Specialty Surgery Center
322 22nd Avenue North | Nashville, TN 37203
(615) 321-6161 | fax (615) 645-9870 | www.ssctn.com

Initial Credentialing Application: Surgical Assistant / Technician

Dear Applicant,

Thank you for your interest in providing services at our facility. Specialty Surgery Center (SSC) is an Ambulatory Surgery Center that is certified by the Center for Medicare/Medicaid Services (CMS) as well as the Accreditation Association for Ambulatory Healthcare Facilities (AAAHC) as a premier provider of outpatient surgical care in middle Tennessee. The following application is required by state regulations and facility bylaws. This application is specifically for an Ophthalmologic Instrument Technician as defined below:

An Ophthalmologic Instrument Technician must:

1. Currently be employed by a licensed, practicing physician in the state of Tennessee
2. Complete the Sterile Technique Seminar provided by Specialty Surgery Center
3. Undergo a background check by Specialty Surgery Center
4. Undergo vendor training on appropriate use of Aura and LensX ophthalmologic systems (if applicable)

In addition to this application, you will need to submit the following documentation before your application is considered complete:

_____Copy of Recent photo ID (Driver's License is acceptable)
_____Copy of current Tennessee issued Surgical Technician license (if applicable)
_____Evidence of Vendor training for use of Aura and LensX (if applicable)
_____Copy of recent tuberculosis skin test results (PPD)
_____Copy of current BLS/CPR certification,
_____$75 application fee

The credentialing process will begin upon receipt of your complete Initial Credentialing Application as well as the initial application fee of $75. Temporary Privileges can be granted within 2 weeks, whereas your full appointment could take up to 6 weeks. Once full privileges are granted, they are active for a period of two (2) years.

If you have any questions or need assistance with this application, please feel free to contact me via email at cdavenport@ssctn.com or phone at (615) 321-6161 ext 1001. We look forward to receiving your completed application and to working with you.

Sincerely,

Christina Davenport
Specialty Surgery Center

Initial Credentialing Application:
Ophthalmologic Instrument Technician

Section I: Demographic Information

____

Last Name First Name Middle Initial Gender

______-______-______ ____/____/________ Preferred Contact Method: E-mail Phone Fax

Social Security Number Date of Birth

_______________________________________ ______________________________

Primary Practice Name Office Manager/Contact

____

Primary Practice Address City State Zip

(______) ______ - ________ (______) ______ - ________ ____________________________________

Practice Telephone Practice Fax E-mail Address

______________________________ (______) ______ - ________ ________________________

Emergency Contact Person Emergency Contact Phone Emergency Contact Relation To You

Section II: Professional License/Certification Information

(Attach copies of all licenses and certifications if applicable)

License Number: _______________ Date Issued: ____/____/________ Expiration: ____/____/________

**Please specify if you hold any of the following certifications and attach proof of certification(s):*

__________Proof of proficiency in using LensX ophthalmologic system

__________Proof of proficiency in using ORA ophthalmologic system

BLS (CPR) Certification Expiration Date: ____/____/________

Section III: Supervising Physician Information

Name of Physician currently on staff at Specialty Surgery Center who will be supervising you:

____
Physician Name (please print)

____ ______________________
Physician Signature Date

Section IV: Health Status

(If you answer "yes" to the following questions, please explain on separate sheet of paper)

1. Do you presently have any physical or mental condition, illness or injury (including use of or dependency on any chemical substance or alcohol) that in any way impairs or limits your ability to practice or perform procedures for the privileges you are requesting at Specialty Surgery Center with reasonable skill and safety? (with or without accommodation)? YES NO

2. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you? YES NO

3. Are you currently engaged in illegal use of controlled dangerous substances? YES NO

4. Have you received treatment or been advised to receive treatment for alcohol or substance dependency? YES NO

5. Are you currently taking any medications that may affect either your clinical judgment or motor skills? YES NO

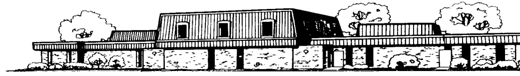
Section V: Conditions of Application

I attest that the information contained in this profile and all enclosed/attached documents, which are agree to provide to support this profile, are complete and accurate. I agree to notify SSC of any change in the information contained in this profile and any attached documents within thirty (30) days of the date that I am aware of the change. Furthermore, I consent to the inspection and copying of all records and documents that may be relevant to my pending credentialing review and decision.

A copy of this authorization and release has the same effect as the original.

____ _________________________
Printed name of Ophthalmologic Tech Applicant Date

____
Signature of Ophthalmologic Tech Applicant



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Authorization for Ophthalmologic Instrument Technician

(To be filled out by sponsoring physician)

This is to certify that I, ______________________________________, a duly licensed Doctor of Medicine admitted to practice the art of medicine in the State of Tennessee do hereby apply for permission from the Credentialing/Medical Director to allow me to employ an assistant while practicing medicine at the Specialty Surgery Center.

I further certify and declare that I am admitted with full staff privileges to the Medical Staff of this facility.

I further certify and declare that the Ophthalmologic Technician, whose name is______________________________________shall at all times be my employee and shall never, for any reason, be considered to be an employee, agent or servant of the facility. I also declare that I shall, at all times, be personally responsible for any and all acts of aforementioned assistant while he/she is on the premises of the Specialty Surgery Center.

I further certify that the assistant is qualified and he/she will provide the Director of Nursing of Specialty Surgery Center acceptable proof of licensure, certification, or training.

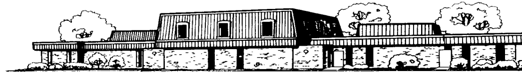
I certify to all parties that I will always have direct supervision over and that I will be physically present to monitor his/her actions when necessary.

I further agree that I shall indemnify and hold the center and the partnership harmless from any and all claims relating to my assistant under the agreement and shall pay all expenses, including attorney's fees relating to any such claims.

A photocopy of this shall serve as the original.

____
Full Name of Sponsoring Physician (Printed)

____ ____________________________________
Signature of Physician Date



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Release of Information

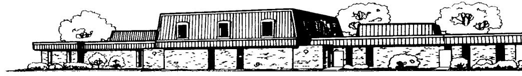
By making application to the Specialty Surgery Center as an Allied Health Professional, I hereby authorize the Director of Nursing, or their designee, to make an inquiry of any of my references and institutions in which I have been enrolled or by whom I have been employed or extended privileges, as to my qualifications.

I further authorize any of the above persons or institutions to forward any and all information their records may contain and agree to hold them harmless from any action by me for their acts.

A photocopy of this shall serve as the original.

____
Full Name (Printed)

____ ______________________________
Signature Date



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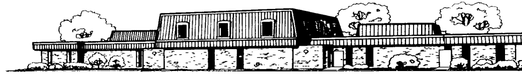
Right of Confidentiality

As a member of the Allied Health Staff of the Specialty Surgery Center, I recognize the patient's right to confidentiality and agree to abide by the Patient's Bill of Rights as posted within the Specialty Surgery Center. Additionally, I agree that information relating to a patient's physical, mental, and/or emotional status will not be released except as set forth within the policies and procedures of the Specialty Surgery Center.

____
Full Name (Printed)

____ ____________________________
Signature Date



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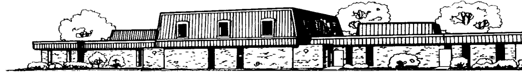
Total Release of Liability

I, ___________________________________, an Allied Health Professional of the Specialty Surgery Center (SSC), understand that SSC's first priority is to meet the needs of the patient. In meeting this goal, I understand that Specialty Surgery Center cannot be held responsible for any injury I may incur during my attending and/or assisting on surgeries while at their surgery center. In signing this form, I am relinquishing Specialty Surgery Center from any liability during my stay as an Allied Health Professional at Specialty Surgery Center.

____
Full Name (Printed)

____ ________________________________
Signature Date

____ ________________________________
Witness Signature Date



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Temporary Staff Privileges for:
Ophthalmologic Instrument Technician

Medical/Credentialing Director:

Please find my attached, completed, application for staff privileges as a Ophthalmologic Instrument Technician. I subsequently request temporary privileges for procedures delineated in my application, under the appropriate supervision, so that I may perform procedures at the Specialty Surgery Center for a period of ninety (90) days or until such time as my application has been approved by the governing board.

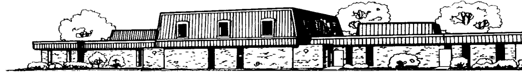
____
Full Name (Printed)

____ ________________________________
Signature Date

(Official Use Only Below Line)

Approved:________ Denied:________ Effective:____/____/________ through ____/____/________

____ ________________________________
Signature of Compliance Officer Date



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Full Approval of Appointment for:
Ophthalmologic Instrument Technician

____
Full Name (Printed)

(This Page Official Use Only)

Approved By Credentialing Staff:

____ ____________________________
Compliance Officer Signature Date

Approved By Governing Body:

____ ____________________________
President, Specialty Surgery Center Date