***Brazos Valley Community Action Agency, Inc.***
Community Health Centers - Credentials Department
1500 University Drive East, Suite 100
College Station, Texas
979-776-7300
979.776.7330 FAX
***Privileged and Confidential Professional Review Committee Proceedings***

**STAFF NAME:** **CONTACT INFORMATION:**

**To assist in expediting your credentials process, please include the following copies of the documents listed below:**

- Sign appropriate **CME/CEU Attestation Form**
- Provide copies of **CME/CEU certifications since last licensure** if applicable
- Sign **Health Attestation Form**
- Sign and complete top portion of **Request for Verification of Fitness** if applicable
- Attach current copy of □ **BLS /CPR *REQUIRED** □NALS □PALS □ATLS □ALSO □ACLS if applicable
- Attach current copy of **Texas Professional License** if applicable
- Attach copy of **Board Certification letter & certificate** □ **National Certification (if applicable)**
- Attach copy of current **Texas Driver's License**
- Attach copies of education **Diplomas** (Clinical Education, Medical school, internship, residency, fellowship, etc.);
- Sign **Request for Transcript**
- Attach copy of **Military DD214** if applicable
- Attach current **Resume/CV**
- Sign **General Authorization/Consent Form**
- Review Position Description enclosed and sign "**Acknowledgment of Position Description**"
- **Peer References** provide a minimum of 3

***Brazos Valley Community Action Agency, Inc.***
Community Health Centers - Credentials Department
1500 University Drive East, Suite 100
College Station, Texas
979-776-7300
979.776.7330 FAX
***Privileged and Confidential Professional Review Committee Proceedings***

# CME/CEU
# CONTINUING MEDICAL EDUCATION ATTESTATION

_____ I certify that **I have completed** the necessary CME/CEU hours required by the Texas Medical Board, and/or other certifying agency as required by my licensure.

_____ While employed by BVCAA, **I agree to provide copies** of appropriate CME/CEU certification to Human Resources upon completion, so that my CME/CEU record can be maintained.

| _____ | _____ | _____ |
|---|---|---|
| Signature | Printed Name | Date |

*****All applicants are required to provide copies of CME/CEU certificates awarded to cover the period since licensure or last renewal period.*****

***Brazos Valley Community Action Agency, Inc.***
Community Health Centers - Credentials Department
1500 University Drive East, Suite 100
College Station, Texas
979-776-7300
979.776.7330 FAX
***Privileged and Confidential Professional Review Committee Proceedings***

# CME/CEU
# CONTINUING MEDICAL EDUCATION ATTESTATION

_____ I certify that **I am not required to complete** any further CME/CEU hours required by my license, and/or other certifying agency and if additional hours are required by my licensure, if requested, I will provide copies of appropriate certificates in evidence thereof if requested.

_____ _____ _____
Signature Printed Name Date

***Brazos Valley Community Action Agency, Inc.***
Community Health Centers - Credentials Department
1500 University Drive East, Suite 100
College Station, Texas
979-776-7300
979.776.7330 FAX
***Privileged and Confidential Professional Review Committee Proceedings***

# HEALTH ATTESTATION STATEMENT

For credentialing purposes, the applicant must illustrate the ability to perform his/her duties as a healthcare provider by providing a document stating that no health problems exist that could affect his/her practice of medicine.

If yes to any of the following questions, you must have your personal physician complete and sign the Request for Verification of Fitness form.

YES NO Within the past five (5) years have you abused or have you been addicted to alcohol or drugs or have you been treated for alcohol or other substance abuse or dependency?

YES NO Within the past five (5) years have you been diagnosed with or have you been treated for any of the following: schizophrenia or any other psychotic disorder, delusional disorder, bipolar or manic depressive mood disorder, major depression, personality disorder, or any mental condition which impaired your behavior, judgment, or ability to function in important life activities (such as learning, performing or completing work responsibilities, or other professional requirement)?

YES NO Within past five (5) years, have you had or do you currently have any physical or neurologic condition, including any disease or condition generally regarded as chronic by the medical community, which impaired or does impair your behavior, judgment, or ability to function in important life activities (such as learning, performing or completing work responsibilities, or other professional requirement)?

I, _____, certify that the above is true to the best of my knowledge and understand that falsification or misrepresentation of any response above is a sufficient basis for denying credentialing, privileging and/or continuing my employment with the agency.

_____ _____

Signature Date

***Brazos Valley Community Action Agency, Inc.***
Community Health Centers - Credentials Department
1500 University Drive East, Suite 100
College Station, Texas
979-776-7300
979.776.7330 FAX

***Privileged and Confidential Professional Review Committee Proceedings***

# REQUEST FOR VERIFICATION OF FITNESS

**Name of your current Physician/Provider**
- Primary Care (Family Physician, Internist, OB/GYN, Psychiatrist): _____

Address: _____ Telephone: _____

_____ Fax: _____

I hereby authorize and consent to the release of information concerning me from the above identified physician and I hereby release from liability the above addressee for complying with this request.

Applicant Name (type or print):
Position applied for:
(Job Description Attached)

Applicant Signature: _____ Date: _____

* * * * * *

The above individual has applied for a staff position or to contract for services for the Center. It is a requirement of the Federal Tort Claims Act liability coverage for the Center and licensed or certified staff that each licensed or certified individual be determined fit to provide services at the Center. This information is requested at the direction of the Professional Review Committee and will become a part of the Confidential File for the above applicant. Please complete and return this form to me at the address above:

I certify that the above individual is/has been under my care as a patient. It is my professional opinion as the applicant's physician that the individual is:

- ☐ fit to provide services in the Center without limitation.
- ☐ fit to provide services in the Center under the following conditions:
  _____
- ☐ not fit to provide services in the Center.

**Signature of Physician/Provider:** _____ Date: _____

Printed Name of Physician/Provider: _____

Thank you for your assistance.

Markie Grisham
979.776.7300 ext 702
979.776.7330 Fax
Credentials Assistant

***Brazos Valley Community Action Agency, Inc.***
Community Health Centers - Credentials Department
1500 University Drive East, Suite 100
College Station, Texas
979-776-7300
979.776.7330 FAX
***Privileged and Confidential Professional Review Committee Proceedings***

Institution Name: _____

Address: _____

_____

Re: **Request for Transcript –**

Applicant *(Name on Transcript)*:

_____

First Middle Maiden Last

Social Security Number: _____ D.O.B. _____

Enrollment dates: _____ to _____

Degree or Certificate Awarded: _____

Date of Graduation or Completion: _____

I hereby authorize and consent to the release of my transcript to the Center Professional Review Committee and I hereby release from liability the above addressee for complying with this request.

Signature _____ Date _____

Printed Name _____

* * *

The above applicant has authorized you to provide a copy of his/her transcript from your institution. This information is requested at the direction of the Center Professional Review Committee and will become a part of the applicant's Confidential File.

Sincerely,

Markie Grisham
979.776.7300 ext 702
979.776.7330 FAX
Credentials Assistant

***Brazos Valley Community Action Agency, Inc.***
Community Health Centers - Credentials Department
1500 University Drive East, Suite 100
College Station, Texas
979-776-7300
979.776.7330 FAX
***Privileged and Confidential Professional Review Committee Proceedings***

# AUTHORIZATION AND CONSENT

I fully understand that any misstatements or omissions in this application constitute cause for denial or termination of privileges and employment. All information submitted by me in this application is true to the best of my knowledge.

In making this application, I acknowledge my obligation to fulfill my responsibilities to provide continuous quality care to patients of the Center, to make decisions as appropriate to the patient's needs, to maintain my practice knowledge and skills current through continuing education opportunities, to abide by the bylaws, rules and regulations of the Professional Staff, and to participate in and cooperate fully with the Compliance/Performance Improvement ("CPI") Program and all programs to improve quality and reduce risks. I agree to participate in the review of records and documents relating to patient care and services, and to subject my performance to the review by the Center and the Staff (its representatives) for the purpose of improving the quality of care and services and reducing risks, and I hold the Center and its directors, officers, healthcare providers, employees, contractors, attorney, agents, and representatives free of all liability for such actions.

I hereby release from liability the Center and all its directors, officers, healthcare providers, employees, contractors, attorney, agents, and representatives for their acts performed in connection with obtaining and evaluating my application, credentials and qualifications. I hereby release from any liability any and all individuals and organizations that provide information to the Center and/or its directors, officers, healthcare providers, employees, contractors, attorney, agents, and representatives concerning my professional competence, character, ethics, and other qualifications for employment and privileges and I hereby consent to the release of such information.

I hereby authorize the Center CPI Committee (and/or Subcommittee) as a Professional Review Committee through the Compliance/Performance Improvement Program to communicate with other entities and individuals concerning knowledge of my professional competence, character and ethics and agree to hold the Center and all its directors, officers, healthcare providers, employees, contractors, attorney, agents, and representatives free of liability. I hereby consent to the inspection by the Center and/or its directors, officers, healthcare providers, employees, contractors, attorney, agents, and representatives of all documents, including medical records at other entities, school transcripts, and county records, that may be material to an evaluation of my qualifications and competence for the clinical privileges and functions requested as well as my moral and ethical qualifications for employment. I agree to hold the Center and its directors, officers, healthcare providers, employees, contractors, attorney, agents, and representatives free of liability.

I hereby consent to the Center through any of its agents obtaining information relating to my criminal history record. The criminal history record, as received from the reporting agencies, may include arrest and conviction data as well as plea bargains and deferred adjudications and delinquent conduct committed as a juvenile. I understand that this information will be used, in part, to determine my eligibility for an employment/volunteer position with this organization. I also understand that as long as I remain an employee or volunteer here, the criminal history records check may be repeated at any time. I understand that I will have an opportunity to review the criminal history as received by the Center and may clarify in writing if I dispute the record as received. I also understand that the criminal history could contain information presumed to be expunged. I hereby agree to hold the Center and each of its directors, officers, healthcare providers, employees, contractors, attorney, agents, and representatives harmless from and against any and all causes and actions, suits, liabilities, costs, debts and sums of money, claims and demands whatsoever (including claims for negligence, gross negligence, and or strict liability of the Center)and any and all related attorneys' fees, court costs and other expenses resulting from the investigation of my background as described above in connection with my application to become a volunteer/staff member.

I hereby accept that I will abide by the requirements for coverage by the Federal Tort Claims Act ("FTCA"), will cooperate fully in all measures to improve quality and reduce risks, and with any investigations and defense of liability claims. I understand that if I am made an offer for privileges or functions and employment that an evaluation of my physical and mental fitness may be requested consistent with the requirements for liability coverage by the FTCA.

I understand that I have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications.
I understand that my employment with the Center, if any, may be terminated at any time without cause.

| Signature | Printed Name | Date |
|---|---|---|

**The Center is an equal opportunity employer and its decisions are made without regard to race, color, ethnicity, religion, sex, age, sexual orientation, disability, citizenship, national origin or veteran status.*

# Position Description
# For
# LVN

The purpose of this job description is to communicate the responsibilities and duties associated with the position of LVN. The following information should not be considered a comprehensive description of this position, it should also be noted that some responsibilities and duties may not be specifically addressed. The Company fully expects every person to perform any reasonable task or request that is consistent with fulfilling company objectives. The Company recommends an ongoing effort to familiarize yourself with the duties and responsibilities of those positions directly above and below your own.

**Position:** L.V.N.

**Supervisor:** Clinic Director

**Location:** Brazos Valley Community Health Centers

## Job Brief:

The position of LVN is responsible for providing counseling and nursing skills according to program protocol.

## Essential Functions:

1. Health Education and Counseling
2. Provide direct client care; Utilization of evidence-based Standards of Care
3. Documentation of care
4. Perform lab work
5. Integrate Chronic Care Model and Performance Improvement Model in delivery of care

## Education Required:

1. L.V.N. Must possess current Texas License

## Practical Experience:

1. Prefer at least 3- 6 months of previous experience as an LVN and previous Pediatric, Women's Health and Obstetrics experience.

## Supervision Received:

1. Medical care monitored by Medical Director, chart review and direct supervision by Clinic Director; must be able to work independently.

## Responsibilities:

1. Maintain standards, instruct, review work and coordinate activities

## Aptitudes Required:

This position requires the following levels of aptitudes:

**Reasoning Development** – must be able to apply principles of logical or scientific thinking to define problems, collect data to establish facts, and draw conclusions. Interpret an extensive variety of technical instructions in mathematical or diagrammatic for. Deal with several abstract and concrete variables.

**Language Development** - must be able to read novels, tech journals, blueprints with understanding. Must be able to prepare business letters, expositions, summaries, and reports that all follow with proper format and grammar.

**Math Development** - must be able to solve mathematical problems using techniques such as algebra, calculus, and statistics.

## Physical Requirements:

1. Have constant need (66% - 100% of time) for standing.
2. Have constant need (66% - 100% of time) for walking.
3. Have frequent need (33% - 66% of time) for sitting
4. Have occasional need (1% -33% of time) for bending, stooping, or squatting
5. Have rare need (less than 1% of time) for climbing stairs.
6. Have rare need (less than 1% of time) for lying down.
7. Have occasional need (1% - 33% of time) for pushing or pulling.
8. Have occasional need (1% - 33% of time) for reaching above shoulders.
9. Have rare need (less than 1% of time) for climbing ladders.
10. Have frequent need (33% - 66% of time) for grasping or gripping.
11. Have constant need (66% - 100% of time) for finger dexterity.
12. Have constant need (66% - 100% of time) for typing or writing.
13. Have occasional need (1% - 33% of time) for driving or operating equipment.

## Lifting/Carrying:

1. Have rare need (less than 1% of time) to lift/carry over 150 pounds.
2. Have rare need (less than 1% of time) to lift/carry 76 - 150 pounds.
3. Have rare need (less than 1% of time) to lift/carry 51 - 75 pounds.
4. Have rare need (less than 1% of time) to lift/carry 26 - 50 pounds.
5. Have occasional need (1% - 33 % of time) to lift/carry 10 - 25 pounds.
6. Have frequent need (33% - 66% of time) to lift/carry under 10 pounds.

## Vision Requirements:

1. Have constant need (66% - 100% of time) to be able to see detail.
2. Have constant need (66% - 100% of time) to be able to see beyond arms length.

## Hearing Requirements:

1. Have constant need (66% - 100% of time) to be able to hear other personnel in order to communicate effectively.

## Speaking Requirements:

1. Have constant need (66% - 100% of time) to be able to hear other personnel in order to communicate effectively.

## Environment- Working Conditions:

1. Have constant need (66% - 100% of time) to work indoors.
2. Have rare need (less than 1% of time) to work outdoors.
3. Have frequent need (33% - 66% of time) to work in confined space.
4. Have rare need (less than 1% of time) for exposure to fumes, chemicals, solvents, etc.
5. Have rare need (less than 1% of time) for exposure to extreme temperatures.
6. Have constant need (66% - 100% of time) for eye/hand/foot coordination.

## Optimum Qualifications:

The successful candidate should have at a minimum good English communication and must also meet the aptitude requirements listed in this description. Exceptional organizational skills are needed.

***Brazos Valley Community Action Agency, Inc.***
Community Health Centers - Credentials Department
1500 University Drive East, Suite 100
College Station, Texas
979-776-7300
979.776.7330 FAX
***Privileged and Confidential Professional Review Committee Proceedings***

# ACKNOWLEDGMENT
# OF
# POSITION DESCRIPTION

**I, , acknowledge that I have received a copy of the position description for the _____ position for the Brazos Valley Community Action Agency. I further acknowledge that I have read the position description and have been given the opportunity to ask any questions that I may have regarding the duties, both physical as well as mental for this position. Based on the information provided to me on the position description, I hereby attest to the following:**

_____ 1. I can meet the minimum physical and mental requirements of the position as outlined on the position description.

_____ 2. I cannot meet the minimum physical and mental requirements of the position as outlined on the position description.

_____ 3. Other (Please explain)

_____

_____

_____

_____ _____

APPLICANT SIGNATURE DATE

_____

PRINTED NAME

***Brazos Valley Community Action Agency, Inc.***
Community Health Centers - Credentials Department
1500 University Drive East, Suite 100
College Station, Texas
979-776-7300
979.776.7330 FAX
***Privileged and Confidential Professional Review Committee Proceedings***

# PROFESSIONAL/PEER REFERENCES

Please list the **names, full mailing addresses, and phone numbers** of a minimum of three professional references (in your same field of service).

***Professional References*** (persons not related to you and with first-hand knowledge of your professional work; supervisors, co-workers that are your peers (example other persons with your same designation *PAs, RNs, LVNs, C.N.A.s, DAs, RDs, RDAs,* etc.).

**1.** **Name:** _____ **Title:** _____

Employer: _____

_____
Address City State Zip

Phone Number: _____ Fax: _____

**2.** **Name:** _____ **Title:** _____

Employer: _____

_____
Address City State Zip

Phone Number: _____ Fax: _____

**3.** **Name:** _____ **Title:** _____

Employer: _____

_____
Address City State Zip

Phone Number: _____ Fax: _____

**4.** **Name:** _____ **Title:** _____

Employer: _____

_____
Address City State Zip

Phone Number: _____ Fax: _____