

MASSACHUSETTS GENERAL HOSPITAL
Department of Nursing

Non-MGH Registered Nurses
REQUEST FOR AUTHORIZATION

1. Institution requesting authorization:

Name

Address

2. Nurse requesting authorization:

Name _____ Area of Practice

Position

Telephone

Massachusetts License _____ Expiration Date

3. Type of authorization requested:

___ Type I Research

___ Type II Patient Care

___ Type III On-Site Review

___ Type IV Facility Screening

___ Type V Consultant staff

4. Brief description of scope of requested activities:

5. Professional activities requested: (check all that apply)

- Collaborating with nurses, physicians, or other health team members
- Reviewing the patient record
- Interviewing the patient
- Documenting in the patient's record
- Participating in patient care conferences
- Providing direct patient care
- Participating in patient teaching and/or discharge planning
- Access to Patient Care Information System (PCIS)
- Access to PatCom System
- Other, explain _____

6. Clinical Areas: (check all that apply)

- Obstetrics, specify area(s) _____
- Pediatrics, specify area(s) _____
- Operating Room, specify area(s) _____
- Intensive Care Unit, specify area(s) _____
- Medical Unit, specify area(s) _____
- Surgical Unit, specify area(s) _____
- Orthopedic Unit, specify area(s) _____
- Neuroscience Unit, specify area(s) _____
- Psychiatric Unit
- Emergency Department
- Other, Specify _____

7. Malpractice Insurance: yes no _____ Amount

8. Have there been, or are there currently pending, any malpractice claims, suits, settlements, or arbitration proceedings involving your professional practice? yes no
If yes, please attach explanation on a separate sheet.

I will maintain any medical information obtained during the course of the medical review as confidential. The release of such information shall be limited to the party for whom I am employed or to other hospitals, facilities or agencies in order to facilitate transfer or the provision of other continuing care following discharge of the patient. No other release of medical information will be made without the written permission of the patient.

Signature of Nurse _____ Date

9. Endorsement of organizational representative of requesting institution:

Comments

Signature/Title

Types I, II, and V Authorization:

10. Reviewed by Chair, Credentialing Steering Committee:

Date _____ Recommended Action

Signature

11. Authorization granted as requested:

Signature _____ Date

Senior Vice President for Patient Care, Chief Nurse

Dates Effective _____ to

Authorization not granted:

Signature _____ Date

Senior Vice President for Patient Care, Chief Nurse

Comments

Type III Authorization:

12. Authorization granted as requested:

Signature _____ Date

Director, Case Manager Support Unit

Dates Effective _____ to

Authorization not granted:

Signature _____ Date

Director, Case Manager Support Unit

Comments

Please complete this form and return to the Massachusetts General Hospital with your application for authorization

Name: _____

HAVE YOU EVER HAD?	YES	NO
German Measles (Rubella)		
Measles (Rubeola)		
Mumps		
MMR Vaccine (Measles, Mumps, Rubella)	Date: _____	
Hepatitis If yes, what kind?		
Known documentation of positive hepatitis B without having had the disease		
Hepatitis B Vaccine received elsewhere If yes, how many doses did you receive?	Date: _____	
Chickenpox (Varicella)		
Tuberculosis If yes, what date were you diagnosed? Where were you treated? Date of most recent TB test? Was there any redness or swelling?	Date: _____ Where: _____ Date: _____	
Most recent chest x-ray, if any	Date: _____	
Last tetanus/diphtheria shot	Date: _____	

I certify that the above answers are true, to the best of my knowledge.

Signature: _____ Date: _____

Reviewed by: _____ Date: _____