Baystate Health, Inc.

Disaster Privileges Request Form for Individuals Employed by Baystate Medical Practices, Inc.

As part of the comprehensive response of Baystate Health, Inc. (BH), to the COVID-19 pandemic, which has created increased demand for clinical services at the hospitals affiliated with BH (the "Emergency"), I, _____, seek to provide services at ☐Baystate Medical Center (BMC), ☐ Baystate Franklin Medical Center (BFMC), ☐ Baystate Noble Hospital (BNH), ☐ Baystate Wing Hospital (BWH) during Emergency and agree to provide professional services that are within the scope of my education, licensure, credentialing, and expertise in a manner consistent with the standards, policies and practices of my profession and BMC, BFMC, BNH, and BWH.

I certify that I am licensed and/or certified by the Commonwealth of Massachusetts as

_____

License/Certificate#_____Expiration date:_____

I certify that I have training, knowledge, and experience to practice in the specialty of:

_____

and that I currently hold membership and/or clinical privileges

in_____

(*describe membership and privileges)*

At _____

(*name, city and state, and phone number of institution)*

I am covered by professional liability insurance:

Insurance Carrier:_____ Policy #:_____

I understand and acknowledge that

(1) Privileges are being granted only for the duration of the Emergency and shall terminate automatically when the designated representative of BH has determined that the Emergency has ended;

(2) Privileges shall be terminated immediately if I have misrepresented or withheld any information required by this application;

(3) Privileges may be denied or terminated at any time at the discretion of the Senior VP of Quality, BH, or designee; and

(4) Denial or termination of disaster privileges, regardless of circumstances, shall not give rise to the right for a hearing, review of appeal under BMC, BFMC, BNH, or BWH Medical Staff Bylaws or Associate Professional Staff Rules and Regulations or any other standard, regulation or law.

In the event of an emergency, please contact the following person: _____

(name, phone number of emergency contact)

_____ _____

Signature of Practitioner Date

The information provided by the practitioner has been reviewed and verified consistent with the Medical Staff Rules and Regulations, policies, and procedures of BM, BFMC, BNH, and BWH. On this basis, this practitioner is hereby granted disaster privileges to provide services to patients presenting to ☐ BMC, ☐ BFMC, ☐ BNH, ☐ BWH during the Emergency.

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