Tree Top Health Pvt Ltd

Tree Top Hospital
c/o 3rd Floor – H. Filigasdhoshuge,
Ameeru Ahmed Magu,
Male', 20066
Republic of Maldives
T: +960 3310681
M: +960 7990496
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INSTRUCTIONS FOR APPLICATION FOR MEDICAL/DENTAL AFFILIATION AT TREE TOP HOSPITAL, REPUBLIC OF MALDIVES

Dear Applicant:

Thank you for your interest in applying to Tree Top Hospital, Republic of Maldives. Please complete the ***Application Form*** provided.

All applicants must fulfil the following conditions to be eligible to practice as a Medical/Dental professionals at Tree Top Hospital. Where in doubt, please contact the undersigned.

1. Graduate of an accredited medical or dental school.
2. Preferably have three (3) years of clinical work experience after post-graduate degree in a government, tertiary, or equivalent facility.
2. Possess an unconditional licence to practise in the Maldives.
3. Possess valid documents (as required by the Ministry of Health of Maldives and Maldives Medical Council) to practice as a certified medical practitioner in the Maldives.
4. Member or fellow of, or board certification by, a specialty college recognized by the Ministry of Health of Maldives and the Maldives Medical Council.
5. Possess specialty qualifications that comply with the guidelines of the Ministry of Health of Maldives and the Maldives Medical Council.
6. Reside in the Maldives and in the vicinity of Tree Top Hospital to be able to respond adequately to patients' needs in the Hospital.
7. A member of an approved medical protection association.

Please ensure the completeness of the Application Form before submitting. Failure to do so (for example if certain sections of the form are left blank or the required documents are not submitted), will delay the processing of your application.

The following items are required for your application to be processed:

1. Current and detailed Curriculum Vitae.
2. A passport-sized photograph.
3. Privileges applied for. A list of privileges relevant to your specialty will be provided for your completion.
4. Description of practice plans, including anticipated use of Tree Top Hospital facilities and types of hospital privileges requested.
5. Case logs and pertinent redacted medical records that document proficiency in requested privileges. These case logs must be certified by Head of Department or Hospital Management where the procedures were done.
6. Certified true copies of the following:
    a. Registration with the Maldives Medical Council.
    b. Current Annual Practice Certificate/License issued by the Medical Council of the respective country.
    c. Membership or fellowship certificates in the appropriate medical, dental or surgical specialty, as proof of satisfactory completion of the said approved program(s).
    d. Board Certification (e.g. American Board Certification) or Specialist Register with the respective sub-specialty, as proof of certification in the said medical, dental or surgical specialty.
    e. CPR/PALS/BCLS/ACLS or related certification where applicable.
    f. Professional Liability Insurance certificate (covering your current medical practice) from an acceptable malpractice insurance carrier. Please justify if this is currently not available.
    g. Health screening test, proof of vaccination or free from infectious diseases, Hepatitis B vaccination or positive Hepatitis titer.

h. Health information disclosure under Section 10 of the Application form, including copies of Health screening test, proof of vaccination or free from infectious diseases, Hepatitis B vaccine or positive Hepatitis B titer.

For applicants who are in the process of obtaining the above certificates at the time of application, please state the approximate time for the issuance of the said certificates.

7. ***Consent for the Release of Information*** allowing Tree Top Hospital to obtain unrestricted access to complete information from all educational and training institutions that the applicant had previously attended, all hospital and outpatient facilities, the Medical Council, Licensing or Physician Quality Assurance Boards of the respective country/state/provincial/etc., and all personal and professional references provided by the applicant.
8. ***Signed Declaration Form*** provided with the Application Form.

All documents submitted as part of this application must be "certified true copies" by a person holding a responsible position and stamped with his/her name and designation in full.

Applicants are required to attend an interview with Tree Top Hospital either in person, by phone or any other suitable media.

The successful applicant is expected to:

1. Demonstrate good character, judgement and competencies in his/her area of specialty. This may require a review and evaluation of the applicant by the peer group or the Head of Department.
2. Act professionally, ethically and with integrity.
3. Adhere to the highest ethical practices required of his/her profession.
4. Abide by the rules and regulations of Tree Top Hospital.
5. Be a team player and work well with management, peers, and all other care givers and staff.
6. Continually improve himself/herself professionally and help others to do so to achieve the best outcome for the patients.
7. Represent the Hospital well and actively contribute to its ongoing development.

You are assured that the information which you have provided to Tree Top Hospital will be used strictly for the purpose of seeking appointment at Tree Top Hospital only and not for any other purposes.

Thank you.

Rupa Rekhraj (Ms)
Authorized signatory for Tree Top Hospital
Email: careers@treetophospital.com

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APPLICATION FORM
FOR MEDICAL/DENTAL AFFILIATION APPOINTMENT & CLINICAL PRIVILEGES

NOTE:
1. Please refer to the instruction sheet and complete all sections of the Application Form.
2. All information must be typed or legibly written.
3. Please indicate **COMPLETE** address including area codes.
4. If more space is needed, attach an additional sheet and reference the question being answered.
5. The term "Medical" used in the form below refers to "Dental" practises

SECTION 1 – PERSONAL DETAILS			
Surname			
First name			
ID No.:			
Citizenship:		Passport No:	
Birth Place:	Date of birth:	Sex:	Religion:
Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Others	Name of Spouse (if applicable):	
Home Address:			
Current Practice Address:			
Type of establishment:	☐ Private hospital ☐ Public hospital ☐ Private ambulatory centre ☐ NGO	Nature of affiliation:	☐ Employed ☐ Private fee-for-service ☐ Group practice ☐ Others
Languages & Proficiencies: E-Excellent G-Good F:Fair	☐ English, Spoken ( ) ☐ English, Written ( )	☐ Dhivehi, Spoken ( ) ☐ Dhivehi, Written ( )	☐ Other languages
Telephone:	Mobile No:	Office No:	Home No:
E-mail address:			
Corresponding Address:			

SECTION 2 – EDUCATION, TRAINING AND PROFESSIONAL EXPERIENCE

[Fellowships, preceptorships, teaching appointments, post-graduate education. List Practitioners responsible for performance (Chief of Staff, Chairman of Departments, Others in Internships, Residences and Fellowships)]

Medical Education (Undergraduate)

Name of University / Medical or Dental School / College or University & complete mailing address	Degree/Qualification	Date obtained

Internship / Housemanship

Name and Address of Institution	Name of Supervisor/Position/ Specialty	Dates (month / year)	
		From	To

Training areas during this period:

Name and Address of Institution	Name of Supervisor/Position/ Specialty	Dates (month / year)	
		From	To

Training areas during this period:

Name and Address of Institution	Name of Supervisor/Position/ Specialty	Dates (month / year)	
		From	To

Training areas during this period:

Name and Address of Institution	Name of Supervisor/Position/ Specialty	Dates (month / year)	
		From	To

Training areas during this period:

Residency /Post-registration / Medical Officer

Name and Address of Institution	Name of Supervisor/Position/ Specialty	Dates (month / year)	
		From	To

Training areas during this period (in details e.g. procedures done under supervision/independently):

Name and Address of Institution	Name of Supervisor/Position/ Specialty	Dates (month / year)	
		From	To

Training areas during this period (in details e.g. procedures done under supervision/independently):

Name and Address of Institution	Name of Supervisor/Position/ Specialty	Dates (month / year)	
		From	To

Training areas during this period (in details e.g. procedures done under supervision/independently):

Name and Address of Institution	Name of Supervisor/Position/ Specialty	Dates (month / year)	
		From	To

Training areas during this period (in details e.g. procedures done under supervision/independently):

Fellowships (Includes Membership or Masters training)			
Name and Address of Institution	Name of Supervisor/Position/ Specialty	Dates (month / year)	
		From	To
Training areas during this period (as detail as possible):			

Name and Address of Institution	Name of Supervisor/Position/ Specialty	Dates (month / year)	
		From	To
Training areas during this period (as detail as possible):			

Other Clinical Training Programmes			
Name and Address of Institution	Name of Supervisor/Position/ Specialty	Dates (month / year)	
		From	To
Training areas during this period:			

Faculty Positions (List all academic, faculty, research, assistantships or teaching positions you have held and the dates of those appointments)			
Programme Specialty / Institution and address	Academic Rank or Title	Dates (month / year)	
		From	To

Continued Medical Education
On separate sheet, list all postgraduate activities which you have attended, or for which you have received credit in the past two years.
State if you have kept your basic life support training current

☐ Yes (Submit a copy of the BCLS or ACLS certificate).	☐ No (I shall take responsibility to be trained in this area prior to my commencement of my practice).

SECTION 3 – MEMBERSHIP IN PROFESSIONAL SOCIETIES (Royal Colleges)		
Name of Professional Societies	Location	Date

SECTION 4 – MEMBERSHIPS (In Medical Associations / Societies / Other Non-medical related organizations)		
Name of Medical Association	Location	Date

SECTION 5 –MEDICAL LICENSING			
Medical Council			
Type of Registration *(Please tick)*	Registration Number / Country	Date	Copy attached
☐ Full ☐ Conditional ☐ Provisional ☐ Others (please specify):			
Annual Practice Certificate / Practice License	Number / Country	Date	Copy attached
Are you registered or registerable with Maldives Medical Council to practice as a medical professional in Maldives? If the answer is Yes, please provide details below (registration no. and etc):			☐ Yes ☐ No
Have you ever been suspended or denied an annual medical practice license? If the answer is Yes, please provide explanation below:			☐ Yes ☐ No
Do you currently hold an unrestricted license to practice in the Maldives? If the answer is No, please provide explanation below:			☐ Yes ☐ No

Other Medical Licensing (e.g. American Board certification, etc).			
Type of Registration (*Please tick*)	American Board Certification Number	Date /Duration	Copy attached
☐ Full ☐ Limited ☐ Provisional			
Please state below all other licensing or Board certification:			
Type of Registration: *(Please tick where appropriate)*	Malaysian Specialist Register	Date /Duration	Copy attached
☐ Full ☐ Limited ☐ Provisional			

SECTION 6 - BIBLIOGRAPHY
On separate sheet, furnish a list of scientific papers or essays you have written, and a list of scientific meetings you have attended during previous three years (including prints).

SECTION 7 - PROFESSIONAL PRACTICE/OTHER MEDICAL FACILITY AFFILIATIONS/WORK HISTORY			
(A curriculum vitae is not sufficient for complete answer to these questions. "See curriculum vitae" is not acceptable.) **Please list in reverse chronological order with the current employment and/or Medical Specialist affiliation(s) first: (A) current hospital affiliations, (B) other current facility affiliations (which includes ambulatory centres, diagnostic centres, dialysis centres, nursing homes and other healthcare facilities) (C) previous hospital affiliations, (D) applications in process, and (E) interruption to professional practice.** **Explain below any gaps greater than thirty (30) days.**			
A. Current hospital affiliations			
Name of current Practice / Employer	Position	Dates (month / year)	
		From	To
Address:	Affiliation Status: (e.g. full-time, part-time, visiting, resident, provisional, etc.)		
Brief description of responsibilities:			

B. Other Facility Affiliation (List all current affiliations with other facilities). ☐ Not applicable

Name of current Practice / Employer	Position	Dates (month / year)	
		From	To
Address:	Affiliation Status: (e.g. full-time, part-time, visiting, resident, provisional, etc.)		

Brief description of responsibilities:

Reason for leaving:

C. Previous Hospital Affiliation (List all previous affiliations) ☐ Not applicable

Name of current Practice / Employer	Position	Dates (month / year)	
		From	To
Address:	Affiliation Status: (e.g. full-time, part-time, visiting, resident, provisional, etc.)		

Brief description of responsibilities:
Reason for leaving:

SECTION 8 - PEER REFERENCES	
(Please list here [3] references, from licensed professional peers who through recent observations have personal knowledge of and are directly familiar with the evaluation of your professional competence, conduct and work. Do not include relatives. At least one reference must be a practitioner in your same professional discipline.	
Name of Reference:	Complete Address:
Job Title:	
Date of Association: from / to /	
Telephone:	
Email:	
Name of Reference:	Complete Address:
Job Title:	
Date of Association: from / to /	
Telephone:	
Email:	
Name of Reference:	Complete Address:
Job Title:	
Date of Association: from / to /	
Telephone:	
Email:	

SECTION 9 –MEDICAL LIABILITY INSURANCE				
Name of Insurance Carrier	Policy Number	Amount of coverage	Duration of coverage	Copy attached
ON SEPARATE SHEET, LIST ALL PREVIOUS INSURANCE CARRIERS, AMOUNT OF COVERAGE AND DATES WITHIN THE LAST 10 YEARS.				

Professional insurance History: Please answer each of the following questions in full. **If the answer to any question is "YES", or requires further information, please give a full explanation of the specific details on an Explanation Form and attach to the Application.**	
1. Has your license to practice medicine in the Maldives or any jurisdiction ever been voluntarily or involuntarily relinquished, denied, limited, surrendered, suspended, revoked or relinquished?	☐ Yes ☐ No
2. Have your clinical privileges at any hospital ever been suspended, diminished, revoked or not renewed?	☐ Yes ☐ No
3. Has your Medical/Dental Professional appointment ever been voluntarily or involuntarily suspended, limited, revoke, refused, denied, or relinquished at any hospital or other healthcare facility?	☐ Yes ☐ No
4. Have any disciplinary actions or investigations ever been initiated, or are any disciplinary actions or investigations currently pending, against you by any hospital Medical Specialist, hospital or Medical Specialist committee, State licensure board (Applicable for American trained doctors), professional society, or other organization authorized to review your professional actions and take disciplinary action against you?	☐ Yes ☐ No
5. Have you ever been suspended, sanctioned, or otherwise restricted from participating in any health insurance program (e.g., ING, AIA, BUPA, etc.)?	☐ Yes ☐ No
6. Have you ever been the subject of an investigation by any private, government agency concerning your participation in any private health insurance program?	☐ Yes ☐ No
7. Have you ever been named as a defendant in any criminal proceeding or in any civil proceeding related to your professional practice or actions?	☐ Yes ☐ No
8. Have judgments or settlements been made against you in professional liability cases, or are there any pending? IF THE ANSWER IS "YES", GIVE DETAILS ON SEPARATE SHEET.	☐ Yes ☐ No
9. Has any liability insurance carrier cancelled, refused coverage or rated up because of unusual risk?	☐ Yes ☐ No
10. Have you ever been convicted of or entered a plea for any criminal offence (excluding parking tickets)?	☐ Yes ☐ No
11. Are any criminal charges currently pending against you?	☐ Yes ☐ No

SECTION 10 – HEALTH STATUS	
(Please answer each of the following questions in full.)	
1. Do you currently have any physical or mental condition(s) that may affect your ability to practice or exercise the clinical privileges or responsibilities typically associated with the specialty and position for which you are submitting this Application? **If the answer to this question is "YES," please give full explanation of the specific details on an Explanation Form and attach to the Application.** (Note: Physical or mental condition(s) include, but are not limited to, current alcohol or drug dependency, current participation in aftercare programme for alcohol or drug dependency, medical limitation of activity, workload, etc., and prescribed medications that may affect your clinical judgment or motor skills.)	☐ Yes ☐ No
2. Are you able to perform all the essential functions for the position for which you are applying, safely and according to accepted standards of performance, with or without reasonable accommodation? If reasonable accommodation is required, please specify such on an **attached Explanation Form**.	☐ Yes ☐ No

3. Have you ever been under treatment for drug addiction or alcoholism?	☐ Yes ☐ No
4. Have you ever received psychiatric treatment or care?	☐ Yes ☐ No
5. Are you a carrier of any infectious diseases?	☐ Yes ☐ No

Health Information

On a separate sheet, furnish date of last physical examination, significant findings, name of physician and / or institution where performed, and dates and causes of all hospitalization for past five years.

Also include copies of Health screening test, proof of vaccination or free from infectious diseases, Hepatitis B vaccination or positive Hepatitis B titer.

SECTION 11 – ANY OTHER STATEMENT YOU WISH TO MAKE IN SUPPORT OF YOUR APPLICATION
(Maximum of 500 characters)

SECTION 12 – PRIVILEGES REQUESTED (Please indicate the clinical practice area(s) that you wish to request for clinical privileges - see List of Privileges provided for your area of specialty. Also state if you have a niche in your specialty to offer. Proof of training is required)

Specialty:	
Special Interest:	

DEFINITIONS:

Core Privileges:
- These are consultation and diagnostic/therapeutic procedures expected to be performed by a specialist who is credentialed in the specific specialty/subspecialty;
- The privileges should be in tandem with the training requirements of the MOH in the Maldives, or any other universally accepted training guidelines.
- Please request for an exclusion if you are not able / does not wish to perform any of the core procedures below:

Exclusion requested:

Special Privileges:
- These are privileges granted in addition to the core privileges defined by a specialty / subspecialty.
- They are for procedure/s which are generally confined to the same specialty / subspecialty.
- Evidence of training and competency is required.
- Examples are: Cardiac CT for cardiologist/radiologists; Prostatectomy for General Surgeons; Laparoscopic Adrenalectomy for Urologists; and Insertion of CVP line.
- Please add more pages if required

Additional Privileges:
- These are for procedure/s which are outside of the confines of the said specialty / subspecialty.
- Evidence of training and competency is required.
- Examples are: Moderate sedation; Acupuncture; Chiropractor.
- Please add more pages if required.

SECTION 13 – MEDICAL PROFESSIONAL AFFLIATION REQUESTED

(Tree Top Hospital seeks to invite interested applicants to be a Full Time Employees of the hospital. If your application is for an affiliation other than Full Time Employee, please tick the correct box)

☐ Full-time employee	☐ Part-time member (runs clinics on fixed days of the week or month. Admits patients)
☐ Visiting member (A) (sees referred patients only, on a need basis or upon request by other medical Professionals Admits patients if required)	☐ Visiting member (B) (uses medical facilities only, e.g. Cath Lab, MRI, CT Scan. Does not admit patients)

☐ Other practice arrangement (please describe below):

SECTION 14 – MEDICAL PROFESSIONAL REMUNERATION

(Please indicate your expected remuneration below in relation to the affiliation requested)

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DECLARATION

I HEREBY CERTIFY that the information contained within this Application, including all subparts and attachments, is complete, current, correct, true and without omission to the best of my knowledge.

I agree, understand and acknowledge that:

Any misstatements or omissions (whether intentional or unintentional) on this Application may constitute cause for denial of my Application or summary dismissal or termination of my clinical privileges, membership or doctor-hospital agreement.

While this Application is being processed, I agree to update the information originally provided in this Application Form should there be any changes in the information.

If granted the privilege to practice at Tree Top Hospital, I hereby subscribe to the following pledges:

1. I shall abide by the rules and regulations for Medical Professionals practicing at Tree Top Hospital, and adhere at all times to the well-recognized principles governing the reputable practice of medicine and surgery.

2. I shall not engage in the division of fees under any guise whatsoever, or knowingly permit any agent or associate of mine to do so, recognizing by this principle that I am not to collect fees from others who refer patients to me.

3. I shall abide by the clinical practice guidelines and practice evidence-based medicine.

4. I shall abide by the practice that requires the Medical/Dental Professionals to undergo periodical review and re-credentialing, and any regulations governing the Medical/Dental Professionals practice at Tree Top Hospital.

5. I shall subscribe to quality accreditation standards and participate in any quality improvement activities of Tree Top Hospital.

Signature: ______________________________ Date: ___________________________

Printed Name:

Please send the completed Application Form to:

Ms Rupa Rekhraj
Authorized representative
For Tree Top Hospital
email: careers@treetophospital.com

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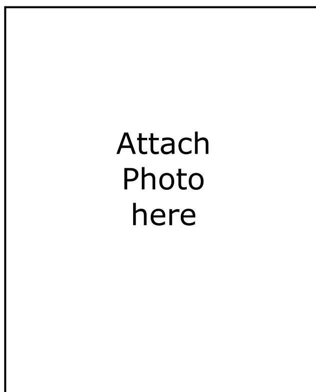
CONSENT FOR THE RELEASE OF INFORMATION

IN CONJUNCTION WITH AN APPLICATION THAT I HAVE MADE FOR MEDICAL/DENTAL PROFESSIONAL APPOINTMENT AND CLINICAL PRIVILEGES, I HEREBY GIVE MY PERMISSION TO TREE TOP HOSPITAL TO CHECK MY REFERENCES; AND BY SO DOING, HEREBY AUTHORISE YOU TO RELEASE ANY INFORMATION REQUESTED CONCERNING MY CREDENTIALS AND MY EXPERIENCE.



____
SIGNATURE OF APPLICANT

____
PRINTED NAME

____
DATE

____
APPROXIMATE DATE
PHOTOGRAPH WAS MADE

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EXPLANATION FORM

Please make as many copies of this page as needed to fully respond to each question. For each response/explanation, please provide your name together with the corresponding page and section number from the Application Form. Thank you.

Name	
Section no.:	**Page no.:**

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1 September 2015

Dear Doctor,

Medical/Dental Professionals Conduct at Tree Top Hospital, Republic of Maldives

It is the policy of Tree Top Hospital that all Medical/Dental Professionals conduct themselves in accordance with the following standards of behavior, acting at all times in a professional and cooperative manner while in the hospital or are involved in hospital or healthcare facility business, and that all colleagues, staff, visitors, patients and their families will be treated courteously, respectfully and with dignity. Instances of unprofessional behavior reported to the Management of Tree Top Hospital will be viewed seriously, investigated and the appropriate action taken accordingly.

We would expect our Medical/Dental Professionals to abide by the Medical Professionals standards of behaviour as outlined below. We request that you read carefully to ensure that you understand and fully meet these requirements:

Medical/Dental Professionals Standards of Behaviour

The Medical Professionals recognizes the considerable interdependence amongst health care providers in the rapidly changing health care environment. It acknowledges that the ability to deliver high quality health care depends in large part upon the ability of all health care providers to communicate well, collaborate effectively, and work as a team to optimize and monitor outcomes.

The Medical/Dental Professionals further acknowledges that there are many participants in the process of effective health care, including patients, their families, hospital staff, allied health professionals, and others, and that working harmoniously with them is a necessary aspect of modern health care. The Medical/Dental Professionals affirms that everyone, both recipients and providers of care, must be treated in a dignified and respectful manner at all times in order for the mutual goal of high-quality health care to be accomplished. The Medical Professionals further affirms that it is the entire staff's mutual responsibility to work together in an ongoing, positive and dynamic manner that requires frequent and continual communication and feedback.

The Medical/Dental Professionals agrees to devote the necessary time and resources toward achieving these goals and maintaining a positive and collaborative relationship amongst its members and with other providers and recipients of care.

In order to accomplish these goals, the Medical/Dental Professionals agrees to the following principles and guidelines and to work collaboratively to promote them in the organization and in the community:

Professionalism:
The Medical/Dental Professionals recognizes its commitment to the highest level of professionalism with regards to its members' practice of medicine. Therefore, he/she encourages cooperation and communication with other providers and displaying regard for their dignity. The Medical/Dental Professionals recognizes that acting professionally entails treating others with courtesy and respect, and refraining from the use of abusive language, threats of violence, retribution, litigation, and actions that are reasonably felt by others to represent intimidation. The Medical/Dental Professionals also recognizes that it is unproductive to make inappropriate remarks concerning the quality of care being provided in front of others or to make such entries in the medical record. Finally, the Medical/Dental Specialist agrees to address concerns about clinical judgments with associates directly and to avoid favoritism or sidestepping rules.

Respectful Treatment: All members of the health care provider team (physicians, hospital staff, vendors, contract personnel, etc) and all direct and indirect recipients of health care (patients, their families, visitors, etc.) shall be treated in a respectful, dignified manner at all times. Language, nonverbal behavior and gestures, attitudes, etc. shall reflect this respect and dignity of the individual and affirm his/her value to the process of effective efficient health care.

Language: All Medical/Dental Professionals agree not to use language that is profane, vulgar, sexually suggestive or explicit, intimidating, degrading, or racially/ethnically/religiously slurring in any professional setting related to the hospital and the care of its patients.

Behavior: The Medical/Dental Professionals agrees to refrain from any behavior that is determined to be intimidating, including but not limited to, using foul language or shouting, throwing of objects, or making inappropriate comments regarding physicians, hospital staff, other providers, or patients.

Confidentiality: The Medical/Dental Professionals agrees to maintain complete confidentiality of patient care information at all times, in a manner consistent with the laws of the Republic of Maldives, local and international best practices, and generally accepted principles of medical confidentiality. The Medical/Dental Professionals further recognizes that physicians and hospital staff have the right to have certain personal and performance problems and concerns about competence dealt with in a confidential manner in a private setting. The Medical/Dental Professionals agrees to maintain this confidentiality and to seek proper, professional, objective arenas in which to deal with these issues.

Feedback: The Medical/Dental Professionals agrees to give all parties prompt, direct, constructive feedback when concerns or disagreements arise. The Medical/Dental Professionals recognizes the necessity of describing such behavior in objective, behavioral terms and such feedback should be given directly to the person(s) involved through appropriate channels, in a confidential, private setting.

Communication: The Medical/Dental Professionals encourages frequent and respectful, and clear communication amongst all members of the health care team. Specifically, he/she encourages its members to respond to calls by the healthcare facilities in a timely and suitable manner, to respond to patient and staff requests appropriately, and to participate in providing adequate information when transferring a patient’s care to another provider.