STANTON TERRITORIAL HEALTH AUTHORITY
CREDENTIALS COMMITTEE

REQUIREMENT CHECKLIST FOR HOSPITAL PRIVILEGES

Physician's Name: ___________________________ Start Date: ________________
Address: ___________________________ Home Phone: ___________________________
___________________________ Work Phone: ___________________________
___________________________ Fax: ___________________________
Place of work in NT ___________________________ Email: ___________________________

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Application for Appointment to the Medical Staff</td>
</tr>
<tr>
<td>2.</td>
<td>Privileges – please see the attached lists of procedures you may request.</td>
</tr>
<tr>
<td>3.</td>
<td>Curriculum Vitae</td>
</tr>
<tr>
<td>4.</td>
<td>NWT License/Permit to Practice - Please contact the Deputy Registrar of Professional Licensing, Jeanne Gagnon, at <a href="mailto:Jeanne_Gagnon@gov.nt.ca">Jeanne_Gagnon@gov.nt.ca</a> or 867 920-3323 in order to apply. Your license will be faxed to this office once issued.</td>
</tr>
<tr>
<td>5.</td>
<td>CMPA Certificate “Membership Update” CMPA # 1-800-267-6522. Please ensure that the NWT is indicated as a territory of work.</td>
</tr>
<tr>
<td>6.</td>
<td>Three (3) Letters of Reference (they may be the same three people that submit references to the Registrar of Professional Licensing but must be on the specific form attached – the two departments do not share references)</td>
</tr>
<tr>
<td>7.</td>
<td>Family Physicians requesting OB privileges must also provide the following:</td>
</tr>
<tr>
<td></td>
<td>• Documentation of having completed a recent ALARM, ALSO, or acceptably equivalent course.</td>
</tr>
<tr>
<td></td>
<td>• And a letter of reference or appropriate other assessment suggesting that the applicant has the skills, training, and proficiency to safely practice in a comparable environment to that of Stanton Hospital from either:</td>
</tr>
<tr>
<td></td>
<td>a) an acceptable obstetrical or medical program director or colleague or</td>
</tr>
<tr>
<td></td>
<td>b) a current member of Stanton’s or Inuvik’s Obstetrical Department.</td>
</tr>
<tr>
<td></td>
<td>➢ This letter of reference can be counted as one of the three letters of reference above in item 6.</td>
</tr>
</tbody>
</table>

Please fax all documents listed above to: (867) 669-4218
Or mail to:
Medical Affairs Department,
Stanton Territorial Health Authority
Box 10, (550 Byrne Road),
Yellowknife, NT X1A 2N1
For more information call (867) 669-4380 or (867) 669-4376
NAME:  

ADDRESS:  

HOME PHONE:  

WORK PHONE:  

E-MAIL ADDRESS:  

AFFILIATED NWT CLINIC:  

Date of Birth:  

☐ Specialist – please specify:  

I am requesting appointment to the following category of medical staff:  

☐ Active  (Medical Practitioners who practice in the City of Yellowknife, appointed by the Board after having completed 6 months satisfactory services as an Associate)  

☐ Associate  (Medical Practitioners who practice in the City of Yellowknife; and are applying for initial appointment to the Medical Staff)  

☐ Courtesy  (The applicant does not reside within the City of Yellowknife; or the applicant’s primary commitment is to another organization, or the applicant requests courtesy privileges; or where the Board deems it otherwise advisable and in the best interests of the Authority)  

☐ Locums Tenens (Medical Practitioners who are working to meet specific clinical needs for a defined period of time, as a planned replacement for practitioners for a specific period of time; or to provide episodic or limited surgical)  

For office use only:  
The STHA Credentials Committee recommends that the physician be appointed to the following category of medical staff at the Stanton Territorial Health Authority.  

☐Active  ☐Associate  ☐Courtesy  ☐Locum Tenens  

I am requesting privileges for the following Health Authority(ies). (Check all that apply)  

☐DehCho (DHSSA)  ☐Fort Smith (FSSHSA)  ☐Hay River (HRHSSA)  ☐Beaufort Delta (BDHSSA)  ☐Sahtu (SHSSA)  

☐Tlicho (TCSA)  ☐Stanton Territorial (STHA)  ☐Yellowknife (YHSSA)  

1. LIABILITY INSURANCE:  ☐ CMPA  Effective Date(s)  

Please attach copy of Update indicating the NT as a territory of work or arrange to have one faxed directly to 867 765-4011.  

2. MEMBERSHIP ON OTHER HOSPITAL MEDICAL STAFF  

☐ No  ☐ Yes (complete section below)  

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. CERTIFICATIONS:

<table>
<thead>
<tr>
<th>CERTIFICATION</th>
<th>Most recent date completed. DD/MM/YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Cardiac Life Support (ACLS) Must be updated every 2 years.</td>
<td></td>
</tr>
<tr>
<td>Required for Emergency Call and Anaesthesia Privileges</td>
<td></td>
</tr>
<tr>
<td>Pediatric Advanced Life Support (PALS or APLS) Recommended</td>
<td></td>
</tr>
<tr>
<td>Neonatal Resuscitation Course (NRP) (optional)</td>
<td></td>
</tr>
<tr>
<td>Advanced Trauma Life Support (ATLS) (optional)</td>
<td></td>
</tr>
<tr>
<td>Advanced Life Support Obstetrics (ALSO) or ALARM or MORE OB</td>
<td></td>
</tr>
<tr>
<td>Other: (please specify)</td>
<td></td>
</tr>
</tbody>
</table>

4. CONTINUING EDUCATION:

Specialist Physicians are required to fulfill the Maintenance of Competency requirements for membership in the Royal College of Physicians and Surgeons, or equivalent.

Family Physicians are required to fulfill CME requirements for membership in the College of Family Physicians of Canada or equivalent.

☑ summary attached

☐ listed below

__________________________________________

5. Please indicate whether you have been a member of any hospital committee(s) requiring medical staff representation within the past year, and, if so, what type of committee and the time period when you were on the committee.

<table>
<thead>
<tr>
<th>Hospital Committee</th>
<th>Time Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I, ____________________________, hereby apply for Appointment to the Medical Staff of the Health Authorities indicated above, with privileges as requested (see attached list of privileges), if applicable, and for privileges to utilize laboratory and diagnostic imaging services of the Stanton Territorial Health Authority.

I affirm that I will abide by the Bylaws, Policies, and Procedures of the health care facilities in which I am working, or in which I will utilize services provided by the facility. I also affirm I will abide by the Hospital & Health Facilities Standard Regulations of the NWT.

I affirm that I will immediately notify the Chairperson of the STHA Credentials Committee should my license to practice be suspended, revoked or altered.

I am aware that in addition to my credentials, privileges granted will depend upon the needs and resources of the individual Health Authorities, as well as the requirements of the medical programs (e.g. Family Practice, Obstetrics, Emergency Medicine) for which I am requesting privileges.

__________________________________________ Date

Applicant’s Signature

Reviewed and Accepted by the STHA Credentials Committee

__________________________________________ Date

Member of the STHA Credentials Committee

__________________________________________ Date

Chairperson of the STHA Credentials Committee

__________________________________________ Date
# PEDIATRIC PROCEDURES

Following is a listing of the procedures currently performed in our facility by our Pediatric specialists. Please check off which, if any, of these procedures you are interested in having privileges for. If there are any procedures you are interested in performing which are not listed here, please list them on a separate page.

- Closed Chest Tube Drainage Aspiration and/or I&D
- Local Excision of Lesion (including skin of nose, external ear and eyelid)
- Phlebotomy (peripheral vessel)
- Thoracentesis
- Suture Uncomplicated Wounds (including external ear and face)
- Arthrocentesis
- Lumbar Puncture
- Intubation Oral/Nasal
- Arterial Blood Gases
- Interosseous Needle Insertion
- Umbilical venous & Arterial Line Insertions
- Bladder Catheter Insertion
- Suprapubic Urine Aspirations
- Femoral Vein Catheter Insertion
STANTON TERRITORIAL HEALTH AUTHORITY
CREDENTIALS COMMITTEE

Reference letter for Health Care Professionals applying for
Privileges in the Northwest Territories

_______________________________________ has applied for privileges in the Northwest Territories and your name was provided as a reference. Please answer the following questions regarding this applicant, and provide details for answers circled “Yes”.

Please fax or mail this completed form directly to Medical Affairs at Stanton Territorial Hospital, P.O. Box 10, 550 Byrne Road, Yellowknife, NT, X1A 2N1. Fax: 867-669-4218

Note: the professional licensing authorities in the NWT, including the Medical Registration Committee, also require reference letters. The licensing bodies are entirely separate from the health authorities within the NWT, and separate from the Stanton Territorial Health Authority Credentials Committee.

How long have you known the applicant, and in what capacity?
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Regarding this applicant, are you aware of any of the following:

● A physical or mental health problem that may interfere with this applicant’s ability to provide an acceptable level of care to their patients/clients? Yes / No
● A drug or alcohol problem (current or past)? Yes / No
● Complaints regarding this applicant which have resulted in a formal investigation or disciplinary proceeding? Yes / No
● Multiple complaints regarding this applicant’s:
  □ Interpersonal relationships with patients/clients, and/or with other health care professionals? Yes / No
  □ Adherence to departmental or hospital policies (including health records and on-call responsibilities)? Yes / No
  □ Clinical judgment regarding and/or medical/surgical management of patients/clients? Yes / No
● Concerns regarding this applicant’s ethical or professional behavior? Yes / No

Please provide details for any questions answered “Yes”, and please write any additional comments you feel are pertinent (may use separate sheet of paper).

_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Name of Referee ___________________________ Signature ______________________ Date _______________________
Phone number and email address