

**UNIVERSITY OF MICHIGAN  
SCHOOL OF NURSING  
PROVIDER CREDENTIALING APPLICATION**

**Initial Credentialing Requirements for Specified Professional Personnel**

- 1 Completed Application
- 2 UMSN Request for Delineation of Privileges
- 3 Current Curriculum Vitae, including work history
- 4 Copies of current RN licensure to practice in the State of Michigan
- 5 Proof of graduation from an approved Nursing Program via notarized copy of transcripts, degree, or diploma
- 6 Copie(s) of Certification/Registration from appropriate Credentialing bodie(s)
- 7 Copy of Michigan Specialty Certification, if applicable
- 8 Two Letters of Recommendation from professional colleagues (see required form)
- 9 Job Description/outline of specific clinical services to be provided
- 10 Completed health clearance release form
- 11 Proof of Basic Cardiac Life Support (or Advanced Cardiac Life Support Certification, if appropriate for the practice setting)
- 12 Malpractice history (last 10 years)
- 13 Documentation of current malpractice insurance
- 14 Copy of DEA license
- 15 Controlled Substance application: DEA License or proof of application
- 16 Statements from the applicant regarding:
  - a. reasons for any inability to perform the essential functions of the position, with or without accommodation
  - b. lack of present illegal drug use
  - c. history of loss of license and/or felony convictions
  - d. history of loss or limitation of privileges or disciplinary activity
  - e. attestation by the applicant of the correctness and completeness of the application
- 17 Signed confidentiality statement

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**OFFICE USE**

- . **Primary Source Verification Requested**
- . **Primary Source Verification Received**

Nurse Practitioner's Name \_\_\_\_\_



**APPLICATION FOR CREDENTIALING  
SPECIFIED PROFESSIONAL  
PERSONNEL**

MSS/OCA Practitioner Number

**PERSONAL INFORMATION**

Name in Full: \_\_\_\_\_  
Last First Middle

Other Names Used: \_\_\_\_\_

Sex (circle): M or F Social Security No. \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Unique Name: \_\_\_\_\_

Place of Birth: State \_\_\_\_\_ Country \_\_\_\_\_

Citizenship: \_\_\_\_\_ VISA Yes \_\_\_\_ No \_\_\_\_

**DEPARTMENT INFORMATION**

Primary Department \_\_\_\_\_ Service \_\_\_\_\_

Applicant UM Mailing Address and Zip-Box # \_\_\_\_\_

Applicant UM Office Phone Number \_\_\_\_\_

**EDUCATION** (Dates must be in MM/DD/YY format)

Undergraduate Education College or University \_\_\_\_\_  
Degree \_\_\_\_\_ Date of Graduation \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YY MAJOR

Undergraduate Education College or University \_\_\_\_\_  
Degree \_\_\_\_\_ Date of Graduation \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YY MAJOR

**GRADUATE/OTHER ADVANCED EDUCATION** (Dates must be in MM/DD/YY format)

College or University \_\_\_\_\_

Certificate/Degree \_\_\_\_\_ Date of Graduation \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YY AREA/MAJOR

College or University \_\_\_\_\_

Certificate/Degree \_\_\_\_\_ Date of Graduation \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YY

AREA/MAJOR

Nurse Practitioner's Name \_\_\_\_\_

**ADDITIONAL ADVANCED SKILLS TRAINING** Attach copies of Certificates

Agency/Program/School \_\_\_\_\_ Area \_\_\_\_\_

Award/Certificate \_\_\_\_\_ Date of Completion \_\_\_\_\_

Agency/Program/School \_\_\_\_\_ Area \_\_\_\_\_

Award/Certificate \_\_\_\_\_ Date of Completion \_\_\_\_\_

**CERTIFICATION/REGISTRATION(S)** Attach copies of certificates

Specialty \_\_\_\_\_ Date \_\_\_\_\_

Certifying Agency \_\_\_\_\_ Expiration Date \_\_\_\_\_

Certification Number \_\_\_\_\_

**If not certified, give current status:**

Specialty \_\_\_\_\_ Date \_\_\_\_\_

Certifying Agency \_\_\_\_\_ Expiration Date \_\_\_\_\_

Certification Number \_\_\_\_\_

**OTHER CERTIFICATION/REGISTRATION**

Certification/Registration \_\_\_\_\_ Certification/Registration Number \_\_\_\_\_

Certifying/Registering Organization \_\_\_\_\_ Expiration Date \_\_\_\_\_

Certification/Registration \_\_\_\_\_ Certification/Registration Number \_\_\_\_\_

Certifying/Registering Organization \_\_\_\_\_ Expiration Date \_\_\_\_\_

ACLS Certification (as applicable) \_\_\_\_\_ Expiration Date \_\_\_\_\_

Nurse Practitioner's Name \_\_\_\_\_

**LICENSURE** Copies of the following must be attached to this application. If in the process of applying for licensure, please provide copy of license application.

**(1) Current Michigan Practitioner License (RN)**

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Expiration Date

**(2) Current Michigan Specialty Certification**

\_\_\_\_\_

\_\_\_\_\_  
Expiration Date

**(3) DEA License (as applicable)**

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Expiration Date

**(3) Other Professional Licensure (in or out-of-state)**

\_\_\_\_\_  
Description of License

\_\_\_\_\_  
Active or Inactive

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Expiration Date, if active

\_\_\_\_\_  
Description of License

\_\_\_\_\_  
Active or Inactive

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Expiration Date, if active

**PREVIOUS MALPRACTICE COVERAGE**

**What are the names/addresses of your current and past (last 5 years) malpractice insurance carrier(s)?** (attach additional sheet, if necessary) \_\_\_\_\_

Current

\_\_\_\_\_  
Previous

\_\_\_\_\_  
Previous

Nurse Practitioner's Name \_\_\_\_\_

**TO BE COMPLETED BY APPLICANT**

*If the answer to any of the following questions is YES, please give full details on a separate sheet of paper.*

Has your license to practice as a health professional in any jurisdiction ever been limited, suspended or revoked, or have you ever been reprimanded, fired, or otherwise disciplined by a licensing board or similar agency in any jurisdiction?  Yes  No

Has your license, certification, or other authorization to prescribe or dispense medications ever been limited, suspended, or revoked (includes DEA, State Controlled Substance License, etc.)?  Yes  No

Have you ever been placed on probation or subject to other disciplinary action in any training program?  Yes  No

Do you have any contagious or communicable diseases that could endanger others?  Yes  No

Has your membership or your privileges at any group practice, academic institution, hospital or other health care facility or at any health plan ever been denied, suspended, restricted, otherwise limited, revoked or not renewed?  Yes  No

Have you ever voluntarily restricted or withdrawn your privileges from any hospital or other health facility, or limited or terminated your employment with any such institution or with any affiliated academic institution or group practice?  Yes  No

Have any Medicare, Medicaid or other federally funded health program sanctions ever been imposed on you?  Yes  No

Have you ever voluntarily restricted or not renewed your license to practice a health profession in any state, or your State Controlled Substance or DEA license?  Yes  No

Has any formal or informal disciplinary actions ever been imposed on you by any group practice, academic institution, hospital (including a clinical department thereof), other health care facility (including a clinical department thereof), health plan, professional society, or licensing agency?  Yes  No

Has a malpractice judgment been made against you or settled out of court in the past 10 years, or is a malpractice claim anticipated or pending?  Yes  No

Have you ever pled guilty, nolo contendere/no contest, or been convicted of any crime (include all misdemeanors or felonies) or named in a civil suit (excluding divorce proceedings) or administrative action? Include any litigation (claims, pre-suit notice, lawsuits) related in any way to your practice. For each felony or misdemeanor, list date, type of crime, specific charge, and location. For each lawsuit or administrative action, list other party/parties, date, nature of action, and resolution. Additional details may be requested.  Yes  No

Have you ever opted out of Medicare?  Yes  No

Have you used, purchased, or sold illegal drugs or abused prescription drugs within the last two years?  Yes  No

Do you have any injury, illness or impairment that may adversely affect your ability to practice medicine without reasonable accommodation?  Yes  No

**REFERENCES** List three references with **direct knowledge of your clinical competence** with current complete addresses (preferably preceptors or previous medical directors/supervisors/instructors).

Name	Address/Phone Number
_____	_____
_____	_____
_____	_____

Nurse Practitioner's Name \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION  
PROFESSIONAL CREDENTIALS PRIMARY SOURCE VERIFICATION**

In applying for appointment to practice as a/an \_\_\_\_\_ at the University of Michigan School of Nursing, I understand that misstatements or omissions in this application may be grounds for corrective action, including disciplinary sanctions and/or discharge. Any and all actions will comply with the required University and/or contractual processes. I agree to immediately report any changes in the status of my license and/or certification to the Office for Community Partnerships and to my immediate supervisor.

I agree to report any changes in my health status that could adversely affect my ability to practice and agree, with cause, to submit to a physical examination, drug and alcohol screens and other assessments consistent with policy and/or contractual agreements.

I hereby authorize agents of the University of Michigan to consult with other employing agents, professional peers/colleagues and licensing/certification boards regarding my competence, character and ethical qualifications. I further authorize agents of the hospital to make inquiries from the said individual hospitals, boards, and courts concerning any claims, lawsuits, disciplinary actions, license restrictions or denials, or any other matters affecting my ability to practice my profession. I hereby consent to the release from any source, including information that would otherwise be privileged or confidential, to the University of Michigan, of any and all information concerning my abilities to practice.

I hereby release from liability all individuals and organizations who provide information concerning my qualifications for clinical privileges. I further release from liability the University of Michigan, its staff, officers and employees who make inquiries concerning my abilities to practice, and I hereby indemnify them from any claim arising from their consideration, award or denial of my application.

Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_

## University of Michigan Health System Code of Conduct Statement and Certification

**The University of Michigan Health System (UMHS) is committed to excellence and leadership in patient care, education and research.** As an employee, faculty member, student, trainee, visitor, scholar, volunteer or vendor, I understand that I play a vital role in the success of the UMHS mission and that I will be held accountable for compliance with applicable law and University and UMHS policies and procedures. This statement *summarizes* the standards of conduct that UMHS requires me to uphold:

- ❖ ***Knowledge, understanding and compliance with the policies and procedures that apply to my work.*** I agree to comply with all of the policies and procedures that relate to my work at UMHS, including the [Code of Conduct](#). I agree that if I do not know whether an action is permitted, I will ask my supervisor or review the relevant policies. Sources include the [U-M Standard Practice Guide](#), [UMHS policies](#), and unit (e.g., Medical School, Hospital, M-CARE), department, and division-level policies and procedures. The [UMHS compliance website](#) has additional information. If I do not know what is permitted or required, I may contact the UMHS Compliance Office at (734) 615-4759 or the Health System Legal Office at (734) 764-2178 for guidance.
  
- ❖ ***Avoiding fraud, waste and abuse.*** I will accurately and honestly perform my work for UMHS, and will not engage in any activity intended to defraud anyone of money, property or services. I will not request or accept payment, either directly or indirectly, that is intended to induce referrals, or to induce the purchasing, leasing, ordering or arranging for any item or service at or from any organization or facility. I will comply with UMHS and University policies on conflicts of interest and on interactions between vendors and faculty/staff. I have reviewed and understand the [summary](#) of federal and state false claims and whistleblower protection laws. I will report any potential fraudulent or false claims, inappropriate billing practices, or similar concerns to my supervisor or the [Compliance Office](#).
  
- ❖ ***Protecting the confidentiality and security of information.*** I may have access to proprietary or confidential information (including [protected health information](#)) about UMHS operations, workforce members, subjects, and/or patients (“sensitive information”). All of this information, in whatever form transmitted or received (e.g., oral, fax, photographic, written, electronic), must be treated by me in a confidential and secure fashion. I have completed and understand any [UMHS HIPAA training](#) required for my position.
  - I will not access, release, or share sensitive information – even demographic screens with addresses and phone numbers – unless doing so is necessary as a part of my assigned duties, or I am authorized to do so by a [Release of Information form](#). **I understand that my access to UMHS systems containing sensitive information may be audited at any time**, with or without cause. I understand that I am responsible for any access that occurs using my password.
  
  - I will protect sensitive information. **I will not share my passwords or access to any UMHS systems or applications with any other person.** I will be careful to avoid inadvertently revealing sensitive information, including avoiding discussions of sensitive information in public places. I will not remove sensitive information from UMHS without my supervisor’s permission and I understand that I am responsible for maintaining the security of such information in accord with UMHS standards. **If I use a portable electronic device (e.g., laptop, PDA), I will ensure that it meets UMHS security standards.**

- I understand that when my employment, affiliation, visitation or assignment with UMHS ends, I may not take any sensitive information with me and I may not reveal any UMHS sensitive information to any third person except as permitted by a [Release of Information form](#).

❖ ***Disclosing actual and potential conflicts of interest or commitment and complying with any plans imposed to manage those conflicts.*** I agree to report any potential or actual conflicts of interest or commitment, and I have reported any current potential or actual conflicts of which I am aware. An actual or potential conflict occurs if I or a family or household member has an outside personal, professional, commercial, or financial interest. While outside relationships and activities that further the University’s academic and clinical missions are encouraged, conflicts can arise. The existence of a conflict is not inappropriate in and of itself. However, in an academic or clinical setting, these relationships or activities can compromise or be perceived to compromise basic values of openness, scientific integrity, independence, and public trust. I understand that for these reasons, actual or potential conflicts must be disclosed and managed to assure that they do not compromise my judgment, bias my research, influence my decisions with respect to academic or clinical matters or University business, result in personal advancement at the expense of the University, or otherwise interfere or compete with the University’s educational, research, or service missions, or with my ability or willingness to fulfill my responsibilities. I will disclose actual or potential conflicts of interest and conflicts of commitment as required by [University and Health System policies](#).

**I understand that if I do not comply with University or UMHS policies and procedures or applicable law or, or if I otherwise engage in misconduct, I may be subject to immediate disciplinary or corrective action, up to and including dismissal or loss of access to UMHS property or resources.** I understand that noncompliance with federal or state law may result in criminal and civil penalties against the University and/or me personally.

**I agree to immediately report suspected noncompliance or misconduct** to my supervisor, or to the UMHS Compliance and Privacy Office, 7300 Medical Science I, Box 0625, (734) 615-4759. I understand that I may also make such a report anonymously to (888) 296-2481 or through the [compliance website](#). I agree to cooperate with any investigation of possible noncompliance or misconduct and not to withhold relevant information. UMHS does not tolerate retribution or retaliation against anyone reporting suspected noncompliance or misconduct in good faith. I will immediately report to my supervisor and Medical Staff Services (if I am a member of the medical staff, physician’s assistant, advanced practice nurse) or Human Resources (if I am licensed, certified, or registered as a health professional) any suspension, restriction, termination, or change in status of any health professions license that I hold.

**BY SIGNING BELOW, I CERTIFY THAT I AM IN COMPLIANCE WITH ALL UNIVERSITY AND UMHS POLICIES AND PROCEDURES, INCLUDING THOSE THAT REQUIRE ME TO REPORT ANY SUSPECTED NON-COMPLIANCE OR OTHER MISCONDUCT.**

Name	Date
Signature	Employee ID # or Vendor Employer ID #

Nurse Practitioner's Name \_\_\_\_\_

**REQUEST FOR CREDENTIALING**

I personally have reviewed the information contained in this application, and find it to be accurate to the best of my knowledge.  
I have personally reviewed the attached application for credentialing at the University of Michigan School of Nursing.

ASSOCIATE DEAN  
OFFICE FOR COMMUNITY PARTNERSHIPS

_____	
<b>Printed Name</b>	
_____	_____
<b>Signature</b>	<b>Date</b>
_____	(____)_____
<b>SON Address</b>	<b>Telephone</b>

**CONFIDENTIALITY STATEMENT**

I understand that the University of Michigan *School of Nursing's/UMHS'* patient care information is confidential. Patient care information, whether in written, unwritten, or electronic computer system form, may be accessed only by *UMSN* employees who need that information to perform their *UMSN* job responsibilities. Patient care information may only be released to individuals outside the health system by authorized *UMSN* employees and then only on the prior written permission of the patient or patient's legal representative, or as allowed by law.

I understand that if I do not keep patient information confidential, or if I allow or participate in the inappropriate dissemination of or access to patient care information, I shall be subject to immediate disciplinary action, up to and including dismissal.

_____	_____
Applicant's Signature	Date



## Scope of Services Nurse Practitioner School of Nursing Practice Plan

### LEVEL I

Requested	Granted	Privileges	Minimum Training and Experience
<input type="checkbox"/>	<input type="checkbox"/>	<p>Initiates and provides ongoing health and medical assessment and management of the health status of patients as defined by their national certification (i.e. pediatric, adult, geriatric, women's health etc.).</p> <p>Authorized prescribing for all but scheduled substances (Scheduled substances must be authorized on a separate form).</p> <p>Ordering IV fluids.</p> <p>Ordering diagnostic tests.</p> <p>Ordering medical referrals.</p> <p>Ordering medical equipment, including, but not limited to durable medical equipment, orthopedic devices and test strips, syringes, and lancets for glucose monitoring.</p> <p>Ordering oxygen and equipment for it administration including nasal cannula, trach, mask, CPAP, Bi-PAP and portable ventilators.</p> <p>Ordering respiratory care, including nebulizer mist treatments, suctioning and percussion and postural drainage.</p> <p>Application of casts and splints</p> <p>Insertion and removal of nasogastric or feeding tubes.</p> <p>Ordering nutritional supplements, and tube feedings</p> <p>Ordering or inserting bladder catheters</p> <p>Documentation for insurance forms, release from work, handicapped parking authorizations</p> <p>Writing discharge orders, including but not limited to medications, activity, diet, therapies, referrals, diagnostic studies and return visits.</p> <p>Cryotherapy of warts.</p> <p>Endometrial biopsies.</p> <p>Fitting diaphragms and cervical caps.</p> <p>Removal of IUDs.</p>	<p>Authority to prescribe medical treatment and medications and to order diagnostic tests is derived from the delegation of that authority by a collaborating licensed physician, in accordance with the Michigan Public Health Code (1978 P.A. 368), including, but not limited to Section 16109(2); 16215; 17210; 17708(2).</p> <p>Basic education:</p> <ul style="list-style-type: none"> <li>- Bachelor of Science in Nursing</li> <li>- Masters degree in Nursing or Master of Science in Nursing degree and/or completion of approved nurse practitioner program (as delineated in Michigan Public Health Code)</li> </ul> <p>Licensing/Certification:</p> <ul style="list-style-type: none"> <li>- Current license to practice nursing in the State of Michigan</li> <li>- Certification as Nurse Practitioner by the American Nurses Credentialing Center, National Certification Board of Pediatric Nurse Practitioners and Nurses, National Certification Corporation, or the American Academy of Nurse Practitioners.</li> <li>- Specialty Certification as a Nurse Practitioner in the State of Michigan</li> </ul> <p>New nurse practitioner graduates and/or new prescribers will have a mentoring period that will be defined at hiring, based on training and experience. This mentoring period may last from one to six months and may be extended as needed.</p> <p>Privileges must be re-requested every two years, thereafter. Competency assessment which may include peer review will occur at least annually, utilizing chart reviews and/or other observational methods. At least 10 cases in a 12 month period will be formally reviewed and results documented.</p>

Nurse Practitioner's Name

**LEVEL II**

Requested	Granted	Privileges	Minimum Training and Experience
.	.	Wound care and sharp debridement	Supervised instruction in at least 3 of each requested procedure; independently perform the procedure 3 times under the direct observation of the physician or a trained NP assigned by the physician(s). For renewal, participation in 3 or more of each procedure during a 12 month period.
.	.	Incision and drainage of skin lesions	Supervised instruction in at least 3 of each requested procedure; independently perform the procedure 3 times under the direct observation of the physician or a trained NP assigned by the physician(s). For renewal, participation in 3 or more of each procedure during a 12 month period.
.	.	Removal of surgical drains	Supervised instruction in at least 3 of each requested procedure; independently perform the procedure 3 times under the direct observation of the physician or a trained NP assigned by the physician(s). For renewal, participation in 3 or more of each procedure during a 12 month period.
.	.	Suturing	Supervised instruction in at least 3 of each requested procedure; independently perform the procedure 3 times under the direct observation of the physician or a trained NP assigned by the physician(s). For renewal, participation in 3 or more of each procedure during a 12 month period.
.	.	Skin punch biopsy	Supervised instruction in at least 3 of each requested procedure; independently perform the procedure 3 times under the direct observation of the physician or a trained NP assigned by the physician(s). For renewal, participation in 3 or more of each procedure during a 12 month period.
.	.	IUD insertion	Supervised instruction in at least 3 of each requested procedure; independently perform the procedure 3 times under the direct observation of the physician or a trained NP assigned by the physician(s). For renewal, participation in 3 or more of each procedure during a 12 month period.

**TO BE COMPLETED BY APPLICANT:**

I meet the above mentioned minimum training and experience criteria and request that my application be considered for the delegated functions that I have selected.

**Applicant:** \_\_\_\_\_

Signature

Date

**ACKNOWLEDGMENT OF COLLABORATING PHYSICIAN(S):**

The collaborating physicians are credentialed and privileged members of the University of Michigan Hospitals and Health Centers medical staff.

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Physician Collaborator's Name	Physician Signature	Date
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Physician Collaborator's Name	Physician Signature	Date
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Physician Collaborator's Name	Physician Signature	Date
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Physician Collaborator's Name	Physician Signature	Date
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## Scope of Services Certified Nurse-Midwife School of Nursing Practice Plan

### LEVEL I

Requested	Granted	Privileges	Minimal Training and Experience
☐	☐	Initial and ongoing assessment, diagnosis, management of patient health status, including evaluation and revision of plan of care, as defined by their national certification.  Care provided for Antepartum patients includes:  <b>Outpatient:</b>	Basic education: - Bachelor of Science degree. - Masters degree in Nursing or related field and completion of an accredited Nurse Midwifery education program.  Licensing/Certification:
☐	☐	- Collects and records historical and current medical, family, psychosocial, and obstetrical data.  - Performs complete physical assessment, including pelvic as needed.  - Collects and records physical, psycho-social data on subsequent antepartum visits	- Current RN license to practice nursing in the State of Michigan  - Certification as a Nurse -Midwife by the American College of Nurse-Midwives or ACNM Certification Council.  - Current certificate to practice Nurse-Midwifery in the State of Michigan
		- Orders/interprets diagnostic tests  - Assesses health status of clients and determines management plan.  - Identifies health risks, medical and nursing diagnoses	Consults with physician for deviations from health as per Collaborative Physician Agreement.
☐	☐	<b>Well-Woman/Gynecology Patient Includes:</b>  - Obtains health and medical history - Performs physical examinations - Conducts preventative screening procedures  - Identifies needs, health risks, medical and nursing diagnoses.  - Formulates differential diagnosis - Orders and interprets diagnostic tests - Orders referrals  - Performs diagnostic and/or therapeutic procedures, including but not limited to:  - fitting cervical caps	New practitioners or experienced practitioners adding new skills must be supervised by appropriate provider.

		<ul style="list-style-type: none"> <li>- fitting diaphragms</li> <li>- inserting and removing IUD's</li> </ul>	
<ul style="list-style-type: none"> <li>□</li> </ul>	<ul style="list-style-type: none"> <li>□</li> </ul>	<p><b>Victims of Sexual Assault Who Present to the Emergency Department:</b></p> <ul style="list-style-type: none"> <li>- Obtains relevant history and informed consent</li> <li>- Conducts physical examination including CSR Evidence Collection Kit</li> <li>- Provides pregnancy and STD prevention if desired and appropriate</li> <li>- Consults or refers to physician for complications associated with the assault.</li> <li>- Offers 2 and 6 week follow-up appts.</li> </ul>	<p>New practitioners or experienced practitioners adding new skills must be supervised by an appropriate provider.</p>
<ul style="list-style-type: none"> <li>□</li> </ul>	<ul style="list-style-type: none"> <li>□</li> </ul>	<ul style="list-style-type: none"> <li>- Prescribing treatments and pharmacologic agents. Classes of drugs/specific agents and treatments which are delegated for prescription by this individual:</li> </ul> <p>Antibiotics, Anti-Diarrheals, Anti-Fungal Agents, Anti-Herpes Agents, Anti-Inflammatory Agents, Anti Parasitics, Anti-Pyretic, Contraceptives, Oral Contraceptives, Decongestants, Anti-Histamines, Non-Narcotic Cough Preparations, Acne Preparations, Hemorrhoidal Preparations, Laxatives, Vitamins and Iron, Muscle Relaxants, Topical Steroids and steroid inhalers, Diuretics, Oral Steroids, Bronchodialator Inhalers, Steroidal Nasal Sprays, Durable Medical Equipment, Anti-Depressants, Anti-Anxiety, Anti-Hypertensives, anti-Anginals and Other Cardiac Agents, Anti-Diabetic Agents, Non-Narcotic Analgesics and Migraine Abortives, Hormone Replacement Therapy, Anti-Ulcer Agents, Immunizations, Tocolytics, Smoking cessation agents, Wound Care Products, and Prostaglandin preparations for cervical ripening.</p>	<p>Delegation of responsibility and authority to prescribe medical treatments, tests and medications is written in accordance with the Michigan Public Health Code (1978 P.A. 368), including, but not limited to Section 1621 (S); 17048(4); 17210; 17708(2).</p> <p>Competency assessment will occur at least annually, utilizing chart reviews, peer review and/or other observational methods. At least 10 charts per year will be formally reviewed and results documented.</p>

## LEVEL II

Requested	Granted	Scope of Practice / Privileges	Minimal Training and Experience
<input type="checkbox"/>	<input type="checkbox"/>	- Endometrial biopsies	New or experienced midwives adding this skill must observe a faculty physician or experienced nurse midwife, assist the physician/nurse midwife, and then performance of the skill three times under the direct observation of the physician or nurse midwife.
<input type="checkbox"/>	<input type="checkbox"/>	- Insertion and removal of levonorgestrel implants (Norplant System), including the administration of local anesthetic.	Successful completion of instruction program on levonorgestrel insertion and removals. Successful demonstration of competency three times to an experienced nurse midwife or physician privileged to insert/remove levonorgestrel implants.

## LEVEL III

Requested	Granted	Privileges	Additional Education, Training and Experience
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		

### TO BE COMPLETED BY APPLICANT:

I authorize and release from liability, any hospital, licensing board, certification board, individual or institution who in good faith and without malice, provides necessary information for the verification of my professional credentials for membership to the University of Michigan School of Nursing

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**UNIVERSITY OF MICHIGAN SCHOOL OF NURSING  
FACULTY PRACTICE PLAN**

**ASSESSMENT OF APPLICANT** \_\_\_\_\_

Applicant Name PRINTED

TO: \_\_\_\_\_

The above named applicant has applied for credentialing in the Faculty Practice Plan at the University of Michigan School of Nursing. Please complete the following assessment of the applicant and return it to the Office for Community Partnerships/Faculty Practice Plan at the University of Michigan School of Nursing. The information provided will be confidential. Please contact the Office for Community Partnerships/Faculty Practice Plan (734) 936-3631, if you wish to discuss the applicant with the Chair of the Faculty Practice Plan.

The requested information will assist the Provider Review Board and Faculty Practice Plan Advisory Committee in evaluating the recommended appointment for membership in the Faculty Practice Plan. PLEASE NOTE: This assessment is a requirement for consideration of credentialing for the Faculty Practice Plan at the University of Michigan School of Nursing.

1. Has the applicant ever been suspended, disciplined, placed on probation or had his/her privileges restricted or not renewed?  
NO \_\_\_\_\_ YES \_\_\_\_\_
2. Are you aware of any adverse actions or history with regard to this applicant's license, board certification, professional memberships, or criminal proceedings?  
NO \_\_\_\_\_ YES \_\_\_\_\_
3. To your knowledge, has this applicant ever been sued for malpractice?  
NO \_\_\_\_\_ YES \_\_\_\_\_
4. To your knowledge, has this applicant ever had problems with drugs, alcohol, or chemical substances?  
NO \_\_\_\_\_ YES \_\_\_\_\_

Please complete the following assessment of the applicant's moral, ethical, and professional competence	EXCEEDS STANDARDS	MEETS STANDARDS	DOES NOT MEET STANDARDS*
Appropriate Nursing/Medical Knowledge			
Professional judgment			
Sense of responsibility			
Ethical conduct			
Competence and skill in area of specialty			
Cooperativeness, ability to work with others			
Appearance			
Quality of practice			
Teaching skills			
Patient Management			
Ability to work with other providers			
Ability to understand and speak English			
Compliance with rules and regulations of organization			
Acceptance/compliance with Advanced Practice Nursing responsibilities, rules and regulations			

\*Please provide explanation on separate page for any items marked "Does Not Meet Standards."

**OVERALL RECOMMENDATION:**

- Recommend highly without reservation
- Recommend as qualified and competent
- Recommend with some reservation
- Do not recommend

**RECOMMENDATION BASED ON:**

- Close personal observation
- General impression
- Composite of evaluation by supervisors
- Other \_\_\_\_\_

If you wish to provide any comments regarding this individual, please do so below or as an attachment to this assessment. Thank You.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Title

\_\_\_\_\_  
Print Name of Institution

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

NAME: \_\_\_\_\_

DIVISION: \_\_\_\_\_

Date: \_\_\_\_\_

**University of Michigan  
School of Nursing  
HEALTH REQUIREMENTS, CPR CERTIFICATION and STANDARD  
PRECAUTIONS FOR FACULTY**

All faculty are required to submit documentation of the following immunizations and CPR certification by date of hire. These records are kept by each Division. (See SON website for additional information at [http://www.nursing.umich.edu/ocp/health\\_requirements.pdf](http://www.nursing.umich.edu/ocp/health_requirements.pdf))

Disease	Notes	Result/Date
Tuberculin skin testing	Negative PPD current for each academic year. A current Negative Tuberculin test is required annually.*  If history of a positive PPD, then ONE negative x-ray confirmation is required.*  <i>*TB skin testing is required annually and repeat x-ray is required if exposure to TB or symptoms develop.</i>	✓ _____ Date  ✓ _____ Result
Tetanus Diphtheria booster	Within ten years	✓ _____ Date
Varicella (Chicken Pox)	History of Disease  <i>or</i>  2 doses of vaccine	✓ _____ Date of illness  ✓ _____ Dates
Measles, Mumps, Rubella (MMR)	Persons born before 1957 are considered immune to rubella, rubeola, and mumps.	Date of birth (if before 1957 go directly to Hepatitis B section): ✓ _____ Date of Birth
Rubella (German Measles)	✓ Positive titer (greater than 10) (copy of report) <i>or</i> ✓ Date of first and second dose of MMR after 12 months of age <i>or</i> ✓ History of rubella	✓ _____  ✓ _____ Dates  ✓ _____ Date of illness

Rubeola	<input checked="" type="checkbox"/> Positive Rubeola titer (copy of report) <i>or</i> <input checked="" type="checkbox"/> Date of first and second dose of vaccine after 12 months of age <i>or</i> <input checked="" type="checkbox"/> History of rubeola	<input checked="" type="checkbox"/> _____ <input checked="" type="checkbox"/> _____ <b>Dates</b> <input checked="" type="checkbox"/> _____ <b>Date of illness</b>
Mumps	<input checked="" type="checkbox"/> Positive mumps titer <input checked="" type="checkbox"/> History of mumps <input checked="" type="checkbox"/> If born after 1956, documentation of 2 doses of MMR	<input checked="" type="checkbox"/> _____ <input checked="" type="checkbox"/> _____ <b>Date of illness</b> <input checked="" type="checkbox"/> _____ <b>Dates</b>
Hepatitis B	<input checked="" type="checkbox"/> Hepatitis B immunizations-series of 3 doses. Documentation provided. <i>or</i> <input checked="" type="checkbox"/> Positive Hepatitis B antibody (report attached) <i>or</i> <input checked="" type="checkbox"/> Signed waiver (attached)	<input checked="" type="checkbox"/> _____ <b>Dates</b> <input checked="" type="checkbox"/> ___ <b>Waiver attached</b>
CPR Certification	<input checked="" type="checkbox"/> Current CPR Certification for Health Care Provider (copy of card attached)	<input checked="" type="checkbox"/> _____
Standard Precautions		<input checked="" type="checkbox"/> _____ <b>Date</b>



## Controlled Substances Prescribing Delegation to Nurse Practitioner, Nurse Midwife

*Applicant's Name* \_\_\_\_\_  
*First* *MI* *Last*

\_\_\_\_\_  
*Michigan License Number*

\_\_\_\_\_  
*Location of Delegated Prescribing\**  
*\*(use a separate form for each location)*

\_\_\_\_\_  
*Signature* *Date*

*Choose One:*  
 *Inpatient*  
 *Outpatient*

The above named Nurse Practitioner, Nurse Midwife or Physician Assistant is authorized by my delegation to prescribe controlled substances as indicated below, consistent with the Michigan Public Health Code and the Michigan Administrative Code, as amended by the addition of R 338.2304, R 338.2305, R 338.108a, and R 338.108b.

The named applicant is currently credentialed and privileged by the University of Michigan School of Nursing.

**Note: Privileges for controlled substances prescribing must be renewed annually.**

Authorized prescribing of Schedules 3, 4 and 5 controlled substances with the following exceptions: \_\_\_\_\_

Authorized prescribing of Schedule 2 controlled substances with the following exceptions:

Note: For schedule 2 prescribing, patient must be within a hospital (excluding outpatient areas), freestanding surgical outpatient facility or in a hospice setting in which both the delegating physician and the named applicant practice. Discharge prescribing is limited to a quantity for no more than 7 days. Prescribing may not be delegated for a woman known to be pregnant with the intention of causing either miscarriage or fetal death.

Delegated prescribing of controlled substances also requires that the applicant possess a DEA license and **attach copy of DEA license to this form.**

Nurse Practitioner's Name \_\_\_\_\_

*Physician's Name* \_\_\_\_\_

*Michigan License Number* \_\_\_\_\_ *Date* \_\_\_\_\_

*Signature* \_\_\_\_\_

*Physician's Name* \_\_\_\_\_

*Michigan License Number* \_\_\_\_\_ *Date* \_\_\_\_\_

*Signature* \_\_\_\_\_

*Physician's Name* \_\_\_\_\_

*Michigan License Number* \_\_\_\_\_ *Date* \_\_\_\_\_

*Signature* \_\_\_\_\_

*Physician's Name* \_\_\_\_\_

*Michigan License Number* \_\_\_\_\_ *Date* \_\_\_\_\_

*Signature* \_\_\_\_\_

*Physician's Name* \_\_\_\_\_

*Michigan License Number* \_\_\_\_\_ *Date* \_\_\_\_\_

*Signature* \_\_\_\_\_

*Physician's Name* \_\_\_\_\_

*Michigan License Number* \_\_\_\_\_ *Date* \_\_\_\_\_

*Signature* \_\_\_\_\_

I have reviewed and/or discussed the privileges requested and find them to be commensurate with the applicant's training and experience, and recommend that his/her application proceed.

**Associate Dean Office for Community Partnerships:** \_\_\_\_\_

**Date:** \_\_\_\_\_