**GENERAL STATEMENT of PURPOSE**

The purpose of this policy is to ensure that authentication of documents with a physician’s signature at Northwell Health is in compliance with federal, state, Joint Commission and Northwell Health requirements.

**POLICY**

All physician entries in the patient’s medical record must be dated, timed, and signed.

**SCOPE**

This policy applies to all members of the Northwell Health workforce including, but not limited to: employees, medical staff, volunteers, students, physician office staff, and other persons performing work for or at Northwell Health; faculty and students of the Hofstra Northwell School of Medicine conducting Research on behalf of the School of Medicine on or at any Northwell Health facility; and the faculty and students of the Hofstra Northwell School of Graduate Nursing & Physician Assistant Studies.

**PROCEDURE/GUIDELINES**

**Signature Documentation Requirements**

1. **Rubber/Signature Stamps**

   Rubber stamps shall not be utilized solely to authenticate documentation, as they are not accepted per the Medicare signature requirements. The use of a rubber stamp is permitted when a Physician uses it in addition to the original signature to aid in legibility.
2. Electronic Signatures

Electronic signatures are permissible through a system and/or software product which protects against modification of signatures and applies administrative procedures (appropriate log-on and password requirements) which are adequate and correspond to recognized standards and laws. The Physician bears the responsibility for the authenticity of the information being attested to.

3. Signature Requirements

Signatures shall be legible and consist of at least the first initial and full last name of the recording person, including Physician contact number. If illegible, the printed name must appear underneath the signature.

4. Global-Authentication

Global-authentication of the medical record, whereby a Physician signs one document to “authenticate” all missing signatures, is not acceptable.

5. Late Signatures

Providers shall not add late signatures to the medical record, but instead write a signed and dated attestation statement that declares the provider as the author of the medical record and contains sufficient information to identify the patient. The following attestation statement template is suggested by CMS.

“I, [print full name of the physician/practitioner], hereby attest that the medical record entry for the [date of service] accurately reflects signatures/notations that I made in my capacity as [insert provider credentials, e.g. M.D.] when I treated/diagnosed the above listed patient. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.”

6. Acceptable/Unacceptable Legibility Examples

Below are examples of acceptable signatures.

<table>
<thead>
<tr>
<th>Signature Example</th>
<th>Signature Meets Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Legible full signature</td>
<td>Y</td>
</tr>
<tr>
<td>2. Legible first initial and last name</td>
<td>Y</td>
</tr>
</tbody>
</table>
Below are examples of UNACCEPTABLE signatures.

<table>
<thead>
<tr>
<th>Signature Example</th>
<th>Signature Meets Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>5  Initials NOT over a typed or printed name and unaccompanied by a signature log or attestation.</td>
<td>N</td>
</tr>
<tr>
<td>6  Unsigned typed note with provider’s typed name. Example:</td>
<td>N</td>
</tr>
<tr>
<td>John Whigg, MD</td>
<td></td>
</tr>
<tr>
<td>7  Unsigned typed note without provider’s typed/printed name.</td>
<td>N</td>
</tr>
<tr>
<td>8  Unsigned handwritten note without provider's typed/printed name.</td>
<td>N</td>
</tr>
<tr>
<td>9  Unsigned handwritten note, the only entry on the page</td>
<td>N</td>
</tr>
<tr>
<td>10 &quot;Signature on file&quot;</td>
<td>N</td>
</tr>
<tr>
<td>11 Illegible signature NOT over a typed or printed name, NOT on letterhead or unaccompanied by a signature log or attestation. Example:</td>
<td>N</td>
</tr>
</tbody>
</table>

7. **Scribes**

Scribes shall solely document the physician’s dictation or activities and shall not act independently. The scribe must sign, date, and time stamp all entries into the medical record and the role and signature of the scribe must be clearly identifiable and distinguishable from that of the physician.
Documentation from the physician must include the following:

1. The physician must affirm his/her presence during the time the encounter was recorded.
2. The physician must verify that he/she reviewed the documentation as written by the scribe.
3. The physician must verify the accuracy of the documentation and add any additional information as necessary.
4. The physician must sign, date, and time stamp the medical record. The scribe cannot enter the date and time for the physician.

REFERENCES to REGULATIONS and/or OTHER RELATED POLICIES:

CMS Manual System; Pub. 100-08 Medicare Program Integrity, Transmittal 327; Change Request 6698; Dated March 16, 2010.
http://www2.cms.gov/transmittals/downloads/R327PI.pdf

CMS Memorandum Summary; Subject: Hospitals – Publication of the Hospital Condition of Participation: Requirements for History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Post-anesthesia Evaluations Final Rule; Dated January 26, 2007.

CLINICAL REFERENCES
N/A

FORMS
N/A

ATTACHMENTS
N/A

<table>
<thead>
<tr>
<th>APPROVAL:</th>
</tr>
</thead>
<tbody>
<tr>
<td>System Administrative P&amp;P Committee</td>
</tr>
<tr>
<td>System PICG /Clinical Operations Committee</td>
</tr>
</tbody>
</table>

Standardized Versioning History:
* = Administrative Policy Committee Approval; ** = PICG/Clinical Operations Committee Approval
7/12/11; 10/11/11* 7/28//11; 10/27/11**