencies)

Appointment	Institution	Dates	
		From	To

Post Graduate Qualifications (Certificates/Fellowships) - (Please attach copy of fellowship/certification documentation)

Fellowship/Certificate	Specialty	Dates	
		From	To

Hospital Affiliations (Past and Present)

Name of Hospital/Location	Staff Category	Privileges	Dates	
			From	To

Location and Duration of all Previous Practices	Dates	
Practice location	From	To

Professional Societies and Associations

***** New Credentialing Requirement *** - Bloody Easy Lite**

As per Accreditation Canada standard 4.3, hospitals must have a formal program to maintain team members' competence that includes evaluating their theoretical and practical knowledge on transfusion services. The competency assessment program applies to all team members, including prescribing physicians. As such, effective January 1, 2023, Sensenbrenner Hospital will now require all physicians, including locums, to provide proof of completion of Bloody Easy training prior to obtaining or renewing hospital privileges.

- ☐ I have previously completed the Bloody Easy Lite learning modules through Hôpital Notre-Dame Hospital's Learning Management System.
- ☐ I have previously completed the Bloody Easy Lite learning modules (or equivalent) elsewhere and have attached a copy of my certificate of completion.
- ☐ I have not completed the Bloody Easy Lite learning modules or cannot obtain a copy of my certificate of completion and would like to complete the online modules through Hôpital Notre-Dame Hospital's Learning Management System.
- ☐ Not applicable as I do not order blood products.

PART D: REFERENCES

List below at least three (3) appropriate references including the Chief of Staff of the last hospitals where you held privileges or received training; the Service Head or Head of Training Program if enrolled in a Graduate Training Program within the past three years; and (Applicable ONLY to recent graduates) the Dean of Medicine/Dentistry/Midwifery/Nursing of the last educational institution in which you held an appointment or were trained.

Reference name		**Title**	
Address		**City**	
Province		**Postal Code**	
Phone Number		**Email**	

Reference name		**Title**	
Address		**City**	
Province		**Postal Code**	
Phone Number		**Email**	

Reference name		**Title**	
Address		**City**	
Province		**Postal Code**	
Phone Number		**Email**	

Reference name		**Title**	
Address		**City**	
Province		**Postal Code**	
Phone Number		**Email**	

PART E: DETAILS OF REQUEST FOR APPOINTMENT

Category of Professional Staff Privileges Requested:

☐ Associate ☐ Active ☐ Courtesy ☐ Locum
☐ Temporary ☐ Honourary ☐ Senior

Name of Department/Program/Service/Division to which Appointment Requested:

☐ **EMERGENCY ROOM:**

- ○ Emergency Medicine

☐ **SURGERY:**

- ○ General Surgery ○ Anesthesia ○ Dentistry ○ Obstetrics/Gynecology
- ○ Orthopedics ○ Ophthalmology ○ ENT ○ Urology

☐ **HOSPITALIST**

☐ **DIAGNOSTIC IMAGING/CARDIOPULMONARY**

☐ **OUTPATIENT CLINIC**

☐ **LABORATORY MEDICINE**

PART F: DETAILS OF REQUEST FOR PRIVILEGES:

Please ensure you complete and submit the Standard List of Medical Staff Privileges (SCHEDULE C) for the program to which you are applying.

PART G: PROFESSIONAL LICENSING, PRIVILEGES AND MEMBERSHIP HISTORY

Has your licence to practice medicine/dentistry/midwifery/nursing in any jurisdiction ever been denied, suspended, restricted, terminated, curtailed, revoked, resigned (on a voluntary or involuntary basis), or not renewed?	☐ Yes ☐ No
Have your privileges in any hospital or healthcare institution ever been denied, suspended, restricted, terminated, curtailed, revoked, resigned (on a voluntary or involuntary basis), or not renewed?	☐ Yes ☐ No
Have your qualifications to practice ever been denied, suspended, restricted, terminated, curtailed, revoked, resigned (on a voluntary or involuntary basis), or not renewed?	☐ Yes ☐ No
Has any professional academic appointment ever been denied, suspended, restricted, terminated, curtailed, revoked, resigned (on a voluntary or involuntary basis), or not renewed?	☐ Yes ☐ No

IF THE ANSWER TO ANY OF THE ABOVE FOUR QUESTIONS IS "YES", PROVIDE A STATEMENT OF THE FULL DETAILS. THE STATEMENT MUST INCLUDE:

1. The reasons for the denial, suspension, restriction, termination, curtailment, revocation, resignation (voluntary or involuntary), or non-renewal of your licence, privileges, qualifications to practice, and/or academic appointment;

2. The substance of both the allegations and findings in any such action, proceeding, hearing, or procedure involving the denial, suspension, restriction, termination, curtailment, revocation, resignation (voluntary or involuntary), or non-renewal of your licence, privileges, membership, and/or academic appointment;

3. The date of the denial, suspension, restriction, termination, curtailment, revocation, resignation (voluntary or involuntary), or non-renewal of your licence, privileges, qualifications to practice , and/or academic appointment, and the name and address of the hospital or other institution with which you were affiliated at the time;

4. Any additional information concerning such action, proceedings, hearing, or procedure as you may deem appropriate or relevant.

PART H: DISCIPLINARY HISTORY

Have you ever been subject to disciplinary action by a professional college?	☐ Yes ☐ No
Are there any professional misconduct proceedings, competency investigations, performance reviews, peer review-type proceedings, or malpractice actions pending wherein you are a party in this province or any other province or country?	☐ Yes ☐ No
Have any judgments, settlements, findings, decisions, or any other determinations of any kind whatsoever been entered or made in any professional misconduct proceeding, competency investigation, performance review, peer review-type proceeding, or malpractice action related to your medical practice?	☐ Yes ☐ No

IF THE ANSWER TO ANY OF THE ABOVE THREE QUESTIONS IS "YES", PROVIDE A STATEMENT OF THE FULL DETAILS. THE STATEMENT MUST INCLUDE:

1. The substance of both the allegations and findings in any such proceeding, investigation review or action;

2. The manner in which the proceeding, investigation, review or action was resolved (i.e. dismissed, settled, judgment entered, etc.);

3. The date and jurisdiction in which the judgment, settlement, finding, decision, or determination was made;

4. Any additional information concerning such proceeding or action as you may deem appropriate or relevant.

PART I: APPLICANT'S LEGAL HISTORY

Have you ever been convicted of a crime or been the subject of a criminal proceeding in any province or country that may impact upon your suitability to be granted the privileges for which you are applying?	☐ Yes ☐ No
Have you ever been a party to a civil suit related to your medical practice where there was a finding of negligence or battery or where there was an out-of-court settlement, in any province or country?	☐ Yes ☐ No

IF THE ANSWER TO ANY OF THE ABOVE TWO QUESTIONS IS "YES", PROVIDE A STATEMENT OF THE FULL DETAILS. THE STATEMENT MUST INCLUDE:

1. The substance of the findings in any such criminal proceeding;
2. The manner in which the civil action was resolved (i.e. dismissed, settled, judgment entered, etc), including terms of settlement;
3. The date and jurisdiction in which the judgment, settlement, finding, decision, or determination was made;
4. Any additional information concerning such criminal or civil action as you may deem appropriate or relevant.

PART J: APPLICANT'S HEALTH HISTORY

Are you being treated or have you ever been treated for any medical condition, impairment, disease or illness (either physical or mental) that may impact on your present ability to practice? If yes, please complete and submit **Schedule A**.	☐ Yes ☐ No

Note: If you are over age 65, please provide a letter of recommendation from your present Chief of Staff.

PART K: APPLICANT'S ACKNOWLEDGEMENT:

My making of this application and signature below indicated my understanding of and consent to the following:

1. I fully recognize and agree that any misstatements in, or omissions from, this application constitutes cause for denial of my appointment and may, at the sole discretion of the Hospital, result in a recommendation being made that my privileges be revoked or suspended or otherwise dealt with in compliance with the *Public Hospitals Act* (Ontario).

2. I acknowledge that I have read and understood the *Public Hospitals Act* (Ontario), Regulation 965 "Hospital Management" passed under the *Public Hospitals Act* (Ontario), the Hospital's By-laws, the rules and regulations, the Hospital's Standardized Credentialling Policy and other Hospital policies and the Canadian Medical Association Code of Ethics, and if I am appointed to the Professional Staff of the Hospital, I agree to govern myself in accordance with the foregoing, as they may be amended from time to time.

3. I acknowledge that if I am appointed to the Professional Staff of the Hospital:

    (i) any failure on my part to provide services to the Hospital in accordance with the legislation, By-laws, rules and regulations referred to in paragraph (2) above will constitute a breach of my obligations, and the Hospital may, upon consideration of the individual circumstances, remove my access to any and all Hospital resources, including limiting or restricting of operating room time, or take such actions as is reasonable, in accordance with the *Public Hospitals Act* (Ontario), the Hospital By-laws and rules and regulations, the Hospital's Standardized Credentialling Policy and other Hospital policies; and

    (ii) the Hospital may refuse to appoint an applicant to the Professional Staff where the applicant refuses to acknowledge his or her responsibility to abide by a commitment to provide services in accordance with the privileges granted by the Board, and in accordance with the *Public Hospitals Act* (Ontario), the Hospital By-laws and rules and regulations, the Hospital's Standardized Credentialling Policy and other Hospital policies.

4. I agree to appear for any meetings, hearings or interviews regarding my application at my own expense.

5. I authorize the Hospital, its Chief Executive Officer, Chief of Staff, designated members of the Professional Staff and their representatives to contact and consult with administrators, members of professional staffs and other hospitals or institutions with which I have been associated or affiliated, including without limitation those persons listed on this application as references, and with other individuals and institutions, including past and present malpractice carriers and the Canadian Medical Protective Association (or equivalent associations for dentists/midwives/nurses, directors of post-graduate training programs, or licensing and/or regulatory bodies, who may have information bearing on my professional competence, character and overall qualifications for the privileges for which I am applying.

6. I consent to the inspection by the Hospital, its Professional Staff and their representatives of all records and documents of any kind or nature, including records, at other hospitals, similar institutions or regulatory bodies that are material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested.

7. I agree to sign the Authorization and Consent to the Release of Information which is annexed as *Schedule A* to this application, and to continue to assist the Hospital in any way required to secure information regarding my application and my continuing exercise of clinical privileges and membership on the Professional Staff of the Hospital.

8. I understand and agree that, as an Applicant for Professional Staff membership, I have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications.

9. I confirm that I have not requested privileges for any procedures for which I am not qualified. I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe and represent that I am qualified to perform all procedures for which I have requested privileges.

10. I verify that the information provided by me in this application is true and accurate to the best of my knowledge and belief.

I HAVE BEEN ADVISED OF, AND HEREBY ACKNOWLEDGE, MY OBLIGATION TO ADVISE THE HOSPITAL IN WRITING IMMEDIATELY OF ANY NEW, DIFFERENT OR ADDITIONAL INFORMATION RELEVANT TO ANY OF THE QUESTIONS OR ITEMS OF INFORMATION REQUESTED IN THIS APPLICATION WHICH AT ANY TIME COMES TO MY ATTENTION.

_____ _____

Signature of Applicant Date

HÔPITAL
NOTRE-DAME
HOSPITAL (HEARST)

SCHEDULE A

Application for Appointment to the Medical Staff

AUTHORIZATION AND CONSENT TO THE RELEASE OF INFORMATION FROM TREATING PHYSICIAN

Name of treating physician/hospital/treatment center: _____

Address: _____

I,_____, an applicant for appointment to the Medical Staff of the Hôpital Notre-Dame Hospital hereby authorize and consent to you, my treating physician, discussing with a member of the Credentials Committee of the Hospital the following medical condition, impairment, disease or illness (either physical or mental) which I feel may be relevant to my present ability to practice medicine:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

APPLICANT NAME : (PRINT)	
SIGNATURE OF APPLICANT:	
DATE:	

HÔPITAL
NOTRE-DAME
HOSPITAL (HEARST)

SCHEDULE B

AUTHORIZATION FOR THE RELEASE OF INFORMATION TO THE
Hôpital Notre-Dame Hospital (Hearst)

I, _____ hereby consent to the release of all information with respect to my appointment at any institution described in the attached application and hereby authorize such information to be provided to the Executive and Senior Medical Staff of the Hôpital Notre-Dame Hospital (Hearst), for the purpose of considering my application to the staff of the Hôpital Notre-Dame Hospital (Hearst).

DATED:	**SIGNATURE:**

HÔPITAL NOTRE-DAME HOSPITAL (HEARST)

STANDARD LIST OF MEDICAL STAFF PRIVILEGES
SCHEDULE C

INSTRUCTIONS AND NOTES:

All privileges requested must be indicated with a check mark in the appropriate column.

Failure to respond will mean considerable delay in recommendation by the Medical Advisory Committee (additional references or details may also be requested).

The Medical Advisory Committee will require further information and past experience on any other privileges not listed but requested, or any other references on specific privileges it deems necessary.

Date: _____ Signature: _____

LEGEND
italic and bold: **addition**
~~strike out~~: **deletion**

ANESTHESIA

- ☐ Regional
- ☐ Epidural
- ☐ Spinal
- ☐ General
- ☐ Conscious sedation

- ☐ **Admission of Patient to Hospital**
- ☐ **Ordering Diagnostic and Therapeutic Tests**

GENERAL SURGERY

SKIN & SUBCUTANEOUS TISSUE

- ☐ Tumors e.g. warts, nevus, sebaceous cysts, lipoma, excision of
- ☐ Avulsion of toe-fingernail
- ☐ Onycectomy
- ☐ Repair of lacerations:
- ☐ -simple
- ☐ -complex
- ☐ Cut-down
- ☐ Extensive burns (initial treatment only)
- ☐ Grafts
- ☐ Debridement
- ☐ Abscess I & D
- ☐ Foreign bodies
- ☐ Vein ligation and stripping

EAR, NOSE, THROAT AND EYE

- ☐ Laryngoscopy
- ☐ Nasal polyp, simple removal of
- ☐ Nose, fracture - reduction of deformity
- ☐ Tonsillectomy and / or adenoidectomy
- ☐ Lid wounds suture of
- ☐ Lymph node biopsy
- ☐ Tracheostomy
- ☐ Chalazion
- ☐ Foreign body embedded in cornea, removal of
- ☐ Nasal cautery
- ☐ Nasal packing
- ☐ Tonometry/ applanation

CHEST

- ☐ Breast biopsy and lumpectomy
- ☐ Mastectomy - simple
- ☐ Mastectomy - radical

ABDOMEN

- [ ] Cholecystectomy
- [ ] Cholodochotomy
- [ ] Closure perforated or bleeding ulcer
- [ ] Gastrotomy
- [ ] Gastroenterostomy
- [ ] Splenectomy
- [ ] Laparotomy
- [ ] Laparoscopy
- [ ] Paniculectomy
- [ ] Appendectomy
- [ ] Colostomy
- [ ] Diverticulitis - resection
- [ ] Abdomino - perineal resection
- [ ] I & D intra-abdominal abscess
- [ ] Bowel Resection

RECTUM

- [ ] Banding of hemorrhoids
- [ ] Anal warts, epithelioma
- [ ] Anal fissure-strictures-dilatation, injection of
- [ ] Hemorrhoidectomy
- [ ] Rectal polyp, excision of
- [ ] Rectocele, varicocele repair of
- [ ] Pilonidal cyst - marsupialization of cyst
- [ ] Sphincterotomy & sphincteroplasty

HERNIA

- [ ] Inguinal, child & adult
- [ ] Ventral or femoral
- [ ] Incisional or post-operative
- [ ] Umbilical
- [ ] Wound dehiscence

UROLOGICAL SURGERY

- [ ] Cystoscopy and retrograde pyelogram
- [ ] Suprapubic cystotomy
- [ ] Recto-vesical fistula
- [ ] Biopsy of the prostate
- [ ] Dilatation of urethral stricture
- [ ] Circomcision
- [ ] Testicular surgery
- [ ] Vasectomy

GYNECOLOGY

- [ ] Cone excision of cervix
- [ ] Cervix biopsy, cauterization
- [ ] Cervical polyp, removal of
- [ ] LEEP
- [ ] I & D - Bartholin duct abscess
- [ ] Dilatation and curettage
- [ ] Hysterectomy
- [ ] Marshall - Marchetti
- [ ] Ovarian & fallopian tube surgery
- [ ] Hysterosalpingogram
- [ ] Pessary insertion
- [ ] Tubal ligation
- [ ] Repair of vaginal prolapse
- [ ] Vulvar lesion excision

OBSTETRICS

- [ ] Vaginal delivery
- [ ] Cervical and perineal repair
- [ ] Cervix, incompetent, suture of during pregnancy
- [ ] Perineal tear, complete into rectum (3rd and 4th degree)
- [ ] Placenta, retained, manual removal of
- [ ] D & C, cauterization, cervical biopsy during pregnancy
- [ ] Caesarian section
- [ ] External podalic version
- [ ] Suction and curettage
- [ ] Induction of labor
- [ ] Augmentation of labor
- [ ] Forceps: delivery
- [ ] Vacuum delivery

NURSERY PRIVILEGES

- [ ] Routine newborn care
- [ ] Circumcision
- [ ] Tongue-tie release

MUSCULOSKELETAL

- [ ] Closed reduction
- [ ] Open reduction
- [ ] Bunionectomy
- [ ] Arthroscopy
- [ ] Manipulation under general anaesthesia
- [ ] Release of carpal tunnel
- [ ] Excision of synovial cyst
- [ ] Dupytren's Contracture
- [ ] Ganglion, excision
- [ ] Tendon repair
- [ ] Amputation minor
- [ ] Amputation major
- [ ] Removal of othopaedic plates & screws

PROCEDURES

- ☐ Liver biopsy
- ☐ Thoracentesis
- ☐ Paracentesis
- ☐ Joint aspiration/ injection
- ☐ Bone marrow aspiration
- ☐ Lumbar puncture
- ☐ Insertion and removal of central venous catheter
- ☐ Removal of Hickman catheter or porta-cath
- ☐ Intraosseous
- ☐ Picc line
- ☐ Insertion of LMA

ENDOSCOPY

- ☐ Esophagoscopy
- ☐ Gastroscopy
- ☐ Proctoscopy
- ☐ Sigmoidoscopy
- ☐ Colonoscopy

ORAL AND DENTAL

- ☐ Multiple dental restoration
- ☐ Multiple dental extractions
- ☐ Surgical removal of impacted teeth
- ☐ Surgical removal of embedded teeth
- ☐ Dental implants
- ☐ Frenectomy
- ☐ Alveoloplasty
- ☐ Simple intraoral biopsy
- ☐ Incision and drainage intraoral abcess

OTHERS (PLEASE SPECIFY ANY OTHER SPECIAL PROCEDURES THAT YOU WOULD LIKE TO EFFECTUATE)

_____

_____

_____

_____

_____

Revised October 2010

CPSO

80 College Street
Toronto ON M5G 2E2
www.cpso.on.ca

Membership Services
Email: membership@cpso.on.ca
Fax: (416) 967-2643
Telephone: (416) 967-2673
Toll Free (in Canada): 1-800-268-7096 ext. 673

Request for Certificate of Professional Conduct

I, Dr. _____ holding CPSO Membership number _____

request that the Registrar of the College of Physicians and Surgeons of Ontario issue a Certificate of Professional Conduct to:

Institution or Licensing Body: Hôpital Notre-Dame Hospital (Hearst)

Attention: Melissa Pouliot, Executive Assistant

Street Address: P.O. Box 8000, 1405 Edward Street

City: Hearst Province/State: ON Postal/Zip Code: P0L1N0

Country: Canada Telephone: 705-372-2955

Email: pouliotm@ndh.on.ca

Consent for Release of Information

I, Dr. _____ a member of the College of Physicians and Surgeons of Ontario,

certify that I have read the request for a Certificate of Professional Conduct and the definition of information to be included in that Certificate, printed on the document of which this Consent forms a part. I understand the nature of the information which will comprise the requested Certificate of Professional Conduct which is outlined at the bottom of this form and I further understand that the College will not release this information further to this request unless I consent to its release and evidence at consent by signing this Consent Form.

I hereby consent to the release of the Certificate of Professional Conduct defined in the document of which this Consent forms a part by the Registrar of the College of Physicians and Surgeons of Ontario and request the Registrar do so.

This Consent shall be valid for six months from the day on which I sign it.

Signature: _____ Date of Signature: _____

Mailing Address: _____

Telephone: _____ Email: _____

Information Provided in a Certificate of Professional Conduct

1. The member's qualifications as known to the College (as recorded on the Register) including date and place of primary medical qualification.
2. The class of certificate of registration held by the member and any terms and conditions attached thereto.
3. The current address of the member as recorded on the Register.
4. The speciality qualifications of the member as recorded on the Register.
5. The history of any previous disciplinary or Fitness to Practise findings as recorded on the Register.
6. The history of any terms and conditions attached to the certificate of registration as recorded on the Register.
7. Whether the member's conduct or fitness to practise is or is not the subject of an inquiry by the Discipline Committee or Fitness to Practise Committee at the time of the issuing of this Certificate.
8. Whether the member has in the six years proceeding the issuance of this Certificate been the subject of proceedings before the Discipline Committee or Fitness to Practise Committee and the outcome of those proceedings.
9. Whether any revocation, suspension, restriction, resignation, relinquishment or rejection of privileges or appointment reported to the College by a hospital appears in the records of the College.
10. Any other information respecting the member which has been reported to the College and which is deemed by the Registrar to be relevant to the receiving hospital, medical school, regulatory authority or other organization.
Note: The information provided in this Certificate can be furnished to the requesting institution only where the member physician has fully completed and signed the form of consent, which forms part of this document.

HÔPITAL NOTRE-DAME HOSPITAL (HEARST)

TO: Privacy

CODE: ADM-PRI-5 E

CATEGORY: Access and Correction

DATE OF APPROVAL: February 2005

SUBJECT: Privacy Policy

APPROVAL:

CHIEF EXECUTIVE OFFICER

NOTE: This document is a CONTROLLED document. Any documents in paper form must be used for reference purposes only. The on-line copy must be considered the current documentation.

DATE	REVIEWED	REVISED
May 07		NR
June 12	Pol&Proc	
December 14	NR	
February 16		LGM/SC
January 17		LGM

DATE	REVIEWED	REVISED
Oct 18		S. Camiré
Dec 2023		S. Camiré

Source: OHA – Hospital Privacy Toolkit, September 2004
NEON PPWG Policy N012

Link: Summary of commitment of Hôpital Notre-Dame Hospital towards patients

Preamble

Hôpital Notre-Dame Hospital (Hearst) recognizes the importance of policy and the sensitivity of your personal health information. We are committed to collecting, using and disclosing **personal** information in a responsible way and only to the extent necessary for the services provided. We are committed to protecting any information that belongs to you that we hold in any of our electronic systems. This Privacy Policy outlines how we manage your information and safeguard your privacy.

Definitions

Any references to "your information" means your personal health information as defined by PHIPA. See Appendix A for specific definitions.

PHIPA Is the Law

Starting November 1, 2004, any health information custodian in the Ontario health care system that collects, uses or discloses personal health information must comply with the *Personal Health Information Protection Act, 2004.*

The Hospital is a health information custodian and is responsible for the personal health information we collect, use, maintain and disclose, as set out in this Policy.

Purpose for the Collection, Use and Disclosure of Personal Health Information

NDH and NEON partner hospitals collect, use and disclose personal health information in a number of ways, including but not limited to:

- Provide treatment and care
- Obtain payment for treatment and care
- Plan, administer and manager the partner hospital facilities and their programs
- Conduct risk management and quality improvement activities
- Conduct teaching and research activities
- Compile statistics
- Comply with legal and regulatory requirements and
- Fulfill other purposes as required by law

What Information Do We Collect From You?

Generally, we will ask you to give us whatever information about your health and your family's health that we need to care for you.

We will collect information from you for the following purposes, which are our **"main activities":** caring for you, administration of the Hospital and the health care system, teaching, limited research, statistics and complying with legal and regulatory requirements.

We will either directly tell you why we are collecting your information or we will post a notice or give you information that describes why we are collecting your information.

We will only collect information from you indirectly (e.g., from other health care providers or from your family and friends) if necessary to provide you with care, when you cannot provide the information yourself or cannot consent to provide the information yourself.

How Do We Use Your Information?

Your information is given to your caregivers in the Hospital or any NEON partner hospitals to be used to care for you. Our directors, employees, professional staff (doctors, dentists, pharmacist, nurses, etc.), volunteers and students are trained and understand that your information is private and can only be used or accessed to care for you or carry out our main activities.

Some of your health care information is required to be shared with other health care agencies and network such as PACs, regional laboratory program, OBSP, etc.

If we use your information for any purpose other than our main activities, we will ask your permission.

When Will We Disclose Your Information

Unless you tell us not to, we will disclose your information to other health care providers in the

"Circle of Care" who need to know this information to provide you with care or help to provide you with care. The "Circle of Care" includes health care professionals, pharmacies, laboratories, ambulance, nursing homes, Home Community Care support services and home service providers who provide you with health care services.

Unless you tell us not to, we will tell anyone who calls the Hospital or visits the Hospital asking about you that:

- You are in the Hospital (Room #); and
- Your basic health condition (critical, fair, poor, etc.).

Unless you tell us not to, if you give us information about your religious affiliation, we may give your name and room number to our Hospital's representative of your religious affiliation.

Unless you tell us not to, we may give your name and address to our Foundation - which may contact you for fundraising purposes. You can ask not to be contacted for fundraising at any time.

Sometimes the law requires us to disclose information about you, such as to OHIP for payment purposes. We will only disclose your information when the law requires or permits us to do so.

Getting Your Consent

Your consent to our collection, use or disclosure of your information may be implied or express. In certain circumstances we will always ask for your express consent:

- Where we are disclosing your information to someone who is not a health information custodian (e.g., to your insurer or employer); and
- Where we are disclosing your information to someone who is a health information custodian but for purposes other than providing you with health care.

Where we obtain your implied consent, you will have been provided with a notice (either posted in a place where you are likely to see it or directly given to you) and a chance to withhold your consent.

When we collect personal health information from an individual, the associate who collects the information ensures that the individual has the capacity to consent, or has a substitute decision maker who has the capacity and authority to consent on the person's behalf.

In the event that a substitute decision maker is required to provide consent, this individual is informed of the purpose for collecting the personal health information, and how it will be used and/or disclosed.

When a written express consent cannot be obtained in a timely manner, consent may be requested and provided verbally.

You may withdraw or limit your consent at any time, unless doing so prevents us from recording the information we require from you at law or under professional standards. You can give an express instruction that specific information not be used or disclosed.

We may sometimes collect, use or disclose your personal information without your consent in limited instances that are expressly permitted by PHIPA. For example, some statutes require disclosure of your information, such as the *Coroners Act* and the *Vital Statistics Act.*

Retaining Your Information and Disposing of Your Information

We retain your information in the Hospital or in premises controlled by the Hospital in a secure manner and keep it for as long as necessary to fulfill the purposes for which it was collected, or as required by law.

The Hospital has a policy in place to address the retention and destruction of records in the Hospital. This policy sets out minimum and maximum retention periods and complies with applicable laws governing retention of information.

Where you have requested access to a record with your information, we will retain that record until your access request is exhausted.

Accuracy of Your Information

We take reasonable steps to ensure your information is as accurate, complete and up-to-date as necessary on collection. We will not routinely update information in our control unless routine updates are necessary to fulfill the purposes for which the information was collected. We take reasonable steps to ensure that any information that is used by the Hospital on an ongoing basis, including any information that is routinely disclosed to others under this policy, is accurate, complete and up-to-date. Where we know that information is not accurate, complete or up-to-date, this fact will be indicated at the time of use or disclosure.

Security of Your Information

Your information in the custody or control of the Hospital is protected by security safeguards. These security safeguards are in keeping with industry standards and are designed to protect your information against loss or theft as well as unauthorized access, disclosure, copying, use or modification.

Among the steps we take to protect your information are:

- premises security, including locked filing cabinets where cabinets are located in publicly accessible areas;
- restricted access to information stored electronically;
- using technological safeguards like security software and firewalls to prevent hacking or unauthorized computer access; and
- internal password and security policies.

Hospital agents are aware of the importance of keeping your information confidential. As a condition of employment or obtaining/maintaining privileges, all Hospital agents are required to sign a Confidentiality Agreement annually (January).

We will notify you at the first reasonable opportunity if your information is lost, stolen, or subject to unauthorized access, disclosure, copying, use or modification.

How to Access Your Information

You can request access to any records in the Hospital's custody or control that contain your information by writing to our Privacy Officer. The guidelines for processing these requests are available on request. You will receive at least a preliminary response from the Privacy Officer within 30 days, and a full response within 60 days.

Your right to access your information is not absolute. We may deny access when:

- denial of access is required or authorized by law (e.g., there is a court order prohibiting access); or
- where the request is trivial or annoying or in bad faith.

If the Privacy Officer refuses you access to your records, there will be a reason given, and you will also be notified of your right to complain to the Information and Privacy Commissioner.

You are also entitled to challenge the accuracy or completeness of any of your information in our custody or control. Requests to challenge and/or change your information should be directed to the Privacy Officer. You will receive at least a preliminary response from the Privacy Officer within 30 days, and a full response within 60 days.

We may charge you a reasonable fee (based on cost recovery) for copies of your information. We will advise you of any fee before we make copies.

Challenging Us

You are entitled to challenge our compliance with the principles set out in this policy. Please direct any challenge in writing to our Privacy Officer.

Anyone who submits a written complaint, challenge or inquiry will be given a written copy of our procedures governing such complaints, challenges and inquiries.

We will investigate all complaints received. If a complaint is found to have merit, we will take appropriate measures to address the complaint, including, if necessary, taking disciplinary action against Hospital agents and/or amending our policies and practices relating to management of your information.

Compliance with this Policy

All Hospital agents (employees, directors, volunteers, students, and professional staff «doctors, dentists, pharmacist, nurses, etc.») are required to know and comply with this policy. Annual confirmation of compliance is required. Any breach of this policy may result in significant disciplinary action, including:

- for employees and volunteers, suspension, demotion, and termination; and
- for professional staff members, restriction or revocation of privileges, in whole or in part.

Agents may only use your information as permitted by the Hospital and within the same legal limitations imposed on the Hospital. All agents must notify the Hospital at the first reasonable opportunity if your information is lost, stolen or accessed without authorization.

Our Privacy Officer

The Chief Executive Officer ("CEO") of the Hospital is ultimately responsible for ensuring accountability and compliance with this policy. The CEO appoints a member of our staff to act as the Hospital's Privacy Officer; the Privacy Officer reports directly to the CEO. The Privacy Officer may delegate to others the day-to-day supervision of the collection, use and disclosure of information.

The Privacy Officer for the Hospital is:	Sylvie Camiré
Address	1405 Edward Street
Phone Number	705-372-2958
Fax Number	705-372-2937
E-mail address	privacy@ndh.on.ca

Appendix A – Definitions

Agent

Anyone authorized by the Hospital to collect, use or disclosure of personal health information on behalf of the Hospital and not for the agent's own purposes; (for example, employees; persons contracted to provide services who have access to personal health information (records management, copying or shredding records); health professionals with privileges; volunteers; directors; students

Circle of Care

Those health information custodians indicated under the definition of health information custodian with an asterisk (*health information custodian), for the purpose of providing health care or assisting in providing health care within the continuum of care.

HIC (Health Information Custodian) includes:

- the Hospital
- health care practitioners
  - regulated health professionals; registered drugless practitioner; social worker; person whose primary function is to provide health care (acupuncturist, psychotherapy)
  - NOT aboriginal healers; aboriginal midwives; faith healer
- service providers to Home Community Care support services
- public, private, or mental hospitals
- psychiatric facilities under *Mental Health Act*
- independent health facilities
- homes for aged, nursing homes
- pharmacies
- laboratories
- ambulance
- community health or mental health centres whose primary purpose is providing health care
- evaluators under *Health Care Consent Act* or assessors under *Substitute Decisions Act* (capacity)
- medical officer of health and board of health under *Health Protection and Promotion Act*
- Minister and Ministry
- others as provided under the regulations

IPC - Information and Privacy Commissioner of Ontario

PHI (Personal Health Information)
Information, oral or recorded, about an individual that does or could identify that individual and that:

- relates to physical or mental health
- includes family history as it is reflected in record of personal health information
- identifies the health care provider
- relates to payments or eligibility for health care
- relates to donation of body part or bodily substance
- includes the health number (replaces *Health Cards and Numbers Control Act)*
- identifies substitute decision maker
- includes any non-health info that is in record that is identifying

PHIPA - *Personal Health Information Protection Act, 2004* (Ontario)

Privacy Officer - Hospital employee identified at end of this Policy

SDM - substitute decision maker

CONFIDENTIALITY AGREEMENT
HÔPITAL NOTRE-DAME HOSPITAL (HEARST) (HNDH)
2024

I acknowledge that I have read and understood HNDH's policies and procedures on privacy, confidentiality and security.

I acknowledge that I am entering into this Agreement pursuant to either a new or existing employment relationship or affiliation (independent contractors, privileged physicians, board members and volunteers) with HNDH (the "**Employment Relationship**" or affiliation). Future payment for my services pursuant to the Employment Relationship is sufficient consideration to bind me to the additional covenants contained herein.

I understand that:

- All personal information (PH) and/or personal health information (PHI) that I have access to or learn through my employment or affiliation with HNDH is confidential,
- As a condition of my employment or affiliation with HNDH, I must comply with these policies and procedures, and my failure to comply may result in corrective action including but not limited to discipline up to and including the termination of my employment or affiliation with HNDH and may also result in legal action being taken against me by HNDH and others,
- I am only permitted to access PHI in Meditech or any other data system containing PHI to provide direct care or when needed to perform my assigned duties. I understand that access to PHI is tracked daily and regularly audited,
- I am not authorized to access my own PHI unless needed to perform my assigned duties and that I must follow the same process as a patient to request access to my PHI through Health Records,
- I agree that I will not access, use or disclose any confidential and/or PHI that I learn of or possess because of my affiliation with HNDH, unless it is necessary for me to do so in order to perform my responsibilities. I also understand that under no circumstances may confidential and/or PHI be communicated either within or outside of HNDH, except to other persons who are within the circle of care of the patient,
- I agree that I will not alter, destroy, copy or interfere with this information, except with authorization and in accordance with the policies and procedures,
- I agree to maintain security of my computer so that unauthorized individuals cannot access the system; by the use of strong passwords and locking my workstation or logging-off the system when out of my work area,
- I will protect physical access devices (for example, keys and badges) and the confidentiality of any information being accessed (for example, financial data, in camera discussion),
- I agree to keep any computer access codes (for example, passwords) confidential and secure. I will not lend/give out my access codes or devices to anyone, nor will I attempt to use those of others. I understand that access codes come with legal responsibilities and that I am accountable for all work done under these codes. If I have reason to believe that my access codes or devices have been compromised or stolen, I will immediately contact HNDH,
- HNDH has a Privacy Officer on site and that the Privacy Officer is a resource for all employees and those affiliated with HNDH.

A breach of Personal Health Information Protection Act (PHIPA)/Freedom of Information and Protection of Privacy Act (FIPPA) may lead to penalties being imposed by the applicable jurisdiction, including, without limitation, fines, or to civil suit for damages.

❒ Employee of HNDH **or** **❒ Affiliation with HNDH:** _____

_____

Name (Please Print) **Signature** **Date**

HÔPITAL NOTRE-DAME HOSPITAL (HEARST)

TO: Medical Staff

CODE: GOV-MED-PRO-4

CATEGORY: Procedures

DATE OF APPROVAL: May 26, 1988

SUBJECT: Authentication of Verbal/Telephone Orders
Undated Written Orders and Notes

APPROVAL:

CHIEF OF STAFF

NOTE: This document is a CONTROLLED document. Any documents in paper form must be used for reference purposes only. The on-line copy must be considered the current documentation.

DATE	REVIEWED	REVISED
September 2014		SC/NR
November 2014		NR
January 2019	MAC	
October 2023		MAC

DATE	REVIEWED	REVISED

Source: Hôpital Régional de Sudbury Regional Hospital, Kirkland and District Hospital, Atikokan General Hospital.
Legal: Public Hospital Act
Approved at MAC: June 2, 2008
Approved at MAC: November 12, 2014

PURPOSE:

The Health Record is a record of the patient's stay in hospital and is considered a significant means of communication among health care providers. The health record also serves to protect the legal interests of the patient, health care providers and the hospital.

PREVAILING REGULATIONS:

According to the Public Hospitals Act (PHA):

Section 1(1) "Authenticate" means to identify oneself as the author of a document or a record by personal signature or by any other means authorized by the board.

Section 19(1) **Records of personal Health Information**
Every administrator shall ensure that a system is established for the keeping of records of personal health information for each patient. R.R.O. 1990, Reg. 965, s. 19(1); O. Reg. 332/04, s. 4(2).

Section 19(2) Each entry in a medical record shall bear the date on which it was made and shall be authenticated by the person who authorized the entry.

Section 24(3) **Orders for treatment**

Where an order for treatment or for a diagnostic procedure has been dictated by telephone,

(a) the person to whom the order was dictated shall transcribe the order, the name of the physician, dentist, midwife or registered nurse in the extended class who dictated the order, the date and the time of receiving the order and shall authenticate the transcription; and

(b) the physician, dentist, midwife or registered nurse in the extended class who dictated the order shall authenticate the order on the first visit to the hospital after dictating the order. O. Reg. 761/93, s. 11; O. Reg. 45/98 s. 3.

POLICY:

Recognition of the fact that the verbal/telephone orders should have been signed contemporaneously and are not, led to the following new policy adapted by the Medical Advisory Committee.

The Medical Record charts which are outstanding for signature of authenticated verbal and/or telephone orders and dates for written orders or progress notes that were not dated shall be considered complete for inpatient charts if:

1. The physician concurs (includes locums and post-graduate residents)
2. The patient record contains the following:
   - Completed Discharge Summary
   - Valid signed and dated discharge order
   - As appropriate, completed operative record
   - As appropriate, completed death certificate

For Emergency Outpatient visits:

Every emergency on-call physician is responsible to review their own verbal and/or telephone orders by signing the ER form. Health Records staff will follow-up when needed.

There are still four (4) key elements to ensure good patient care in this completion of charts.

All physicians will identify their choices in these strategies for ongoing by reading and signing the attached forms and returning them to the Health Records Coordinator.

The Health Records Department will continue to follow-up with physicians who want to continue signing verbal/telephone orders and missing dates on written orders and progress notes.

HÔPITAL NOTRE-DAME HOSPITAL (HEARST)

ONGOING CHART COMPLETION AGREEMENT

Preamble: The following process is to ensure timely completion of charts in an alternative and effective manner. Please remember there is an expectation that physicians date and sign all orders and notes that they write on the chart. That is good standard of practice for physicians.

The following policy has been accepted to facilitate completion of charts when signatures have not occurred contemporaneously.

The MAC has recommended and authorized the following policy for authentication of:

i) Verbal/telephone orders
ii) Undated physician written orders and notes

Charts that are outstanding for signature co-signs for verbal/telephone orders and dates for written orders or regular progress notes that were not dated shall be considered complete for inpatient charts if:

1. The physician concurs with this chart completion policy
2. The patient record has a:
   - Completed **Discharge Summary**
   - Valid signed **Discharge Order**
   - As appropriate, completed Operative Report
   - As appropriate, completed Death Certificate

For Emergency Outpatient visits:

Every emergency on-call physician is responsible to review their own verbal and/or telephone orders by signing the ER form. Health Records staff will follow-up when needed.

The following must be signed and dated: Procedure based on hand-written progress notes as well for the Emergency Cardiac reanimation (Code blue).

☐ Yes, I would like to participate in this Ongoing chart completion strategy.
☐ No, I would like to continue signing all my verbal/telephone orders and date any undated written orders, notes.

Name of Physician (printed)	Signature	Date

Notice: Return this copy to the Medical Records Department

HÔPITAL NOTRE-DAME HOSPITAL (HEARST)

TO: Medical Staff

CODE: GOV-MED-PRO-3

CATEGORY: Procedures

DATE OF APPROVAL: May 26, 1988

SUBJECT: Authentication of Dictated Reports

APPROVAL:

CHIEF OF STAFF

NOTE: This document is a CONTROLLED document. Any documents in paper form must be used for reference purposes only. The on-line copy must be considered the current documentation.

DATE	REVIEWED	REVISED
January 2019	MAC	

DATE	REVIEWED	REVISED

Source: Hôpital Régional de Sudbury Regional Hospital, Kirkland and District Hospital, Atikokan General Hospital.

Legal: Public Hospitals Act

PURPOSE:

The health record is a record of the patient's stay in hospital and is considered a significant means of communication among health care providers. The health record also serves to protect the legal interests of the patient, health care providers and the hospital.

PREVAILING REGULATIONS:

According to the Public Hospitals Act (PHA):

Section 34, 1 (1) Where in this Regulation or under by-laws of the hospital a notation, report, record, order, entry, signature or transcription is required to be entered, prepared, made, written, kept or copied, the entering, preparing, making, writing, keeping or copying may be done by such electronic or optical means or combination thereof as may be authorized by the Board.

Section 19(2) Each entry in a medical record shall bear the date on which it was made and shall be authenticated by the person who authorized the entry.

Section 1(1) "Authenticate" means to identify oneself as the author of a document or a record by personal signature or by any other means authorized by the board.

POLICY:

AUTHENTICATION OF DICTATED REPORTS

The use of authentication is **MANDATORY** for all physicians and:

a) each physician must sign an authentication agreement

b) as part of the agreement, the physician certifies that he/she is the only person with access to the access code.

c) the physician who uses the authentication and completes the appropriate documentation will use his/her access code (usual dictation number), which will be maintained in a physician reference file in the Medical Records Department.

d) when a physician accesses the dictation system using his/her individual code, the physician is automatically identified by name and code number.

e) if the physician access code and physician name corresponds with the physician reference file, the reports will be labeled: "BEING AUTHENTICATED AS PER POLICY".

f) it will be the responsibility of the physician to certify the correctness of the report within 7 days of receipt of a copy of the authenticated report.

g) if the physician does not return the report within 7 days of receipt of the authenticated report, the report will be considered correct.

h) if errors are identified, the physician must return the authenticated copy to the Medical Records Department and identify the necessary corrections.

i) a corrected report will be labeled authenticated by the physician and a copy sent to the physician.

j) **Please Note:** If the procedure is not carried out correctly such as wrong access code used, or, if there are any concerns by the medical dictatypist, the report cannot be identified as "authenticated", therefore, the physician will have to sign the report.

All physicians must abide by this policy.

Form must be signed every year and is kept at the Administration's Office. For new Locums, the form will be signed on first visit.

HÔPITAL NOTRE-DAME HOSPITAL
Sac postal 8000/P.O. Bag 8000
1405 rue Edward Street
Hearst ON P0L 1N0
Att: Archives médicales / Health Records
Tel. (705) 372-2909
Fax (705) 372-2937

AUTHENTICATION AGREEMENT FOR DICTATED REPORTS

I, _____, (print name and physician number) understand the authentication of dictated reports proposals and the requirements I must meet in order to fulfill the obligations outlined in the Public Hospitals Act Regulation 965.

I, _____, also certify that I will not make my access code available to anyone else.

_____ _____
Date Signature

HÔPITAL
NOTRE-DAME
HOSPITAL (HEARST)

Application for Temporary Medical Staff Privileges

I, _____

Residence address: _____ Home phone: _____

_____

Office address: _____

Office phone: _____ Fax: _____

E-mail: _____

hereby apply to be granted the privilege of performing within the Hospital effective _____ _____until_____ (Not to extend beyond the date of the next medical Advisory Committee meeting) the following procedures:

_____

_____

AND I SOLEMNLY DECLARE AND WARRANT THAT my past training and experience has been of such a nature and duration that I now consider myself competent and capable of proficiently performing the procedures listed above.

AND I FURTHER AGREE AND UNDERTAKE to conform to, and to govern myself in accordance with, provisions and requirements set out in the by-laws and rules of the Hospital and in the Hospital Management Regulation under the Public Hospitals Act of Ontario.

_____ _____
Dated Witness name

_____ _____
Signature of Applicant Signature of witness

TO BE FILLED BY ADMINISTRATION

After conference with the Chief of the Medical Staff on _____ given approval as per the Medical Staff By-laws.

_____
Hospital CEO

_____
Chief of the Medical Staff

OFFICIALLY REPORTED TO THE MEDICAL ADVISORY COMMITTEE AT ITS MEETING HELD ON _____.

Acknowledged by: _____
Chair of Medical Advisory Committee