Application Statement

In making this application for Membership in the HSS Rehabilitation National Network ("Network") I acknowledge that I have received, read and if approved for membership, will adhere to the policies and procedures of the Network, including but not limited to the policies and procedures pertaining to site visit reviews, membership criteria and standards established by the Network and the marketing and use of the name Hospital for Special Surgery and that of the HSS Rehabilitation Network.

Further, I hereby affirm that this application, and all information furnished by me in connection with it, is and shall be true, accurate and complete, as of this date and that I will make myself and the information required by the application available for such reviews as may be required to process the application in accordance with the policies and procedures of the Network and any applicable laws. I will notify the Network within five (5) business days of any change or proposed change in the information provided and acknowledge that any failure to provide such information or change in information, or any material misstatement or omission in the information provided in connection with my application will constitute grounds for denial of my application or reapplication for Membership or for termination of my membership in the Network.

Signature **Print Name** **Date**

_____ _____ _____

The following are required for submission of your application:

1. Proof of license for all therapists, assistants, and athletic trainers (or registration for NY state).
2. Proof of APTA/AOTA or other appropriate professional membership for owners and therapists (preferred).
3. CEU certificates for the past year for all owners.
4. Proof of facility general insurance coverage, showing expiration date
5. Proof of malpractice coverage and amount of premium paid
6. Evidence of Medicare certification (if participating)
7. Resumes for all treating Staff members.
8. A copy of all required Policies/Procedures
   Please submit only the required policies, not your entire manual.
9. **$600 non-refundable application and site visit fee**

Checks can be made payable to: Hospital for Special Surgery Rehabilitation National Network
Mailed to: Connie Stallone HSS Rehabilitation National Network, 535 East 70th St, New York, NY 10021

Policy and Procedure – Check List

Mission Statement	
Code of Conduct	
Description of Services	
Hours of Operation Stated	
Medical Emergency	
Fire	
General Evacuation	
Utility Failure	
Exit Map	
HIPAA Notice	
Job Descriptions for All	
Staff Licensure, Credentials	
Continuing Education Policy	
Performance Appraisals	
Listing of All Equipment	
Modalities Indications and Contraindications	
New Staff Orientation	
Infection Control Guidelines/Cleaning Equipment	
Clerical and Professional Staff Coverage	
Plan for Referral of Patients due to closing of office	
Plan for Emergency Treatment During Closing	
Written Payment Policy	
Written Explanation of Fees	
Medicare Explanation	
PTA, COTA, ATC Treatment Guidelines	
Incident Report Policy & Form	