

## MEDICAL STAFF APPLICATION CHECKLIST

Thank you for requesting an application for medical staff membership and/or clinical privileges at Foothill Presbyterian Hospital. We are happy to enclose an application. The Medical Staff of Foothill Presbyterian Hospital has over 350 practitioners and the Hospital has 102 beds. All forms must be completed and returned with the application. The Application should be printed and returned to our office with the Privilege Sheet and with your original signatures.

### Application

- { } **One Completed and signed Application Form**
- { } **One Curriculum vitae**
- { } **Two forms of identification that includes your name, picture and signature (i.e. driver's license and/or hospital identification badge) plus a wallet size current photograph**
- { } **Current TB Skin Test Results (within the last 12 months, copy of chest x-ray if your test +)**
- { } **List of CME's for past two (2) years.** (Current CME not required if you have completed residency or fellowship training or obtained board certification within the last two years).
- { } **Signed Privilege Form(s)** (Please complete the columns with an approximate number of procedures performed in the past two {2} years)
- { } **\$550.00 payable to the FPH Medical Staff (non-refundable application fee)**

### Insurance

- { } Copy of your current **Professional Liability Insurance Verification (minimum \$1 million and \$3 million)** (for the previous 10 years to date, claims filed, settled or pending)

### Licenses/Certification

- { } Copy of your current **California Medical License**
- { } Copy of your current **Drug Enforcement Agency** certificate
- { } Copy of your **ECFMG** Certificate, if applicable
- { } Copy of your **California Fluoroscopic Permit** (if applicable)
- { } **ACLS and PALS Certificate** (if you are requesting Anesthesia or Emergency Medicine privileges and are not board certified)

### Other Signatures

- { } **Consent & Waiver of Liability Form** (page 8 of application)
- { } **Signed Physician Acknowledgement Statement**
- { } **M.S. Peer Review Activity/Confidentiality Statement**
- { } **Liability Coverage**
- { } **Attestation Statement**
- { } **Alternate Designation Form**
- { } **Electronic Signature Enrollment Form**
- { } **Physician Confidentiality and HCIS Agreement**

Your signature on the application signifies you agree to be bound by the terms of the Medical Staff Bylaws, Rules, Regulations and applicable policies and procedures. The Credentials Committee will conduct an interview and will notify you in writing as to the date, time and place. Please call the Medical Staff Office (626-857-3241) if you have any questions or require assistance in completing the application.

**APPLICATION FOR APPOINTMENT  
TO THE MEDICAL STAFF OF  
FOOTHILL PRESBYTERIAN HOSPITAL**

Date: \_\_\_\_\_

GENERAL INFORMATION			
Last Name	First Name	M.I.	MD/DO
Is there any other name under which you have been known?		Male / Female (Circle one)	
Birth date	Birthplace	Social Security Number	
NPI#	Tax ID#	UPIN #	
Office Address			
Telephone Number		Fax Number	
Back Line Number ( <b>Medical Staff Use Only</b> )		Cell Phone Number ( <b>Medical Staff Use Only</b> )	
<b>2nd</b> Office Address			
Telephone Number		Fax Number	
Home Address		Phone Number	
<b>SPECIALTY</b>	/	Other medical interests in practice, research, etc.	
Affiliated Practitioner(s)		Address (if different from above)	
Affiliation		Month/Year Affiliation commenced	
PHONE NUMBER OF BACKUP CALL PHYSICIAN ( <i>Must be a member of FPH Medical Staff</i> )		Nature of	
Citizenship		NAME &	
Marital Status		Name of Spouse	
Foreign Language Spoken		e-mail address	

**PREMEDICAL EDUCATION**

College/University Complete Address

Degree Graduation Date

**MEDICAL EDUCATION**

Medical School Complete Address

Graduation Date ECFMG Number

**INTERNSHIP**

**Hospital** Complete Address

(Dates of Internship)  
Month/Year to Month/Year

Type of Internship Specialty

Practitioner responsible for performance

**RESIDENCIES**

**#1 Hospital** Complete Address

(Dates of Residency)  
Month/Year to Month/Year

Type of Residency Specialty

Chief of Department

**#2 Hospital** Complete Address

(Dates of Residency)  
Month/Year to Month/Year

Type of Residency Specialty

Chief of Department

**FELLOWSHIPS**#1 **Hospital**

Complete Address

(Dates of Fellowship)

Month/Year to Month/Year

Type of Fellowship

Specialty

Chief of Department

**AFFILIATIONS**

Previous affiliation with this Hospital (Describe nature of affiliation)

Month/Year to Month/Year  
(Dates of previous affiliation)

Reason for discontinuing affiliation

**LIST ALL CURRENT AND PREVIOUS HOSPITAL AFFILIATIONS** (If insufficient space, provide full response on a separate sheet of paper.)#1 **Hospital**

Complete Address

Month/Year to Month/Year (Dates of affiliation)

Status (Active, Courtesy, etc.)

Reason for discontinuing affiliation

#2 **Hospital**

Complete Address

Month/Year to Month/Year (Dates of affiliation)

Status (Active, Courtesy, etc.)

Reason for discontinuing affiliation

#3 **Hospital**

Complete Address

Month/Year to Month/Year (Dates of affiliation)

Status (Active, Courtesy, etc.)

Reason for discontinuing affiliation

**MEDICAL REFERENCES**

Submit **two** references (local, if possible), other than those who might be listed under "Affiliations." Note: References will be evaluated primarily by the extent of direct clinical observation and other work with the applicant.

#1 Physician Complete Address Phone Number

#2 Physician Complete Address Phone Number

**PREVIOUS PRACTICE** (Include office, clinic and military)

Complete Address Phone Number

**CONTINUING MEDICAL EDUCATION**

On a separate sheet of paper, list all postgraduate activities which you have received credit in the past two years. **PLEASE ATTACH DOCUMENTATION OF CME!**

**MEMBERSHIP STATUS** (Please list current status of memberships)

County Medical Association  Yes \_\_\_Date  Pending  No  
California Medical Association  Yes \_\_\_Date  Pending  No  
American Medical Association  Yes \_\_\_Date  Pending  No

If member, past or present of other County Medical Societies, give names and addresses on a separate sheet of paper.

American College of \_\_\_\_\_

Other specialty colleges \_\_\_\_\_

Specialty Board(s): (Please submit photocopies of certificates)

\_\_\_\_\_  
Name of Board Date Certified  Candidate  Diplomat

\_\_\_\_\_  
Name of Board Date Certified  Candidate  Diplomat

**LICENSING** (Please submit a copy of all licenses and certificates)

California Medical License Number Expiration Date

DEA Expiration Date

**OTHER CERTIFICATIONS (E.G., FLUOROSCOPY, RADIOGRAPHY, ETC.)** Please provide a copy of certificate.

Type	Number	Expiration Date
------	--------	-----------------

**CARDIOPULMONARY RESUSCITATION**

Submit most recent documentation of completion of BASIC CPR.

**Other State Medical Licenses:**

State	License Number	Expiration Date
-------	----------------	-----------------

State	License Number	Expiration Date
-------	----------------	-----------------

**PROFESSIONAL LIABILITY**

Name of Professional Liability Insurance Company	Policy Number
--	---------------

Amount of Coverage	Expiration Date
--------------------	-----------------

Yes  No Has any judgment or settlement been made against you in any professional liability case or are any pending? If yes, a brief summary or details MUST be submitted in writing.

Yes  No Has your professional liability insurance ever been terminated, not renewed, restricted, or modified, (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability insurance carrier provided you with written notice of any intent to deny, cancel, not renew or limit your professional liability insurance or its coverage of any procedures?

**PRIVILEGES DESIRED**

Submit applicable privileges request form. Request only those privileges that you intend to exercise and for which you can demonstrate sufficient qualifications.

**MEDICAL STAFF STATUS APPLIED FOR:** (After the Provisional Period has been successfully completed as required in the FPH Medical Staff Bylaws.)

Active  Courtesy  Locum Tenens

**HEALTH STATUS**

Are you able to perform all the services required by the applicable participating physician agreement, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?  Yes  No

Health Status: \_\_\_\_\_

Name of Physician: \_\_\_\_\_

Date of Last Physical/Where: \_\_\_\_\_

**IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS “YES,” PLEASE GIVE FULL DETAILS ON A SEPARATE SHEET OF PAPER.**

Yes  No Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, suspended, revoked, not renewed, or subject to probationary conditions, or have you been fined or received a letter of reprimand--or is such action pending?

Yes  No Have you ever been charged, suspended, fined, disciplined or otherwise sanctioned, restricted or excluded for reasons relating to possible incompetence or improper professional conduct, by Medicare, Medicaid or any public program--or is any such action pending?

Yes  No Have you ever been denied for possible incompetence or improper professional conduct, clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) or have your clinical privileges, membership, participation or employment at any such organization ever been suspended, restricted, revoked or not renewed--or is any such action pending?

Yes  No Has your medical staff membership ever been voluntarily or involuntarily terminated, limited or reduced, or have you experienced a loss of clinical privileges? Have you every surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g. hospital medical staff, medical group, independent practice association IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO) private payer (including those that contract with public programs), medical society, professional association, medical school or faculty position or other health delivery entity or system) at any time while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action or challenge pending?

Yes  No Has your membership or fellowship in any local, county, state, regional, national or international professional organization ever been revoked, denied, limited or not renewed--or is any such action pending?

Yes  No Have you been denied certification/recertification, or has your eligibility status changed with respect to certification/recertification by a specialty board?

Yes  No Do you presently use drugs illegally?

Yes  No Have you ever been convicted of any crime (other than a minor traffic violation)?

**I HEREBY APPLY FOR APPOINTMENT TO THE FPH MEDICAL STAFF**

I recognize that initial and continued membership on the Medical Staff of this Hospital are dependent on professional competence and ethical practice in keeping the qualifications, standards and requirements set forth in the Medical Staff Bylaws and Rules and Regulations.

I understand that the Medical Staff of this Hospital must evaluate my professional competence and qualifications and make appropriate recommendations to the Governing Board of this Hospital and that such responsibility extends to both the processing of my initial application and the continual assessment of my performance should I be granted membership and privileges. It will be necessary to investigate my professional training, experience and professional conduct and judgment; accordingly, it will be necessary to inquire of other persons and institutions, including medical schools, hospitals, medical societies, professional liability insurance carriers, individual practitioners and other appropriate sources, as to information regarding my qualifications. Additionally, I understand that the Hospital and Medical Staff may receive requests from other hospitals, medical societies, and other legitimately interested organizations and institutions, for information pertaining to my qualifications and performance as an applicant and/or member of this Medical Staff. I recognize that all evaluations, inquiries and responses to inquiries regarding my professional competence and qualifications shall be carried out in a professional and ethical manner, with due regard for appropriate confidentiality of the information in issue. I also agree that the hospital may disclose my NPI (National Provider Identification) number to third parties in order to facilitate billing for services rendered.

I also recognize that I will be afforded the fair procedure prescribed in the Medical Staff Bylaws in the event that action on this application, or with respect to my privileges is adverse. Recognizing these facts, I specifically agree and consent to the following:

- a. To appear if requested before the Medical Staff Officers, department and service chiefs and Medical Staff committees for interviews or inquiries regarding this application;
- b. To assist, in every possible, this Medical Staff, and its representatives in gathering the information necessary to determine my qualifications. In this regard, I recognize that I have the burden of resolving any reasonable doubts about my qualifications for Staff membership and the requested privileges;
- c. To the inspection by the hospital, its medical staff and its representatives of all records and documents, including medical records at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff memberships;
- d. To be bound by the terms of the Medical Staff and Hospital Bylaws in all matters relating to the consideration of this application, regardless of whether I am granted Medical Staff membership and the privileges sought. In this regard, I acknowledge that I have received and had the opportunity to review the Medical Staff Bylaws and Rules and Regulations, and any Hospital Bylaws or Rules and Policies which may pertain.

I pledge to maintain an ethical practice, to provide for continuous care of all my patients, and to acknowledge and abide by any Medical Staff Bylaws requirements for release and immunity from civil liability. I further release from liability any persons or entities which request or provide information in furtherance of the above-described purposes, whether or not such release is specifically required by pertinent bylaws, to the fullest extent established by applicable statutes, regulations and judicial decisions.

I fully understand that any significant misstatements in or omission from this application will constitute cause for denial of requested membership and medical privileges or cause for revocation of membership privileges. I hereby affirm that the information furnished by me to the Medical Staff is true to the best of my knowledge and is furnished in good faith.

\_\_\_\_\_  
Signature of Applicant  
(Stamped Signature is Not Acceptable)

\_\_\_\_\_  
Date

Aptapp 5/07, 1/2010





## LIABILITY COVERAGE

The Medical Staff is required to maintain information regarding your professional liability insurance coverage. Please complete the following and sign the release allowing your liability carrier to provide current information:

The current professional liability insurance requirement is \$1 million per occurrence and \$3 million aggregate.

NAME OF CARRIER \_\_\_\_\_

ADDRESS \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_ AMOUNT OF COVERAGE \_\_\_\_\_

DATE CURRENT CERTIFICATION EXPIRES \_\_\_\_\_

*I hereby authorize the release of a copy of my current certificate of professional liability coverage, a history of any incidents reported within the last 7 years and all subsequent changes in liability coverage to:*

*MEDICAL STAFF OFFICE  
FOOTHILL PRESBYTERIAN HOSPITAL  
250 South Grand Avenue  
Glendora, CA 91741*

PLEASE PRINT

PHYSICIAN NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

I HEREBY ATTEST THAT THE PROFESSIONAL LIABILITY INSURANCE POLICY I NOW (OR IN THE FUTURE) CARRY INCLUDES COVERAGE FOR ALL PRIVILEGES I AM REQUESTING.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**MEDICAL STAFF LITIGATION INFORMATION FORM**

PHYSICIAN: \_\_\_\_\_

TITLE OF CASE: \_\_\_\_\_

ARE YOU THE PRIMARY DEFENDANT?     YES     NO

IS THIS CASE CURRENT:     YES     NO    CASE CLOSED?     YES     NO

IS THE CASE OFFICE BASED OR HOSPITAL BASED? \_\_\_\_\_

PLEASE DESCRIBE THE ALLEGATIONS AGAINST YOU TO THE BEST OF YOUR KNOWLEDGE:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

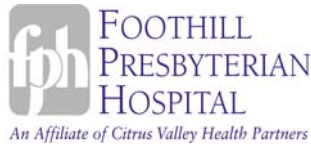
IF ADDITIONAL SPACE IS NECESSARY, PLEASE USE THE BACK OF THIS FORM OR ATTACH A SEPARATE SHEET OF PAPER.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

THIS FORM IS A CONFIDENTIAL MEDICAL STAFF DOCUMENT AS SUCH IS PROTECTED FROM DISCOVERY BY SB 1156-1157.

claim2



## ATTESTATION STATEMENT

Dear Doctor \_\_\_\_\_:

The Centers for Medicare and Medicaid Service, (CMS) requirement that all physicians requesting admitting privileges to an acute hospital and plan on treating Medicare or HMO Senior Patients must sign this Physician Acknowledgement Statement.

This is currently a one time signature requirement and must be completed prior to admission of your first Medicare patient.

Please sign your name at the designated line following the Physician Acknowledgement Statement. This statement has been written as specifically stated by CMS.

Thank you for your cooperation.

Respectfully,

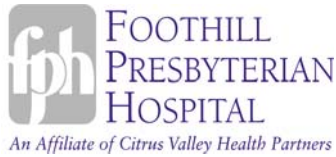
*John J. DiMare*  
John J. DiMare, MD  
Chief Medical Officer

### **Physician Acknowledgement Statement**

*“Notice to Physicians: Medicare payment to hospitals is based in part on each patient’s principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.”*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**ALTERNATE DESIGNATION FORM**

I hereby designate the following physician:

\_\_\_\_\_  
Name of Alternate

(Alternate must have the same level of privileges you are requesting)  
My alternate is a member of the Medical Staff of Foothill Presbyterian Hospital and has either the same or comparable privileges as myself, to be called for any of my patients if the hospital is unable to reach me. I will notify the Medical Staff Office in writing if I should wish to change this designation at any time.

\_\_\_\_\_  
Physician - Print Name

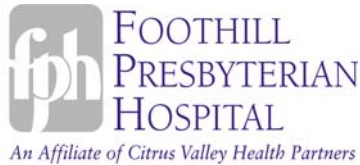
\_\_\_\_\_  
Physician - Signature Date

THIS FORM MUST BE SIGNED BY BOTH YOU AND YOUR ALTERNATE BEFORE THE FORM IS RETURNED TO THE MEDICAL STAFF OFFICE. PLEASE FAX COMPLETED FORM TO (626) 857-3273.

I hereby agree to act as alternate for the above named physician.

\_\_\_\_\_  
Alternate - Print Name

\_\_\_\_\_  
Alternate - Signature Date



## MEDICAL STAFF PEER REVIEW ACTIVITY CONFIDENTIALITY AGREEMENT

Confidentiality is vital to the free, open and candid discussions necessary for medical staff performance improvement and peer review activities designed to improve the quality of care at the Hospital. My participation in such activities is in reliance on the confidential treatment of those activities by all members of the medical staff and other individuals involved. For these reasons, I agree to keep confidential all information (oral or written) of which I am aware in connection with medical staff performance improvement and peer review activities. I acknowledge that disclosure of such information except as hospital policy, to law enforcement agencies, or to professional or institutional licensing agencies, is prohibited. I agree that action, including suspension or termination of my relationship with the Hospital or my eligibility to serve on committees may be taken against me if I fail to maintain the confidentiality of such information. I acknowledge and agree that my agreement to keep medical staff information confidential is a material condition to my relationship with the Hospital, including any employment relationship.

I agree to notify the Medical Staff Office of any request or demand made to me (whether by subpoena or otherwise) to disclose confidential information related to my participation on or work for a medical staff committee and that I will not voluntarily disclose confidential medical staff information except as specifically provided in this agreement. I further agree that the medical staff or the hospital may seek to enjoin my violation of this Agreement if necessary.

---

Medical Staff Signature

---

Date

---

Printed Name



I, the undersigned, request to be enrolled and thereafter use the electronic signature application to authenticate my medical records in accordance with the medical staff rules and regulations and Title 22 at any of the three CVHP campuses where I have privileges.

I certify that I am the only person who will have possession of my electronic signature password and pin number and I am the only person who will authenticate my medical records.

It has been made clear to me that *all* my verbal orders *and* my dictated reports will be queued up as documents to be electronically signed and that they will be held to the same completion requirements as specified in the medical staff rules and regulations. I understand that all documents and orders signed electronically will automatically be date and time stamped by the system. \_\_\_\_\_(initials)

In addition, it has been explained to me that corrections/edits to the transcribed document must be made either electronically or through the dictation process. Corrections/edits made on the paper document will result in disparate patient information. \_\_\_\_\_(initials)

As an electronic signature user, I acknowledge that the following will appear in my signature queue:

- History & Physicals
- Consultations
- Operative Reports
- Discharge Summaries
- Emergency Department Summaries
- Cardiology Reports
- All other dictated reports
- Verbal Orders

\_\_\_\_\_  
(Print) Last Name                      First                      MI

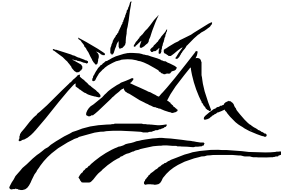
\_\_\_\_\_  
Phone#

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Email Address

Active in Meditech



# CITRUS VALLEY HEALTH PARTNERS

## PHYSICIAN CONFIDENTIALITY AND HCIS AGREEMENT

You have been given a password which allows you to access patient information from Citrus Valley Health Partners' Healthcare Information System (HCIS). By using this password, you acknowledge the following:

1. That computer-based patient information is subject to the same restrictions and protections as is information stored in paper medical records and is covered by the same organizational policies which govern the paper record.
2. Physicians who possess passwords to the HCIS may share them with office staff who have reason to access information contained on the HCIS in order to perform their jobs. Involved staff understand that their access to and use of such information is limited to a "need to know" basis.
3. Physicians may request a unique password for office staff. That access will be limited to the physician's patient list. The physician is responsible for appropriate use of the office password.
4. The Physician will immediately notify CVHP's Information Services Help Desk at 626 938-7590 if the physician learns that a security breach has occurred.

---

### PASSWORD CONFIDENTIALITY PCI ACCESS AUTHORIZATION

I would like a password for myself. Yes  No

I would like a unique password for my office staff.  Yes  No

I would like training for myself  or my office staff

I acknowledge that the purpose of the password assigned to me is to allow my use of the Citrus Valley Health Partners HCIS to facilitate timely access to patient data which I have need to know. The use of the password is my sole responsibility and all access using this password will be under my direction.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name