Emergency Credentialing
JCAHO approves new emergency credentialing standard

An overview of the provisions of MS.5.14.4.1

A new JCAHO standard outlines how hospitals may credential and privilege licensed independent practitioners (LIPs) who aren’t members of the medical staff, but volunteer their services during an emergency. The accrediting body’s Board of Commissioners approved this standard, MS.5.14.4.1, July 17, 2002, according to JCAHO spokesperson Mark Forstneger.

MS.5.14.4.1 takes effect immediately for all JCAHO-accredited hospitals, reports the July 2002 JCAHOOnline. So you, your credentialing office colleagues, and medical staff leaders should become familiar with its provisions as soon as possible. This special report will help you do just that. The articles that follow will focus on key aspects of this standard and offer tips for compliance. The text below gives a general overview and context for those articles.

The nuts and bolts of the standard

MS.5.14.4.1 allows a hospital’s chief executive officer (CEO) or medical staff president (or their designees) to grant emergency privileges when its emergency management plan is activated and the organization is unable to handle immediate patient-care needs. The emergency management plan must identify the individual(s) responsible for granting emergency privileges, along with any alternates, according to the June 2002 JCAHO update posted to the “Members Only” section of the American Hospital Association’s (AHA) Web site.

The new standard doesn’t require the responsible individual to grant emergency privileges to anyone—he or she must make each decision on a case-by-case basis after receipt of a “key identification [ID] document,” says the AHA e-mail blast.

A “key identification document,” according to the AHA posting, includes any of the following:

- A current hospital photo ID card
- A current medical license with valid photo ID issued by a state, federal, or regulatory agency
- An ID that certifies an LIP is a member of a state or federal disaster medical assistance team
- An ID that certifies the LIP has been granted authority by a federal, state, or municipal entity to administer patient care in emergencies
- Presentation by a current hospital or medical staff member who can vouch for the LIP’s identity

In addition to identifying which individual may authorize emergency privileges, the intent statement says hospitals’ emergency plans also must

- spell out the responsibilities of the individuals with emergency privileging authority
- develop a plan for managing volunteer LIPs with emergency privileges (this plan should include a mechanism that allows for quick identification of these LIPs)
- recognize the credentials verification process as a high priority (i.e., once the immediate situation is under control, the hospital must begin to verify a volunteer’s credentials using a process identical to that of granting temporary privileges)

“Medical staff services professionals [MSSPs] should bring this new standard to the attention of whoever handles the disaster plan at their hospital,” advises medical staff consultant Kathy Matzka, CMCS, CPSC, of Lebanon, IL.

Standard in response to recent national disasters

JCAHOOnline reports that the JCAHO developed this standard in response to the 2001 floods in Houston, and the terrorist attacks in New York City and Washington, DC.

“I’m glad the JCAHO is looking at this issue,” says Susan Rowland, medical staff services manager of Community Hospital of the Monterey Peninsula, Monterey, CA, “[It’s] formalizing what many hospitals already have in place, and at the same time is really giving guidance to those who have never considered [emergency credentialing] before.”
Emergency credentialing doesn’t end with quick ID check

MSSPs must follow up with traditional verification activities

The JCAHO’s new emergency credentialing standard (MS.5.14.4.1) allows a hospital’s chief executive officer (CEO) or medical staff president (or their designee(s)) to grant emergency privileges to physicians who volunteer their services during a disaster but aren’t members of the medical staff. But before a volunteer may care for patients, he or she must first present an acceptable identification document that confirms he or she is a licensed physician. Sounds quick and simple, right? Well, not exactly.

Industry insiders agree that the new standard makes it easier for hospitals to bring extra help into their organizations during a crisis, but they stress that it doesn’t allow for credentialing to stop with a quick identification (ID) check. MSSPs must follow up on each volunteer with thorough credentials verification as soon as the emergency is under control. The standard says this follow-up process must be “identical to the process . . . for granting temporary privileges.”

This article discusses how the concepts of emergency credentialing and temporary privileges work together in MS.5.14.4.1 to safeguard your patients and your institution against substandard or even fraudulent physicians.

Get the help you need . . . quickly

When a disaster strikes locally and your emergency department (ED) becomes overwhelmed with critically ill or injured patients, the hospital’s first concern is to give those patients immediate life-saving care. But your hospital can’t deliver this kind of care to all patients if there aren’t enough physicians and other practitioners on hand to help. Enter emergency credentialing.

During an emergency, physicians from other parts of the state and even the country might volunteer their services to help your overtaxed medical staff handle patient overflow. MS.5.14.4.1 allows the hospital CEO or other designated official to grant emergency privileges to volunteers only after the receipt of at least one of the following documents:

- A current hospital photo ID card
- A current medical license and a valid photo ID issued by a state, federal, or regulatory agency
- ID that certifies the individual is a member of a Disaster Medical Assistance Team
- ID that certifies a state, federal, or municipal entity has granted the individual the authority to administer patient care under emergency circumstances
- Presentation by a current hospital or medical staff member who can vouch for the individual’s identity

Editor’s note: For further explanation of these ID types, see p. 5.

“We chose these forms of ID based on what physicians traditionally carry around with them,” said JCAHO Vice President for Standards Robert Wise, MD, at the 2002 Credentialing Forum in Washington, DC, July 24–25. “Our research and experience told us that physicians generally don’t walk around with their license in their back pocket, but they usually have their hospital ID card with them.”

Once the CEO or other designee inspects one of the above-listed IDs and determines the volunteer’s services are needed, the volunteer can begin to administer care immediately. But the credentialing process shouldn’t end there.

Follow up with full credentialing

Once a volunteer physician begins to work in your facility, you must verify his or her credentials as soon as the immediate situation is under control. Such credentials include “the usual suspects,” according to Deb Ankowicz, RN, BSN, CPQH, risk management consultant with PIC Wisconsin, in Madison, WI.

“Verify the physician’s licensure, medical school, training, and current competence as soon after the initial disaster as possible,” she clarifies.

Temporary v. emergency privileges

The new standard says the credentials verification process should mirror the process continued on p. 4
already established under your temporary privileges policy. Does that mean temporary privileges are the same thing as emergency privileges?

“The JCAHO mentions temporary privileges in the new standard to illustrate the fact that you can’t simply look at a hospital ID card and call it a day,” explains Steven Bryant, practice director of accreditation and regulatory compliance services at The Greeley Company, a division of HCPro, in Marblehead, MA.

“Once a physician goes to work with temporary privileges, [the hospital] must still verify all of his or her other credentials [beyond the initially required licensure and clinical competence] to make sure he or she can continue to work,” Bryant says. “If you should find a problem in the physician’s background, the hospital would probably want to terminate his or her temporary privileges.” The same principle applies to physicians with emergency privileges.

If you uncover any problems while verifying a volunteer’s credentials, bring them to the attention of the appropriate department chair and other key medical staff leaders,” says Ankowicz. “They may decide to terminate his or her emergency privileges immediately.” Be sure to write this stipulation into your policy as a safeguard against any legal action the physician might take in response.

Emergency privileges differ most from temporary privileges in that they are granted upon receipt of one of the above-listed ID items. A CEO may not grant temporary privileges to fulfill an urgent patient-care need before the physician’s licensure and current clinical competence are verified. (See the clarification of MS.5.14.4 at www.jcabo.org.)

Also, emergency privileges are intended for the duration of an emergency, whereas temporary privileges can be granted for longer periods, typically 90 to 120 days, points out Mark Forstneger, JCAHO spokesperson.

“The temporary privileges standard just doesn’t address the immediacy of a true emergency situation,” said Wise. “We wanted to bring forward a very flexible standard that didn’t require the verification of any credentials up-front. It’s all done after the privileges are granted.”

Terminate privileges when emergency ends

Ankowicz adds that, like temporary privileges, emergency privileges should be specialty-specific and time-limited. In other words, the hospital should not allow a volunteer physician to perform tasks outside his or her scope of practice, and that his or her privileges should expire the moment the emergency ends. (See the sample emergency privileges form on p. 6.)

“But when exactly does an emergency end?” asks Ankowicz. “Many hospitals consider an emergency to be over once the state’s governor or other elected official publicly announces it. The CEO then makes an official declaration for the hospital.” However your hospital determines the end of a disaster, make sure to write it into your emergency credentialing and emergency management policies, she advises.

And what is meant by “specialty-specific?” Bryant explains that volunteer physicians cannot carry out any clinical activities for which they don’t already hold privileges at another institution.

Make privileges verification part of your follow-up credentialing process. This information is sometimes difficult to obtain from other hospitals, so do your best and document your efforts.

Bryant points out that MS.5.14.4.1 empowers hospitals to accept outside help for the basics of emergency care: stabilizing and triaging patients.

“It doesn’t really contemplate more complicated, advanced procedures like neurosurgery, for example,” he notes.

But hospitals certainly should consider how they might find adequate backup should they need a particular specialist during an emergency. -\-
Acceptable IDs for emergency credentialing

Under its new standard (MS.5.14.4.1), the JCAHO permits hospitals to grant emergency privileges to volunteer physicians upon receipt of at least one of the five identification (ID) documents below. An explanation follows each item.

1. **Current hospital photo ID card**

   This item is straightforward. All U.S. hospitals issue their medical staff members some type of ID card. Make sure it includes a photograph that matches the cardholder. Also remember to check the card’s expiration date.

2. **Current medical license and a valid picture ID issued by a state, federal, or regulatory agency**

   Check the physician’s medical license to make sure it’s current. Whenever possible, look at the original, not a copy, advises Steven Bryant, practice director of accreditation and regulatory compliance services at The Greeley Company, a division of HCPro, Marblehead, MA. A current, government-issued, picture ID (e.g., a driver’s license or passport) should accompany the license.

   “When presented with an out-of-state license, defer to your state law on whether he or she may practice without an in-state license,” advises JCAHO Vice President for Standards Robert Wise, MD.

3. **ID that certifies the individual is a member of a disaster medical assistance team (DMAT)**

   The National Disaster Medical System (NDMS), under the auspices of the U.S. Public Health Service (PHS), develops and organizes DMATs, which are groups of professional medical personnel designed to provide emergency medical care during a disaster. DMATs deploy to disaster sites with medical supplies and equipment to sustain themselves for a 72-hour period while providing care at a fixed or temporary medical care site.*

   The PHS issues ID cards to all DMAT members every two years. The card includes a picture of the cardholder, as well as an expiration date and the DMAT team name (e.g., “Georgia 1”). The PHS and National Disaster Medical System insignias appear on the front.** Check for these characteristics when presented with a DMAT card.

4. **ID that certifies a state, federal, or municipal entity has granted the individual the authority to administer patient care under emergency circumstances**

   “Such IDs would include those held by FEMA [the Federal Emergency Management Agency] personnel, the state medical examiner, and so on,” explains Bryant. FEMA badges include the holder’s name, picture, and a bar code.***

5. **Presentation by a current hospital or medical staff member who can vouch for the practitioner’s identity**

   “If I were a hospital, I’d be less willing to rely on this particular option,” says Wise. “We [the JCAHO] thought it was fair to include it, since so many physicians within a given community know each other well, but I’d proceed with caution and diligence.”

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* Definition provided by the NDMS. For a more extensive definition, go to http://oep.osophs.dhhs.gov/dmat/.

** Information provided by customer service representative for the NDMS’s Office of Emergency Preparedness.

*** Information found on FEMA’s Web site at www.fema.gov/diz01/d1369n11.shtm.
Emergency privileges form

I, __________________________________, certify that I am licensed/certified as a ________________ in the state of __________________, license # ______________. I certify that I have the training, knowledge, and experience to practice in the specialty of ____________________________.

I hereby volunteer my medical services to [ ] during this emergency and agree to practice, as directed and under the supervision of a member of the medical staff of [ ].

I also acknowledge that my privileges at this hospital shall **immediately terminate** once the emergency has ended, as notified by the hospital.

_______________________________________________
Signature of practitioner

_______________________________________________
Date

The information as provided by the practitioner has been reviewed and verified, as possible, by Professional Affairs. On this basis, this practitioner is hereby granted emergency privileges to treat patients presenting to [ ] during this disaster.

_______________________________________________
Signature of medical staff president

_______________________________________________
Date

_______________________________________________
Signature of medical director

_______________________________________________
Date

_______________________________________________
Signature of CEO/president

_______________________________________________
Date

Source: Developed by Nilda Conrad, MBA, CMSC, CPCS, director of medical staff services, North General Hospital, New York City. Reprinted with permission.
Disaster plan should include emergency privileging policy

In most cases, a hospital’s emergency plan designates the chief executive officer (CEO) or medical staff president as the individuals who grant privileges to volunteer practitioners during a crisis situation. But a plan can designate any number of other hospital officials to serve in that role as well.

A new standard recently approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) addresses the topic of emergency privileges. Standard MS.5.14.4.1 states that in disaster situations that lead a hospital to activate its emergency plan, the CEO or medical president, or their designee(s), may grant emergency privileges. Approved by the JCAHO board July 17, 2002, the standard went into effect immediately.

Others who may be designated with the task of granting emergency privileges include the chief of services, chair of emergency management, vice president of the medical staff, chief of the emergency department, chair of the credentials committee, executive vice president, and the chief operating officer, according to Steven Bryant, practice director of accreditation services for The Greeley Company in Marblehead, MA.

“You can designate a handful of folks in your emergency plan,” says Bryant. “If I were a CEO, I’d designate myself, a few administrators, and a few physician leaders.”

Don’t forget your emergency plan

The key is to make sure your emergency plan addresses the situation, fulfilling JCAHO standard EC.1.4, which requires hospitals to have a plan addressing emergency management in place. As part of that plan, hospitals must now ensure that steps are in place to credential and privilege practitioners during an emergency.

The new medical staff standard’s intent statement stipulates that emergency privileges may be granted when the organization is unable to handle the immediate patient needs. “There’s got to be an important patient care need,” says Bryant. “It should be a situation where you need additional resources or don’t have the appropriate expertise.”

In addition to identifying those individuals responsible for granting emergency privileges, the emergency plan should describe the responsibilities of these individuals.

These responsibilities include ensuring that volunteer physicians have been properly credentialed and privileged to an acceptable minimum level, and assigning a temporarily privileged physician to a member of the medical staff in the same specialty, who must then supervise the visiting physician.

“At minimum, you have to verify some level of competency for [volunteer practitioners],” Bryant says. “The individual’s responsibilities lie in

continued on p. 8

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quick verification of credentials and competence.”

The responsible individual is not required to grant privileges to any individual and should make such decisions on a case-by-case basis at his or her discretion, according to the intent statement.

**It’s all about quick verification**

The idea is to develop a quick process for verification, says Joseph Sabato, Jr., MD, executive board member of the New Hampshire chapter of the American College of Emergency Physicians. “The traditional process is pretty laborious,” he says. “You have to have a process that will at least verify that the person is qualified.”

The JCAHO’s new standard should help hospitals improve their emergency privileging processes, says Sabato. “It has not been done well in my experience,” he adds. “This is all new to everybody. But I can see that changing . . . I think the standard is a good idea and departments of emergency medicine should be leading that.”

Although the standard doesn’t introduce a radical concept, Bryant says it still represents new thinking for many hospitals. “I don’t know if a lot of hospitals contemplated this, to tell you the truth,” he says. “Most have mechanisms to grant temporary privileges . . . I don’t recall seeing this in an emergency plan.”

The standard gives hospitals a lot more flexibility to deal with situations such as the September 11 terrorist attacks in New York City and Washington, DC, Bryant says. “If instead of 3,000 dead, they had 3,000 seriously injured, New York hospitals would have needed a lot of help,” he adds. “There’s no time to do primary source verification. You just need some type of identification . . . If there’s a plane crash outside your hospital, you’re not going to worry about the Joint Commission.”

Many hospitals likely follow most of the steps outlined in the new standard, designating individuals to grant emergency privileges. But the language is written into the hospital’s credentialing policy, not in the emergency plan, where it also needs to be addressed.

“It’s probably what happens anyway. Now the JCAHO is making it official,” Bryant notes. 

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On the morning of September 11, 2001, Edmund Geigerich, MD, was in a meeting at a hospital in Manhattan when terrorists attacked the World Trade Center.

Geigerich, the senior vice president for medical affairs at Long Island College Hospital (LICH) in Brooklyn, was unable to return to his hospital, along with LICH’s chief executive officer and medical director. “I was trapped at a senior staff meeting. We couldn’t move [from our location],” he says.

Geigerich managed to contact LICH using a cell phone and learned that LICH staff members, volunteer physicians, and medical students descended upon the Long Island facility to offer their help when the expected casualties arrived. The president of the medical staff and credentials committee chair were at the hospital and able to grant emergency privileges under the hospital’s policy.

“That’s the purpose of having a disaster plan. Other people can do it,” Geigerich says. “In this situation, you don’t want to deny someone who has the ability, but you want to protect the patients.”

A nearby hotel was hosting a conference attended by a group of Canadian physicians, who came to LICH offering their help. “Since we didn’t know the magnitude of the event, we tried to privilege them,” Geigerich says.

**Plenty of help available, but few injured**

As it turned out, LICH only granted emergency privileges to one emergency physician September 11 who treated a few patients, he adds. The hospital was busy, but it did not receive the expected influx of patients from the World Trade Center; sadly, there were more dead than injured victims.

“We didn’t need to go further with [the volunteer physicians],” Geigerich says. “We were ready to grant privileges, but didn’t have to.”

Geigerich says the hospital’s existing temporary privileges policy worked September 11, but LICH is in the process of developing a specific policy for its emergency plan. “We certainly have had a policy in place. It goes a little beyond temporary privileges,” he says. “We can check people quickly on the Internet. But a lot of telephone and Internet access on September 11 was tied up. You’re really dependent on access to communication.”

In emergency situations, LICH uses a physician’s driver’s license to verify identity and checks New York–based physicians through a state-run database.

**Policy revision underway**

LICH awaits the full language of the new Joint Commission on Accreditation of Healthcare Organizations’ emergency credentialing standard to use as it develops an emergency privileges policy specifically for its disaster plan, Geigerich says. “For the future, this is going to be critical for us to look at,” he adds. “Managing your volunteers, whether community or professional, must be part of your disaster plan because people will come [to volunteer their services]. What this standard does is allow us to consider what we will accept as far as proof of who someone is, and proof of privileges.”

In addition, LICH will require visiting physicians to work under the supervision of a medical staff member. “I’d hope we’d have enough staff to proctor or mentor someone. We’d try to have someone buddy up with someone on our staff,” he says.

The revision process began even before September 11. “We were in the process of modernizing our disaster plan before this occurred,” says Geigerich. The hospital conducted tabletop drills before September 2001, completed a major disaster drill since, and plans another drill in the near future.

One item the hospital wants to address is how to handle credentialing and privileging, as well as other essential functions, if communications go down in an emergency. “What happens when you have no communications?” asks Geigerich. “Had it been a different type of incident, we don’t know what would have happened.”
New standard requires monitoring of patient care by volunteer physicians

The introduction of the JCAHO’s new emergency credentialing standard has taken many industry experts by surprise. Despite the lack of publicity about the standard prior to its approval, your facility is expected to take steps now to ensure compliance the next time JCAHO surveyors come knocking on your door.

The new standard requires hospitals to “set forth a plan to manage individuals who have been granted emergency privileges.” This plan must also specify the mechanism used by the hospital to identify practitioners granted emergency privileges.

Turn to standard interpretations
Because of the lack of fanfare surrounding the standard’s development and eventual approval, most hospitals have not even begun to introduce policies and procedures that address the standard’s requirements. This lack of preparedness and absence of policies after which facilities can model their procedures means most hospitals will have to start from scratch.

“As I read this new standard, I try to apply it to the New York situation and what we heard from physicians who were present. None of [the standard’s requirements] could possibly have happened,” says Linda Haddad, Esq., partner at the law firm Hory Springer and Mattern, in Pittsburgh.

“It’s just impossible to carry out all this information when people are flooding into the hospital to help in a major crisis. I’m not sure if the JCAHO has helped us one bit with this standard.”

Although the accreditsor has not been forthcoming with details about what exactly it will be looking for in regard to compliance with this standard, John Rosing, FACHE, senior consultant at The Greeley Company, a division of HCPro, in Marblehead, MA, suggests you turn to past interpretations of JCAHO standards to get started developing your organization’s policies on managing volunteer practitioners.

“ ‘Set forth a plan to manage individuals who have been granted emergency privileges’ is JCAHO code for having some method to monitor the quality of work performed while the physicians provide care with emergency privileges,” Rosing explains.

You can modify your hospital’s current mechanism for monitoring physician performance and apply it to licensed independent practitioners who are not members of your medical staff.

Note: Because most quality monitoring is done retro-spectively, you must develop a concurrent assessment to monitor physicians granted emergency privileges, according to Cris Mobley, CMSC, president of C. Mobley & Associates in Colorado Springs, CO.

Rosing suggests keeping the following in mind when drafting your policy:

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• The quality monitor(s) should vary based on the physician’s specialty so that the hospital can “evaluate something pertinent to what the physician is doing.”

• The quality monitor(s) could be exactly the same as those used by the hospital to look at members of its medical staff in the same specialty.

• Increase the frequency and intensity of the data collection and analysis for non-medical staff members to reflect the real-time nature of the emergency situation.

“While you might routinely monitor a staff surgeon over a more leisurely, quarterly basis because you are generally aware of the person’s capability and are merely measuring ongoing stability and conformance to the mean performance on a control chart,” Rosing says, “a surgeon granted emergency privileges may warrant per-case data collection and analysis to ensure that a poor-performing surgeon has not sneaked into the organization, taking advantage of the emergency and perhaps attendant confusion.”

To properly monitor the care provided by physicians granted emergency privileges, keep track of which patients these providers treat. (See p. 12 for a sample form.)

**Bylaws help**

Although there aren’t many sample policies circulating that address the monitoring of physicians with emergency privileges, you can likely find some guidance in your state emergency credentialing laws, state emergency health powers act, and state and national hospital association provisions.

For example, the Florida Hospital Association (FHA) developed a model credentialing provision for hospitals to use in times of emergency, according to William Bell, FHA general counsel. The model bylaw was developed in the early 1990s and provides for assigning a physician with emergency privileges to the appropriate department and member of the existing staff.

The standard states, “The practitioner shall be assigned to a department of the medical staff, and a member of the (active) staff designated to who the practitioner shall report for assignment for the treatment of patients.”

In addition, the FHA model bylaw requires the “assignment of the temporary credentialed physician to the clinical department/division of their (sub) specialty, with supervisory authority granted to the respective department/division chief or other appropriate designated physician.”

**Identify practitioners**

The JCAHO’s emergency credentialing standard also requires hospitals to implement a “mechanism to allow [practitioners granted privileges in an emergency] to be readily identified.”

Rosing explains that this mechanism may include any or all of the following:

• A picture identification/name badge worn by non-medical staff personnel providing care during an emergency.

• A flyer or electronic message distributed throughout the organization that includes the names, photographs, and basic demographic information about volunteer practitioners. In addition, these messages should list the privileges each practitioner has been granted.

• A special armband to identify volunteer practitioners quickly.

Again, state and local associations and regulatory bodies could provide your facility with direction in regard to this issue. The FHA is pursuing a policy initiative that requires the “issuance of standardized photo identification cards to physicians.”

These cards would include information about the physician’s licensure, specialty, and privileges delineation.

This initiative is one of several others the FHA is pursuing on both the state and national level regarding emergency privileges.
**RECORD OF PATIENTS SEEN BY PRACTITIONER DURING EMERGENCY**

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