Same -Day Ambulatory Surgery Center

23 Hour Stay Permitted

State Licensed By NJDOHSS

Joint Commission Accredited

Medicare Certified

2 Operating Rooms

**Application to Join the Medical Staff**



444 Market Street Suite 1

Saddle Brook, NJ 07663

Tel: (201)843-9441

Fax: (201)843-9442

**Surgicore Surgical Center**

**Required Documents for Privileges Application**

* Resume/CV
* Completed & Signed Application (Attached), Listing what procedures each doctor intends to do.
* Any & all awarded diplomas (i.e. Medical School, Internship, Residency, Fellowship, Board Certification Letter)
* Hospital Affiliation Letter
* Any applicable certificates of Training for Special Procedures
* Two (2) Reference Letters from Peers (**blank form provided)**
* Driver’s License Copy
* Copy of NJ Medical License
* Copy of Malpractice Certificate of Insurance/Binder showing Limits & Coverage Period
* Copy of Federal Drug Enforcement Authority (DEA) Certificate
* Copy of NJ Controlled Dangerous Substance (CDS) Certificate
* Completed & Signed Delineation of Privileges
* If Needed, Preference Card listing preferred supplies and/or equipment required in OR for cases
* Latest History & Physical, within 1 year **(blank form provided)**
* Titers/Vaccines for Measles, Rubella, Rubeola, Hepatitis
* Flu Shot within 1 year
* TB (PPD) 2 steps tests, within 1 year
* ACLS, BLS Certificates Current (required for Anesthesiologist

We will then conduct a NPDB search, Primary Source Verification via the AMA, NJ Medical License Verification & submit the Application for Committee Review.

**The entire process normally takes approximately 1 week.**

Thank you very much for your interest in our facility!

Any questions please do not hesitate to call and speak with me.

Best Regards,

Monique Morris, Administrator Leticia Hoyle, Director of Nursing

Tel: (201) 843-9441 Tel: (201) 843-9441

Fax: (201) 843-9442 Fax: (201) 843-9442

Cell: (201) 403-5017 Cell: (917) 674-769

*Surgicore Surgical Center, LLC*

*444 Market Street, Saddle Brook, NJ 07663*

**GENERAL INTRUCTIONS**

Complete the application in full. Print or type all responses. Attach additional sheets if necessary to complete your response & reference the question being answered. Submit photocopies of all other Required Documentation as per attached sheet.

**PERSONAL INFORMATION**

Physician Name:

Office Address:

Office Telephone: Office Email:

Office Contact Office Fax:

Home Address:

Home Telephone: Cell Phone:

Personal Email:

Birthplace: \*Date of Birth:

Citizenship: \*Social Security #:

**EDUCATION**

School Name & Location Degree Dates Attended

Medical School

Institution & Address Dates Attended

Internships

Residencies

Fellowships

Preceptorships

**CURRENT HOSPITAL & SURGERY CENTER PRIVILEGES**

Institution Dates From - To Staff Status: Active Courtesy

**BOARD CERTIFICATIONS**

Board Name Year Certified Year Recertified

Activate Candidate for Board of:

Name of Board Date of Exam

**LICENSING**

New Jersey License No. Date Issued

In what other States you Licensed?

**PROFESSIONAL LIABILITY INSURANCE**

Carrier $ Limits Specialty & Special Procedures Included

Copy of Certificate of Insurance must be attached

**STATEMENT OF HEALTH**

Answer one (1) of the following:

1. I certify that I am in good health and have no physical or mental limitations.
2. I do have chronic illness, physical disability or mental limitation to my health, which may include alcohol or drug abuse but believe that this does not significantly impair my ability to render quality patient care.

If you answered #2 and there has been any significant change in your health status in the past two (2) years, a full statement of explanation must be attached. This statement must include the name and address of your personal PCP.

**MEDICAL** List three (3) Peer Reference & their address/contact information:

**REFERENCE** 1.

2.

3.

**PROFESSONAL STATUS**

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONSIS “YES”, PLEASE GIVE FULL DETAILS ON SEPARATE SHEET(S) OF PAPER.

**Within the past six (6) years:**

1. Has your license to practice medicine been voluntary or involuntary limited,

suspended, revoked or restricted? ……………………………………………….. Yes\_\_\_ No\_\_\_

1. Has your license to prescribe narcotics been voluntary or involuntary refused,

suspended or revoked? …………………………………………………………… Yes\_\_\_ No\_\_\_

1. Have you relinquished or reduced your privileges at any hospital or dropped any?

hospital from your practice? ……………………………………………………… Yes\_\_\_ No\_\_\_

1. Have you ever been denied requests for privileges at any hospital or surgery?

center? …………………………………………………………………………… Yes\_\_\_ No\_\_\_

1. Have you ever resigned or been asked to resign from a Medical Staff or a?

professional society? ……………………………………………………………. Yes\_\_\_ No\_\_\_

1. Has any hospital or surgery center ever suspended, diminished, revoked, or failed

To renew your privileges? ………………………………………………………... Yes\_\_\_ No\_\_\_

1. Have you ever been convicted of a crime (other than a motor vehicle citation)? …. Yes\_\_\_ No\_\_\_
2. Have you ever been denied membership or renewal thereof, or been subject to?

disciplinary proceedings in any medical organization? …………………………… Yes\_\_\_ No\_\_\_

1. Have you ever had professional liability insurance denied, cancelled, issued on?

special terms or renewal refused? …………………………………………………. Yes\_\_\_ No\_\_\_

1. Do you have any malpractice claims pending? ……………………………………. Yes\_\_\_ No\_\_\_

Have you had any malpractice judgements or settlements made against you?.......... Yes\_\_\_ No\_\_\_

If “Yes” to either, please describe the date and nature of the alleged malpractice, name

of insurance company defending you, settlement amount if settled, judgment amount or

verdict if case went to trail, status if case is not resolved.

**STATEMENT OF APPLICANT**

I fully understand that significant misstatement in or omission from this application or any future application constitutes cause for denial of appointment to or dismissal from the Medical Staff. All information submitted by me in this application is true to the best of my knowledge and belief.

I have read the Bylaws and Rules and Regulations of the Medical Staff. In making application for appointment to the Medical Staff of ***Surgicore Surgical Center****,* I agree to abide by the Bylaws of the Medical Staff, as same may be amended from time to time, and by such Rules and Regulations as may be adopted in accordance with these Bylaws. I further agree to abide by all policies enunciated by the Medical Advisory Board of ***Surgicore Surgical Center***.

I agree to carry at least minimum professional liability insurance in accordance with the Bylaws of the Medical Staff of ***Surgicore Surgical Center***. I understand I am not permitted to exercise any clinical privileges until appropriate evidence of professional liability coverage has been submitted to the Medical Staff. I agree to notify ***Surgicore Surgical Center***of any malpractice claim or suit that may be filed against me resulting from my practice from ***Surgicore Surgical Center*** or elsewhere. Furthermore, should any malpractice insurance coverage be interrupted or terminated for any reason, I will notify the Medical Director immediately.

I hereby authorize ***Surgicore Surgical Center***, its Medical Staff and their representatives to consult with administrators and members of the medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present professional liability carriers, who may have information bearing upon my professional competence, character and ethical qualifications. I further consent to the inspection by ***Surgicore Surgical Center****,* the Medical Staff and their representatives of all documents, including medical records at other hospitals, that be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges, and I hereby consent to the release of such information.

I hereby release from liability all representatives of ***Surgicore Surgical Center*** and its Medical Staff their acts performed without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to ***Surgicore Surgical Center***or its Medical Staff, without malice concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I hereby believe that I am qualified to perform all ***Surgicore Surgical Center*** procedures for which I have applied in this application.

I agree that I shall not rebate a portion of a fee or accept other inducements in exchange for a patient referral, that I shall not deceive a patient as to the identity of an operating surgeon of any other medical practitioner providing treatment or services and that I shall not delegate the responsibility for diagnosis or care of patients to another medical practitioner unless I believe such practitioner to be qualified to undertake responsibility.

Signature of Applicant Date

**NOT TO BE FILLED IN BY APPLICANT**

The attached privileges are recommended to the Board of Directors for:

* Approval as requested
* Approval with conditions as specified:
* Denial-Reason for Denial:

Signature – Medical Director Date



**Surgical Center**

DELINEATION OF PRIVILEGES

PRACTICE AREA: GYNECOLOGY SURGERY

GYNECOLOGICAL PRIVILEGES – I am requesting Gynecology privileges for:

|  |  |  |  |
| --- | --- | --- | --- |
| Requested | Not Req | Granted | Procedure |
|  |  |  | Dilation & Curettage of the uterus and endo-cervical curettage |
|  |  |  | Endometrial Ablation |
|  |  |  | Biopsy & simple excision of masses of the anus, perineum, vulva, vagina, and cervix |
|  |  |  | I & D vulvar / vaginal abscess, I & D marsupialization Bartholin’s cyst / abscess |
|  |  |  | Hyster-salpingogram (HSG), saline infusion sono-hysterogram (SIS) |
|  |  |  | Colposcopy of cervix, vagina, vulva, anus, +/- biopsy |
|  |  |  | LEEP or cold knife cone of the cervix |
|  |  |  | Diagnostic Hysteroscopy |
|  |  |  | Operative Hysteroscopy |
|  |  |  | Endometrial Ablation, ( Thermachoice or Novasure) |
|  |  |  | Diagnostic Cystoscopy |
|  |  |  | Diagnostic Laparoscopy |
|  |  |  | Laparoscopic Tubal Ligation |
|  |  |  | Trans-cervical sterilization |
|  |  |  | Operative Laparoscopy |
|  |  |  | Removal of ovarian / tubal cyst or mass |
|  |  |  | Aspiration of ovarian / tubal cyst |
|  |  |  | Removal of one or both ovaries |
|  |  |  | Removal of one or both fallopian tubes |
|  |  |  | Treatment of ectopic pregnancy (salpingostomy / salpingectomy) |
|  |  |  | Removal of Sub-serosal uterine fibroid |
|  |  |  | Laparoscopic supracervical hysterectomy with or without removal of B/L ovaries and fallopian tube |
|  |  |  | Other |
|  |  |  | Other |
|  |  |  | Other |

I agree to admit patients, request consultations, provide consultations within the scope of my privileges, use all skills normally learned during Chiropractor school, and render any care in a life-threatening emergency or as requested by the Clinical Administration should there be a physician crisis in the Facility.

I will practice within the bounds of my training and competence and will not attempt to treat cases which are not in my scope of practice. I understand that any newly developed treatment modalities are not included in this request and must be cleared by the Medical Executive Committee and Governing Board before their performance. I will become familiar with the capabilities and limitations of the Facility.

I understand that in making this request I am bound by the applicable Bylaws and/or Policies & Procedure of *Surgicore Surgical Center*, and hereby stipulate that I meet the threshold criteria for this request. I also certify that I have knowledge to operate all the equipment necessary to carry our requested procedures.

Applicant’s Name Printed

Applicant Signature Date:

Privileges:

Granted Deferred

Medical Director Signature Date

Modifications:

**Surgical Center**

**Release of Information Form**

I understand that the medical staff at the **Surgicore Surgical Center**, is responsible for the evaluation of my professional competence and qualifications and has the obligation to inquire into my professional training, experience, professional conduct and judgment and to make appropriate recommendations to the governing body of this center.

By Filing and application for appointment to the medical staff, I acknowledge that I have received and read the bylaws of the medical staff and that I am familiar with the principles of the medical ethics of the American Medical Association, American Podiatric Association, American Dental Association, American Osteopathic Association or American Chiropractic Association and I agree to be bound by the terms thereof without regard to whether I am appointed to the Medical Staff. I agree to be bound by the bylaws, rules and regulations of the Medical Staff.

I hereby authorize **Surgicore Surgical Center**, its Medical Staff and their representatives to consult with administrators and members of the medical staffs of other hospitals or institutions which I have been associated and with others, including past present professional liability carriers, who may have information bearing upon my professional competence, character and ethical qualifications. I further consent to the inspection by the **Surgicore Surgical Center**, the Medical Staff and their representatives of all documents, including medical records at other hospital that may material to an evaluation of my professional qualifications and competence to carry out the clinical privileges, and I hereby consent to the release of such information.

I hereby release from Liability all representatives of **Surgicore Surgical Center** and its Medical Staff for their acts performed without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to **Surgicore Surgical Center** or its Medical Staff, without malice concerning professional; competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

Signature of Applicant Date:

Print Name

**Surgicore Surgical Center**

**ORIENTATION CHECKLIST / SKILLS LIST**

Regulation: 8:43A-3.5

Surgicore Surgical Center

Staff Orientation

|  |  |  |  |
| --- | --- | --- | --- |
| **Subject** | **Date Completed** | **Trainer Initials** | **Initials** |
| Licensure Information and Copy |  |  |  |
| CPR/ACLS/PALS Information & Copy |  |  |  |
| Health Forms |  |  |  |
| **Tour of Facility** |  |  |  |
| Patient and Family Waiting Room |  |  |  |
| Telephone Instruction |  |  |  |
| Introduction to other policies |  |  |  |
| Job Description, Duties and Responsibilities |  |  |  |
| Fire and Safety |  |  |  |
| Policy and Procedure Manuals |  |  |  |
| Patient’s Rights and Confidentiality |  |  |  |
| Infection Control |  |  |  |
| Review of patient’s charts |  |  |  |
| Personnel Handbook received (including sexual harassment) |  |  |  |
| Emergency crash Cart and Code procedures |  |  |  |
| **INSERVICING** |  |  |  |
| Fire Extinguisher |  |  |  |
| Fire and Disaster Drill (egress routes, emergency code and alarms) |  |  |  |
| Child / Elder Abuse |  |  |  |
| Universal Precautions (read and understood) |  |  |  |
| Bloodborne Pathogens Preventing Disease Transmission |  |  |  |
| Malignant Hyperthermia |  |  |  |
| Fire Safety |  |  |  |
| Radiation Safety |  |  |  |
| Regulated Medical Waste |  |  |  |
| **Facilities Operations** |  |  |  |
| Structure |  |  |  |
| Hours of Operation |  |  |  |
| Breaks |  | N/A |  |
| Time Assignments |  | N/A |  |
| Time-off requests |  | N/A |  |
| Paychecks |  | N/A |  |
| Illness and Tardiness |  | N/A |  |
| Evaluations |  | N/A |  |
| Policy and Procedure Books |  | N/A |  |
| **O.R Equipment (OR Staff Only)** |  |  |  |
| Overhead lights |  |  |  |
| Suction Lines |  |  |  |
| Washer Disinfector |  |  |  |
| Sterilizers |  |  |  |
| Steris / Starred |  |  |  |
| Monitors |  |  |  |
| O.R Tables |  |  |  |
| Electro-Surgical Units |  |  |  |
| Anesthesia Machines |  |  |  |
| **O.R Equipment Cont.** |  |  |  |
| Tourniquets |  |  |  |
| Nitrogen Outlets |  |  |  |
| **OR, PACU, PRE-OP Equipment** |  |  |  |
| Crash Cart and Defib. |  |  |  |
| Gurneys |  |  |  |
| Blanket Warmer |  |  |  |
| Emergency Trays |  |  |  |
| Malignant Hyperthermia Cart |  |  |  |
| **EMERGENCIES** |  |  |  |
| Code Blue |  |  |  |
| Fire and Disaster |  |  |  |
| Malignant Hyperthermia |  |  |  |
| Patient Transfers |  |  |  |
| **OTHER** |  |  |  |
| Policy and Procedure Manuel |  |  |  |
| Performance Improvement Plan |  |  |  |
| Narcotics Record |  |  |  |
| Equipment Manuel |  |  |  |
| Fire and Disaster Plan |  |  |  |
| OSHA Manual |  |  |  |
| MSDS Protocol |  |  |  |
| Case History Logging |  |  |  |

**Surgicore Surgical Center**

**ORIENTATION CHECKLIST / SKILLS LIST**

Regulation: 8:43A-3.5

Surgicore Surgical Center

Staff Orientation

Print Name: Signature: Date:

Director of Nursing Signature: Date:



**Surgical Center**

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**Pre-Employment Physical Form**

Name: DOB:

Address: City: State: Zip Code

Height: Weight: BP: Pulse:

1. Eyes Visual Acuity: Left Right Glasses Contacts
2. Skin:
3. Ears:
4. Nose:
5. Mouth/Throat:
6. Thyroid:
7. Lungs: History of TB? Yes No

(Must complete Tuberculosis Test Form)

1. Hernia:
2. Varicose Veins:
3. Nervous System:

History of Mental or Nervous Disorder?

Current Medications/OTC drugs, Vitamins:

(Attached additional sheet if needed)

1. Please list all medications/things you are allergic to: (i.e. Latex, Food, Dust, etc.)
2. Skeletal System:

Can applicant lift 50 pounds? Yes \_\_\_\_ No \_\_\_\_ (such as would be needed in wheelchair or bed transfers, etc.)

Signature of Examiner:

Printed Name:

Date of Exam:



**Surgical Center**

444 Market St Suite 1, Saddle Brook NJ 07663

Tel: (201)843-9441 Fax:(201)843-9442

Hello Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_:

You have been requested to provide reference information for Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

an applicant for admitting privileges to *Surgicore Surgical Center.* Pertinent information concerning the applicant will be helpful to the Governing Body of *Surgicore Surgical Center* in processing his/her application for privileges.

As one of the applicant’s references, you are familiar with his/her professional work and have knowledge of his/her ability, character and reputation. The Board would appreciate information that bears upon the extent of the responsibility borne by the applicant in his/her professional work as well as your opinion of his/her professional competence in his/her medical specialty and moral character.

This form is to be completed by a physician and the recommending physician must have known the applicant for at least six months. Recommending physicians are strongly urged to include additional comments. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included.

The Board appreciates your cooperation in supplying the information requested on the enclosed sheet. Once you have completed the form, please either mail it or fax it back to the address and fax # provided above.

Please use a separate piece of paper to clarify any area that rates unsatisfactorily.

EXCELLENT SATISFACTORY UNSATISFACTORY

Moral Integrity of Applicant \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emotional Stability of Applicant \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Professional Competence \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Relationship \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Relationship \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Availability for Patients \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many years have you known the applicant?

Is the applicant’s health adequate to perform the privileges associated with his/her specialty?

Yes NO

Does the applicant have any substance abuse, mental/emotional illness or disruptive behavior problems/history?

Yes NO

Is there any additional *confidential* information that you feel may be helpful in our consideration of this applicant?

Yes NO

Print Name Signature Date



**Surgical Center**

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Hello Dr.

You have been requested to provide reference information for Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

an applicant for admitting privileges to *Surgicore Surgical Center.* Pertinent information concerning the applicant will be helpful to the Governing Body of *Surgicore Surgical Center* in processing his/her application for privileges.

As one of the applicant’s references, you are familiar with his/her professional work and have knowledge of his/her ability, character and reputation. The Board would appreciate information that bears upon the extent of the responsibility borne by the applicant in his/her professional work as well as your opinion of his/her professional competence in his/her medical specialty and moral character.

This form is to be completed by a physician and the recommending physician must have known the applicant for at least six months. Recommending physicians are strongly urged to include additional comments. All questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included.

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EXCELLENT SATISFACTORY UNSATISFACTORY

Moral Integrity of Applicant \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emotional Stability of Applicant \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Professional Competence \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Relationship \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Relationship \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Availability for Patients \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many years have you known the applicant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the applicant’s health adequate to perform the privileges associated with his/her specialty?

Yes NO

Does the applicant have any substance abuse, mental/emotional illness or disruptive behavior problems/history?

Yes NO

Is there any additional *confidential* information that you feel may be helpful in our consideration of this applicant?

Yes NO

Print Name Signature Date

**Confidentiality & Non-Solicitation Agreement**

I understand that Surgicore Surgical Center LLC (the “SSC Practice”) has a legal and ethical responsibility to safeguard patient’s privacy and to protect the confidentiality of their health information. Additionally, the Practice must assure the confidentiality of its human resources, payroll, fiscal, research, computer systems, and management information (collectively referred to as “Confidential Information”). During my employment / engagement by the Practice, I understand that I may come into the possession of Confidential Information. I further understand that I must sign and comply with this agreement to get authorization for access to any of the Practices Confidential Information.

* I will not disclose or discuss any Confidential Information with others, including friends, family or co-workers, who do not have a need to know it. In addition, I understand that my personal access to information used to access computer systems are also an integral aspect of this Confidential information. I will not willingly inform another person of my computer password or knowingly use another person’s computer password instead of my own for any reason.
* I will not access or view any Confidential Information, or utilize equipment, other than what is required to do my job.
* I will not discuss Confidential Information where others can overhear the conversation (for example, in hallways, on elevators, in the cafeteria, on public transportation, at restaurants, and at social events). It is not acceptable discuss Confidential Information in public area even if a patient’s name is not used. Such a discussion may raise doubts among patients and visitors about our respect for their privacy.
* I will not make inquiries about Confidential Information for other personnel who do not have proper authorization to access such Confidential Information.
* I will not make any unauthorized transmission, inquiries, modifications, or purging’s of Confidential Information in the Practice’s computer system. Such unauthorized transmission includes, but are not limited to, removing and / or transferring Confidential Information from the Practice’s computer system to unauthorized locations (for instance, home). I further understand that all computer access activity is subject to audit.
* I will log off any computer or terminal prior to leaving it unattended.
* I will comply with any security or privacy policy promulgated by the Practice to protect the security and privacy of Confidential Information.
* I will immediately report to my supervisor any activity, by any person, including myself, that is a violation of this Agreement, any applicable Federal or State law, rule, or regulation or of any security or privacy policy.
* Upon termination of my employment / engagement, I will immediately return any documents or other media containing Confidential Information to the Practice.
* I agree that my obligations under this Agreement will continue after the termination of my employment.
* I understand that violation of this Agreement will continue after termination of my employment.
* I understand that violation of this Agreement may result in disciplinary actions, up to and including suspension and / or termination of employment or engagement by the Practice.
* During the Term and for period of two (2) years after termination of this Agreement, Physician will not directly or indirectly, without the prior written consent of SSC: (i) induce or attempt to influence any person who is an employee or independent contractor of, or has a contractual or business relationship with SSC, to terminate such relationship or to the extent any such relationship terminates for any advertisement that are not specially directed to SSC’s employees; or (ii) engage, hire, offer to engage or hire, or employ or contractor (other than vendors and suppliers providing services on a non-exclusive basis) SSC during the preceding years; or (iii) directly or indirectly interfere with the relationship between SSC and any of SSC’s patients, other health care providers, distributors or suppliers. Group acknowledge and agrees that this is reasonably necessary for the protection of the business of SSC and that this provision will survive the expiration or termination of this Agreement for any reason, for a period of two (2) years.

By signing this document, I understand and agree to the following;

I have read the above agreement and agree to comply with all its terms.

Signature of Physician / Employee / Independent Contractor / Volunteer:

Print Name: Date:

**Surgicore Surgical Center**

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