LOMA LINDA UNIVERSITY
HEALTH SYSTEM

Medical Staff Administration
11314 Mountain View Avenue
Cambridge Building
Loma Linda, CA 92354
(909) 558-6052 Fax (909) 558-6053

Dear Practitioner:

Thank you for your interest in membership and practice privileges with Loma Linda University and its related facilities. We are pleased to enclose the following forms, which need to be fully completed in order for your application to be accepted:

- Required Items Checklist
- Allied Health Professional Initial Application
- Addendums A & B (Addendum A is n/a for LLUMC employed NPs)
- Practice Privilege form
- Tuberculosis Policy and Screening Questionnaire
- Alternate Admitting Agreement (n/a for LLUMC employed NPs)
- HIPAA Compliance Acknowledgement Agreement
- AHP Confidentiality Agreement
- Medicare Penalty Acknowledgement Statement
- DEA Waiver
- X-ray Supervisor/Fluoroscopy Certificate Waiver
- Access Request Form (n/a for LLUMC employed NPs)

Please note that all forms must be filled out completely in blue or black ink only, and all required items must be received with the application forms. If the form is not applicable to your specialty write "N/A" and sign the form. An incomplete application cannot be processed, and may be returned to you for completion. **White out and/or correction tape is not permitted on any document.**

Copies of the Bylaws, Rules and Regulations, and Policies for each facility are located at www.llu.edu/llumc/medicalstaff/forms.html also on the **VIP page** under "Departments", "LLUMC Departments", "Medical Staff Administration (MSA)", Physicians Resource Directory, "LLUMC" for your information. Please familiarize yourself with your requirements and prerogatives.

LLUMC has agreed to provide a community service and to accept Medi-Cal and Medicare patients. The administration and enforcement of this agreement is the responsibility of the California Health Facilities Financing Authority and this Facility.

We look forward to receiving and processing your completed application. Please do not hesitate to contact Medical Staff Administration at (909) 558-6052 if you have any questions regarding the enclosed forms or our processing procedures.

Sincerely,
Medical Staff Administration for
Loma Linda University Related Facilities
Attachments

Loma Linda University Related Facilities
Initial Application Recommendations

Dear Applicant:

In order to avoid confusion, if you have questions regarding any of the attached forms, please contact Medical Staff Administration at 909/558-6052 or x66052.

DO NOT CONTACT RISK MANAGEMENT regarding insurance, claims, or Addendum B.

All forms must be signed. If any are "not applicable" to you, note "n/a" and sign the forms.

To avoid delays, return the application packet directly to Medical Staff Administration. The application will not be processed without the application fee.

If you request Moderate or Deep Sedation privileges, be sure to attach the appropriate Sedation Certificate. Your application will be processed without the certificate, but the privilege to administer Sedation will be withheld until the certificate is received.

Thank you for your interest in Loma Linda University and it's related facilities. We look forward to receiving your application.

Medical Staff Administration

REQUIREMENTS FOR ALLIED HEALTH PROFESSIONAL INITIAL APPLICATION

Practitioners must NOT begin patient care activities until notified of approval by Medical Staff Administration
Processing is typically 90 days if the application is received complete.
The process may be longer if there is a long and varied history or several malpractice insurance carriers, etc.

☐ **ORIGINAL APPLICATION, including Addendums A and B** - Fill in all blanks, use an extra sheet of paper if needed.

☐ **CURRICULUM VITAE -** Current copy with chronological history in from /thru month/year format of education, hospital affiliations, work experience independent and/or private practice.

☐ **TIME GAPS -** all time gaps must be accounted for with any gaps fully explained. Time gaps greater than 90 days (3 months) must be accounted for by you in writing.

☐ **DELINEATION OF PRIVILEGES (N/A for UHC)** – Submit current privilege form and/or standardize procedures. **Must be signed by Supervising Physician**.

- ✓ Nurse Practitioners will submit: Signed Privilege Form and Standardize Procedures.
- ✓ Physician Assistant will submit: Signed Privilege Form and Signed PA Delegation of Service Agreement.
- ✓ Nurse Anesthetists will submit: Signed Privilege Form.
- ✓ Clinical Psychologist will submit: MC and/or BMC Signed Privilege Form.
- ✓ LCSW, MFT, PsyD will submit: BMC Signed Privilege Form.

☐ **INTERVIEW BY SERVICE CHIEF/DEPARTMENT CHAIR:** It is the applicant's responsibility to contact the Service Chief/Department Chair to make an appointment for an interview. At that time the Service Chief will review and sign the Delineation of Privilege request form (N/A for UHC).

☐ **PICTURE ID –** A copy of your Driver's License or Passport, must be made and signed by an LLUMC employee, the likeness on the copy must be identifiable.

☐ FEE - The initial application processing fees must be submitted with the application. **Please make check payable to "LLUMC Medical Staff Administration". (*see attached Processing Fee Schedule*)**

☐ **RADIOGRAPHY/FLUOROSCOPY X-RAY SUPERVISOR AND OPERATOR CERTIFICATE** – Indicate by checking and signing the appropriate space on the attached form. If radiography or fluoroscopy is used, copy of certificate is required.

☐ **BOARD CERTIFICATION(S) -** Copy of certification(s) and/or renewal(s).

☐ **CPR/ACLS/PALS/etc** - Required by various departments. Check with your individual Service.

☐ **DIPLOMAS** - Copy of diploma and/or certificates from all Undergraduate/Graduate/Postgraduate Education.

☐ **ATTESTATION** - Submit a list which includes the subject, # of credit hours, and dates is preferred, but copies of certificates will be accepted also.

☐ **MALPRACTICE INSURANCE** - Documentation of malpractice insurance. Minimum $1 million/$3 million required. A current face sheet which includes your name and the amount of coverage must be submitted. You must provide information on all professional policies under which you may be covered. If insured as an employee of a hospital provide hospital insurance information. If insured as a physician's employee provide policyholder information.

☐ **PROFESSIONAL REFERENCES –** Provide contact information for your current supervising physician and two peers, who have knowledge of your current clinical abilities in the same field and/or specialty. Include address, phone, email and fax.

☐ **PROGRAM DIRECTOR –** If your training was completed within the past 7 years provide your program director contact information.

☐ **MEDICARE PENALTY STATEMENT** - Provided by LLUMC. Must be **signed *and* dated.**

☐ **HIPAA CONFIDENTIALITY ACKNOWLEDGEMENT** - Provided by LLUMC. Must be **signed *and* dated.**

☐ **AHP CONFIDENTIALITY AGREEMENT** - Provided by LLUMC. Must be **signed *and* dated.**

☐ **DEA WAIVER** - Provided by LLUMC. Must be **signed *and* dated.**

☐ **XRAY CERTIFICATE WAIVER** - Provided by LLUMC. Must be **signed *and* dated.**

☐ **LASER CERTIFICATION WAIVER**- Provided by LLUMC. Must be **signed *and* dated.**

☐ **SEDATION -** If you Standardize Procedure requires Moderate Sedation, you must complete the appropriate test. Tests and instructions are available on the LLUMC VIP page under "Departments, LLUMC Department, "Medical Staff Administration (MSA)", Physicians Resource Directory, LLUMC Sedation (Study Guides & Test) **OR** on the LLUMC web site at **https://www.llu.edu/llumc/medicalstaff/forms.html.**

☐ **TB SCREENING QUESTIONNAIRE –** Provided by LLUMC. Must be **signed *and* dated.** Complete the first page, if any yes answers complete the second page**.**

☐ **TUBERCULOSIS TEST –** Submit proof of TB screening done.

☐ **COMPUTER LOG-ON FORMS –** Sign and complete the highlighted portions ONLY. Return it with the application. Medical Staff Administration will complete the other areas of the form.

☐ **VERIFICATION OF CONTRACTUAL STATUS for *Radiology, Pathology, Anesthesiology*, *Emergency Medicine.***

Return all forms and documents to your perspective Department contact or directly to:

Loma Linda University Medical Center
Attn: Medical Staff Administration
11314 Mountain View Ave., Cambridge Bldg.
Loma Linda, CA 92354

909/558-6052

If you have questions about any portion of the application forms or process please do not hesitate to contact us.
We are happy to assist you.

LOMA LINDA UNIVERSITY
MEDICAL CENTER

Medical Staff Administration

APPLICATION PROCESSING FEE SCHEDULE

(Includes both Licensed Independent Practitioners and Allied Health Professionals)

INITIAL CREDENTIALING APPLICATIONS

(All LLU Related Facilities, except for Murrieta)

- \$800 1st facility
- \$200 each additional facility

MURRIETA INITIAL CREDENTIALING APPLICATIONS

(If currently on staff at a LLU Related Facility)

- \$200 - Paid to LLUMC Medical Staff
- \$600 - Paid to Murrieta Medical Staff

RECREDENTIALING APPLICATIONS

- \$200 1st facility
- \$100 each additional facility

Fine for Late Reappointment Application \$10/working day

REINSTATEMENT FEE SUSPENIONS

- **\$25** for Suspensions for expired license or expired malpractice insurance

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Examples:

***Initial Credentialing**: UHC (\$800) + LLUMC (\$200) + BMC (\$200) + LLUCH (\$200) = \$1400*
Recredentialing: *UHC (\$200) + LLUMC (\$100) + LLUCH (\$100) = \$400*

California Participating Allied Health Professional Application

This application is submitted to: _Loma Linda University Related Facilities_, herein, this Healthcare Organization[1]

APPLICATION FOR FACILITY/FACILITIES

Please select the applicable Facility/Facilities this **INITIAL** application is applicable for from below and include the appropriate Department/Service and Section (if applicable) for that particular Facility.

☐ Check here if you are an Allied Health Professional (AHP)

☐ **Loma Linda University Medical Center (LLUMC)**
Specialty: ______________________ Sub-Specialty______________________

☐ **Loma Linda University Behavioral Medicine Center (BMC)**
Specialty: ______________________ Sub-Specialty______________________

☐ **Loma Linda University Children's Hospital (LLUCH)**
Specialty: ______________________ Sub-Specialty:______________________

☐ **Loma Linda University Health Care (UHC) –** ***PSM from Department Required***
Specialty: ______________________ Sub-Specialty:______________________

☐ **Loma Linda University - Murrieta – for LLUMC Physicians Requesting Murrieta Hospital Privileges only**
Specialty: ______________________ Sub-Specialty:______________________

☐ **Social Action Community Health Systems (SACHS) - for LLUMC Physicians Requesting SACHS Privileges**
Specialty:______________________ Sub-Specialty:______________________

I. INSTRUCTIONS

This form should be legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application, include month and year. Current copies of the following documents must be submitted with this application:

- **Board Certification (if applicable)**
- **Face Sheet of Professional Liability Certificate**
- **Photo ID (Drivers License, ID Card, Passport)**
- **Curriculum Vitae**
- **X-Ray Certificate (if applicable)**

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known? Name (s):		

Home Mailing Address:	City: State: ZIP:
Home Telephone Number: Home Fax Number:	E-mail Address: Pager Number:
Birth Date: Birthplace (city/state/country):	Citizenship (If not a US citizen, please include copy of Alien Registration Card):
Social Security #:______________ Cell Phone #:	Gender: ☐ Male ☐ Female
Spouse Name:	NPI# UPIN#

III. PRACTICE INFORMATION

Practice Name (if applicable):	Department Name (If hospital based):
Primary Office Street Address:	City: State: ZIP:
Telephone Number:	Fax Number:
Office Manager/Administrator:	Telephone Number: Fax Number:
Name Affiliated with Tax ID Number:	Federal Tax ID Number:

Print Applicants Name: ____

Secondary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number:	
	Fax Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Tertiary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number:	
	Fax Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Other Medical Interests in Practice, Research, etc.:		

IV. UNDERGRADUATE EDUCATION (Attach additional sheets if necessary. Reference this Section Number and Title)

College or University Name:		Degree Received:	Date of Graduation: (mm/dd/yy)
Mailing Address:		City:	
		State:	Zip:
Phone:	Fax:	Department Email:	

V. GRADUATE/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference this Section Number and Title)

Medical/Professional School:		Degree Received:	Date of Graduation: (mm/dd/yy)
Mailing Address:		City:	Program Dir:
		State & Country:	Zip:
Phone:	Fax:	Department Email:	
Professional School:		Degree Received:	Date of Graduation: (mm/dd/yy)
Mailing Address:		City:	Program Dir:
		State & Country:	Zip:
Phone:	Fax:	Department Email:	

VI. INTERNSHIP (Attach additional sheets if necessary. Reference This Section Number and Title)

Institution:		Program Director:	
Phone:	Fax:	Program Director Email:	
Mailing Address:		City:	
		State & Country:	Zip:
Type of Internship:			
Specialty:		From: (mm/dd/yy)	To: (mm/dd/yy)

Print Applicants Name: ____

VII. POST-GRADUATE TRAINING

Include fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education since completion of medical/professional education in chronological order, giving name, address, city and ZIP code, and dates (month and year). Include **all** programs you have attended, whether or not completed.

Institution:		Program Director:		
Phone:	Fax:	Program Director Email:		
Mailing Address:		City:		
		State:	Zip:	
Type of Training (e.g. Fellowship, etc.):		Specialty:	From:	To:
Did you successfully complete the program? ☐ Yes ☐ No (if "No," please explain on separate sheet.)				
Institution:		Program Director:		
Phone:	Fax:	Program Director Email:		
Mailing Address:		City:		
		State:	Zip:	
Type of Training (e.g. Doctorate, etc.):		Specialty:	From:	To:
Did you successfully complete the program? ☐ Yes ☐ No (if "No," please explain on separate sheet.)				
Institution:		Program Director:		
Phone:	Fax:	Program Director Email:		
Mailing Address:		City:		
		State:	Zip:	
Type of Training (e.g. Fellowship, etc.):		Specialty:	From:	To:
Did you successfully complete the program? ☐ Yes ☐ No (if "No," please explain on separate sheet.)				

VIII. BOARD CERTIFICATION

Include certifications by board(s) which are duly organized and recognized by:

Name of Issuing Board-Specialty:	Date Certified/Recertified:	Expiration Date(if any):

Have you applied for board certification other than those indicated above? ☐ Yes ☐ No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for Certification on separate sheet.

Print Applicants Name: ____

IX. OTHER CERTIFICATIONS (E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.)

Type:	Number:	Expiration Date:

X. PROFESSIONAL LICENSURE/REGISTRATION (Remember to attach copies of documents)

California Professional License Number:	Issue Date:	Expiration Date:
California Professional License Number:	Issue Date:	Expiration Date:
California Professional License Number:	Issue Date:	Expiration Date:
California Professional License Number:	Issue Date:	Expiration Date:
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
Controlled Dangerous Substances Certificate (C.D.S.) (if applicable):		Expiration Date:
Medicare UPIN:	National Physician Identifier (NPI):	Medi-Cal/Medicare Number:

XI. ALL OTHER STATE PROFESSIONAL LICENSURE/REGISTRATION

State:	License Number::	Expiration Date:
State:	License Number:	Expiration Date:

XII. PROFESSIONAL LIABILITY List all past and present carriers. (Remember to attach copy of professional liability policy or certification face sheet for all carriers if possible.)

<u>**Current**</u> Insurance Carrier:	Policy #:	Effective Date - Expired Date	
Mailing Address:		City:	
		State:	ZIP:
Per claim amount: $	Aggregate amount: $	Expiration Date:	
Previous Name of Carrier:	Policy #:	From:	To:
Mailing Address:		City:	
		State:	ZIP:
Previous Name of Carrier:	Policy #:	From:	To:
Mailing Address:		City:	
		State:	ZIP:
Previous Name of Carrier:	Policy #:	From:	To:
Mailing Address:		City:	
		State:	ZIP:

Print Applicants Name: ____

XIII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in reverse chronological order (with the current affiliation (s) first) all institutions where you have current privileges/affiliations (A). and all previous hospital privileges/affiliations (B). This includes hospital, surgery centers, institutions, corporations, military assignments, or government agencies.

A. CURRENT AFFILIATIONS (Attach additional sheets if necessary. Reference This Section Number and Title.)

Name and Mailing Address of **Primary Hospital:**	City:	
	State:	Zip:
	Phone:	Fax:
Department/Status (active, provisional, courtesy, temporary, etc.)	Appointment Date: From:	
Name and Mailing Address of **Other Hospital/Institution:**	City:	
	State:	Zip:
	Phone:	Fax:
Department/Status:	Appointment Date: From:	
Name and Mailing Address of **Other Hospital/Institution:**	City:	
	State:	Zip:
	Phone:	Fax:
Department/Status:	Appointment Date: From:	

B. PREVIOUS HOSPITAL AND OTHER INSITUTION AFFILIATIONS

Name and Mailing Address of **Other Hospital/Institution:**		City:	
		State:	Zip:
		Phone:	Fax:
From:	**To:**	Reason for leaving:	
Name and Mailing Address of **Other Hospital/Institution:**		City:	
		State:	ZIP:
		Phone:	Fax:
From:	**To:**	Reason for leaving:	
Name and Mailing Address of **Other Hospital/Institution:**		City:	
		State:	Zip:
		Phone:	Fax:
From:	**To:**	Reason for leaving:	
Name and Mailing Address of **Other Hospital/Institution:**		City:	
		State:	Zip:
		Phone:	Fax:
From:	**To:**	Reason for leaving:	
Name and Mailing Address of **Other Hospital/Institution:**		City:	
		State:	Zip:
		Phone:	Fax:
From:	**To:**	Reason for leaving:	
Name and Mailing Address of **Other Hospital/Institution:**		City:	
		State:	Zip:
		Phone:	Fax:
From:	**To:**	Reason for leaving:	

Print Applicants Name: ____

XIV. PEER REFERENCES: Please list sponsoring physician/employer. In addition, please list two (3) peers who have personal knowledge of your current clinical abilities in the same field and/or specialty.

Supervising/Sponsoring Physician/Employer:		Specialty:	
Phone:	Fax:	Email:	
Complete Mailing Address:		City:	
		State:	Zip:
Name of Reference:		Specialty:	
Phone:	Fax:	Email:	
Complete Mailing Address:		City:	
		State:	Zip:
Name of Reference:		Specialty:	
Phone:	Fax:	Email:	
Complete Mailing Address:		City:	
		State:	Zip:
Name of Reference:		Specialty:	
Phone:	Fax:	Email:	
Complete Mailing Address:		City:	
		State:	Zip:

XV. WORK HISTORY

Chronologically list all work history activities since completion of professional school. This information must be complete. This should include all hospital, surgery centers, institutions, corporations, military assignments, or government agencies. Please explain any gaps in professional work history on separate page. (Attach additional sheets if necessary. Reference This Section Number and Title.)

Current Practice:	Contact Name:	Telephone Number:	
		Fax Number:	
Mailing Address:		City:	
		State:	ZIP:
From:	Thru:		

Name of Practice/Employer:	Contact Name:	Telephone Number:	
		Fax Number:	
Mailing Address:		City:	
		State:	ZIP:
From:	Thru:		

Name of Practice/Employer:	Contact Name:	Telephone Number:	
		Fax Number:	
Mailing Address:		City:	
		State:	ZIP:
From:	Thru:		

Name of Practice/Employer:	Contact Name:	Telephone Number:	
		Fax Number:	
Mailing Address:		City:	
		State:	ZIP:
From:	Thru:		

Print Applicants Name: ____

XVI. ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no". If your answer to questions A through K is "yes", or if your answer to L is "no", please provide full details on separate sheet.

A. Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?

Yes ☐ No ☐

B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?

Yes ☐ No ☐

C. Have your clinical privileges, membership, contractual participating 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, ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for **any reason**, or is any such action pending?

Yes ☐ No ☐

D. Have you ever 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), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for **any reason**, or is any such action pending?

Yes ☐ No ☐

E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?

Yes ☐ No ☐

F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed , or is any such action pending?

Yes ☐ No ☐

G. Have you been denied certification/rectification by a specialty board, or has your eligibility, certification or rectification status changed (other than changing from eligible to certified)?

Yes ☐ No ☐

H. Have you **ever been** arrested, charged, or convicted of any crime (other than a minor traffic violation)?

Yes ☐ No ☐

I. Do you presently use any drugs illegally?

Yes ☐ No ☐

J. Have any judgments been entered against you, or settlements been agreed to by you ever in professional liability cases, or are there any filed and served professional liability/arbitration against you or are any pending?

Yes ☐ No ☐

K. 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 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?

Yes ☐ No ☐

L. Are you able to perform all the services required by your agreement with, or the professional staff bylaws of, the Healthcare Organization to which you are applying, 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 ☐

I hereby affirm that the information submitted in this Section XVI, Attestation Questions, and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material, omissions or misrepresentations may result in denial of my reapplication or termination of my privileges, employment or physician participation agreement.

Print Name Here ____

Applicant Signature ______________________________________ Date: ______________

(Stamped Signature Is Not Acceptable)

INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), for the purpose of evaluating this credentialing reapplication and any credentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. Without limiting the foregoing authorization in any way, I specifically recognize and agree **that Loma Linda University Medical Center, Loma Linda University Health Care, and Loma Linda University Behavioral Medicine Center**, **Loma Linda University Children's Hospital, and other Affiliates,** all affiliated within the same healthcare system, have a particular interest in sharing credentialing information, and will do so among and between any of these specific healthcare organizations where I am an applicant, staff member, or hold clinical_privileges of any kind."_In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state[2] laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participating in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et. Seq, if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (I) the unstayed suspension, revocation or non-renewal of my license to practice medicine in California; (ii) any suspension, revocation or non-renewal of my DEA or other controlled substances registration; or (iii) any cancellation or non-renewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (I) receipt of written notice of any adverse action against me by the Medical Board of California taken or pending, including by not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, non-renewal or voluntary relinquishment by resignation of medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action, or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my reapplication or termination of my privileges, employment or physician participation agreement. A Photocopy of this document shall be as effective as the original however, original signatures are required.

Print Name Here ______________________________

Applicant Signature ______________________________ Date ______________

(Stamped Signature Is Not Acceptable)

Print Applicants Name: ____

Addenda Submitting (Please check the following):	*This Application and Addenda A & B were created and endorsed by:*
☐ Addendum A - Health Plan and IPA/Medical Group ☐ Addendum B - Professional Liability Action Explanation	• American Medical Group Association - (310/430-1191 x223) • California Association of Health Plans - (916/552-2910) • California Healthcare Association - (916/552-7574) • California Medical Association - (415/882-5166) • National IPA Coalition - (510/267/1999) • The Medical Quality Commission - (310/936-1100 x230)

Individual healthcare organizations may request additional information or attach supplements to this form. They are not part of the California Participating Physician Application nor have they been endorsed by the above organizations. Any questions about supplements should be addressed to the health care organization from which it was provided.

SUPPLEMENT QUESTIONS FOR LOMA LINDA UNIVERSITY & RELATED FACILITIES

I. COMPLIANCE WITH LAWS RELATED TO PATIENT CARE		
If you answer "YES to any of the following questions, please give full details on an additional page.		
A. Are there any pending or completed administrative agency, government, or court cases, decisions or judgments involving allegations that you:		
1. Failed to comply with laws, statues, regulations, or other legal requirements which may be applicable to the practice of your profession or to your rendition of services to patients?	☐ Yes	☐ No
2. Violated any criminal law (excluding minor traffic violations)?	☐ Yes	☐ No
B. Are there any prior or pending government agency or third party payor proceedings or litigation challenging or sanctioning your patient admission, treatment, discharge, charging, collection, or utilization practices, including but not limited to, Medicare and Medicaid fraud and abuse proceedings or convictions?	☐ Yes	☐ No
II. COMPLIANCE WITH LAWS RELATED TO PHYSICAL AND MENTAL HEALTH STATUS		
A. Do you have any physical or mental disability which impairs or could impair your ability to carry out your professional obligations in a manner that meets the standards of care in the community and the Bylaws, Rules and Regulations of this Healthcare Organization? (When answering this question, please consider all types of physical or mental disability, including past or present substance abuse.)	☐ Yes	☐ No
B. Considering the essential functions of a practitioner in your area of practice, are you suffering from any communicable health condition that could pose any significant health and safety risk to your patients?	☐ Yes	☐ No
C. In the past five (5) years, up to and including the present, have you had a history of chemical dependency or substance abuse that might adversely affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?	☐ Yes	☐ No
D. If you answered A, B or C "YES", could accommodations be made to allow you to practice at this Healthcare Organization?	☐ Yes	☐ No
If you answer "Yes" to any of the above questions, please describe on a separate page all physical and/or mental disabilities you have which impair or could impair your ability to carry out your professional obligations in a manner that meets the standards of care in the community and the Bylaws, Rules and Regulations, and Policies of this Healthcare Organization and the accommodations that could be made to enable you to practice at this Healthcare Organization.		
III. MILITARY STATUS		
1. Are you in a military Reserve Status? If "Yes", please explain:	☐ Yes	☐ No
2. Are you on Active Duty Status? If "Yes," please explain:	☐ Yes	☐ No

Print Name Here ____

Applicant Signature ______________________________________ Date ____________
(Stamped Signature Is Not Acceptable)

California Participating Allied Health Professional Application

Addendum A

Health Plans and IPA's/Medical Groups

This Addendum is submitted to: ***Loma Linda University Related Facilities*** , herein, this Healthcare Organization[1]

I. IDENTIFYING INFORMATION

Last Name:	First:	Middle:

Medical Group(s)/IPA(s) Affiliation:

Do you intend to serve as a primary care provider? ☐ Yes ☐ No

Do you intend to serve as a specialist? ☐ Yes ☐ No (If yes, please list specialty(s))

Please check all that apply:

☐ Solo Practice ☐ Single Practice

☐ Group Practice ☐ Multi specialty

II. BILLING INFORMATION

Billing Company:

Street Address:	City:	
	State:	ZIP:
Contact:	Telephone Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

III. PRACTICE INFORMATION

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc)? ☐ Yes ☐ No

If so, please list:

Name: Type of Provider: License Number:

____

____

____

____

____

If you are a Physician Assistant Supervisor, please include State License Number: ________________________

Do you personally employ any physicians (do not include physicians that are employed by the medical group)? ☐ Yes ☐ No

If so, please list:

Name: California Medical License Number:

______________________ ____

______________________ ____

Please list any clinical services you perform that are not typically associate with your specialty: ______________________________

Please list any clinical services you **do not** perform that are typically associated with your specialty: ___________________________

[1] The term "this Healthcare Organization" shall refer to the entity to which this Addendum is submitted as identified above.

Is your practice limited to certain ages?	☐ Yes ☐ No
If yes, specify limitations: _____	
Are you Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council?	☐ Yes ☐ No
Do you participate in EDI (electronic data interchange)? If so, which Network ?____	☐ Yes ☐ No
Do you use a practice management system/software: If so, which one? ____	☐ Yes ☐ No

What type of anesthesia do you provide in your group/office?

☐ Local ☐ Regional ☐ Conscious Sedation ☐ General ☐ None ☐ Other (please specify) ___________________________

Has your office received any of the following accreditations, certifications or licensures?

☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
☐ California Department of Health Services Licensure
☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
☐ Medicare Certification
☐ The Medical Quality Commission (TMQC)
☐ Other ____

IV. OFFICE HOURS – Please indicate the hours your office is open:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Holidays

V. COVERAGE OF PRACTICE (List your answering service and Supervising/Sponsoring physicians by name. Attach additional sheets if necessary)

Answering Service Company:	Phone Number: ( )	Fax Number: ( )
Mailing Address	City:	
	State:	ZIP:
Supervising/Sponsoring Physician Name:	Telephone Number:	
Supervising/Sponsoring Physician Name:	Telephone Number:	
Supervising/Sponsoring Physician Name:	Telephone Number:	
Supervising/Sponsoring Physician Name:	Telephone Number:	

If you do not have hospital privileges, please provide written plan for continuity of care:

____

____

____

____

VI. FOREIGN LANGUAGES SPOKEN

Fluently by Applicant:	Fluently by Staff:

VII. LABORATORY SERVICES

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

Tax ID #:	Billing Name:	Type of Service Provided:

Do you have a CLIA certificate?	☐ Yes	☐ No
Do you have a CLIA waiver?	☐ Yes	☐ No

Certificate Number:	Certificate Expiration Date:

VIII. PROFESSIONAL ORGANIZATIONS

Please list country, state or national medical societies, or other professional organizations or societies of which you are a member or applicant

Organization Name	**Applicant**	**Member**
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

I certify that the information in this document and any attached documents is true and correct.

Print Name Here ____________________

Applicant Signature ____________________ Date __________
(Stamped Signature Is Not Acceptable)

California Participating
Allied Health Professional Application

Addendum B

Professional Liability Action Explanation

This Addendum is submitted to: ***Loma Linda University Related Facilities***, herein, this Healthcare Organization[1]

Please complete this form for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

I. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Street Address:	City:	
	State:	ZIP:

II. CASE INFORMATION

City, County and State where Lawsuit filed:	Court case number, if known:		
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suit Filed:	Sex of patient:	Age of patient: ______

Location of Incident:
☐ Hospital ☐ My Office ☐ Other doctor's office ☐ Surgery Center
☐ Other, (please specify)

Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consultant, etc.):

Allegation:

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ☐ Yes ☐ No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number of insurance company, or other liability protection company or organization.

____

If you would like us to contact your attorney regarding any of the above information, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization.

Name ______________________________ Phone Number (   ) ____________________

Name ______________________________ Phone Number (   ) ____________________

[1] As used in the Information Release section of this Addendum, the term "this Healthcare Organization" shall refer to the entity to which this Addendum is submitted as identified above.

III. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (CHECK ONE)

- ☐ Lawsuit/arbitration still ongoing, unresolved.
- ☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: $____________________
- ☐ Judgment rendered and I was found not liable.
- ☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: $____________________
- ☐ Lawsuit/arbitration settled, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include 1) condition and diagnosis at time of incident, 2) dates and description of treatment rendered, and 3) condition of patient subsequent to treatment. **Please print**.

☐ **I have had no lawsuits, arbitrations, judgments, settlements, or payments.**

SUMMARY OF CASE

____

____

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I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Physician Application. In order for participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization information about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorney(s) listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization."

Print Name Here ____

Applicant Signature ____________________________________ Date ________________
(Stamped Signature Is Not Acceptable)

Loma Linda University Related Facilities
SUBJECT: XRAY SUPERVISOR/FLUOROSCOPY CERTIFICATE WAIVER

Any Physician Assistant who Supervises Technologists or Operates Fluoroscopy or Radiography equipment in the course of his/her practice is required by the State of California, Title 17, to maintain the appropriate permit.

Supervise/Operate consists of any of the following activities:
1. PA activates or energizes the equipment personally
2. PA directly controls radiation exposure to the patient during the fluoroscopy procedure
3. PA supervises one or more persons who hold a radiologic technologist fluoroscopy permit. Includes such activities as:
   a. PA directs the technologist to activate the equipment
   b. PA positions the equipment or the patient personally
   c. PA directs the technologist to position the equipment or patient

To Supervise and/or Operate the equipment, you must have the privilege to do so. You must:
1. request the privilege on your appropriate privilege request form **and**
2. sign and attach this form **and**
3. attach a current copy of your Permit

These forms must be submitted to Medical Staff Administration for processing.

In general, Radiologist, Urologists, Gastroenterologists, Pulmonologists, Orthopedists, Podiatrists, Surgeons, and Cardiologists are required to maintain a permit unless the use of such equipment is waived.
****

Please mark the appropriate box and sign the form.

☐ **I plan to OPERATE AND/OR SUPERVISE fluoroscopy or radiography equipment and I have attached a copy of my current permit.**

☐ **I AM IN THE PROCESS of applying for a certificate to Supervise Technologists or Operate Fluoroscopy and/or Radiography equipment. When I have received it I will provide you with a copy and a request for that privilege. Until that privilege is granted to me I will not supervise radiology technologists or operate fluoroscopy or radiology equipment.**

☐ **I DO NOT operate or supervise fluoroscopy or radiography equipment and I waive that privilege.**

______________________________	______________________________
Applicant Signature	Applicant Print Name
______________________________	______________________________
Applicant Primary Specialty	Date

Return this signed form to Medical Staff Administration
11314 Mountain View Ave-Cambridge Bldg
Loma Linda, CA 92354
or Fax 909/558-6053 or Fax 66053. Medstaff/Forms-Misc/F-Xray Waiver 6-29-11 FINAL.doc

LOMA LINDA UNIVERSITY
HEALTH SYSTEM

Medical Staff Administration
11314 Mountain View Ave
Cambridge Building
Loma Linda, CA 92354
(909) 558-6052   Fax (909) 558-6053

PHYSICIAN/AHP ACKNOWLEDGEMENT of PENALTY STATEMENT

"Notice to Physicians/AHP: Medicare payment is based on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to be 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 law."

I have read the above PENALTY STATEMENT and agree to abide by it. I understand it will be kept on permanent file within Loma Linda University Related Facilities (LLURF) (Loma Linda University Medical Center (LLUMC), Loma Linda University Behavioral Medical Center (LLUBMC), and/or Loma Linda University Health Care (LLUHC)) and that it will be made available upon request to those acting on behalf of Medicare.

____
Date *(not valid unless dated)*

____
Signed *(Stamped Signature is not acceptable)*

____
Print Name

LOMA LINDA UNIVERSITY
HEALTH SYSTEM

Medical Saff Administration
11314 Mountain View, Cambridge Building
Loma Linda, California 92354
(909) 558-6052 FAX: (909) 558-6053

ALLIED HEALTH PROFESSIONAL CONFIDENTIALITY AGREEMENT

As an Allied Health Professional involved in the evaluation, peer review and quality of care rendered at any of the Loma Linda University Related Facilities. I recognize that confidentiality is vital to the free and candid discussion necessary to effective medical staff peer review and committee activities. Therefore, in accordance with the confidentiality provisions, I agree to respect and maintain the confidentiality of all discussions, deliberations, minutes of committee meetings, records, files, and any and all other information generated in connection with any medical staff and AHP activities. Furthermore, in the conduct of medical staff matters, I agree to make no voluntary disclosure of such information except to persons authorized to receive it or as expressly required by law in the authorized conduct of medical staff proceedings, or with the express approval of the Medical Staff Executive Committee, or its designee.

Moreover, my participation in committee, peer review, and quality improvement activities is in reliance on my understanding that the confidentiality of these activities and matters will be similarly preserved by every other member of the medical staff and other individual(s) involved. I understand the LLU Related Facilities and medical staff are entitled to undertake such action as is deemed appropriate to ensure that this confidentiality is maintained. This action may include corrective action and/or an application to a court for injunctive or other relief in the event of a breach or threatened breach of this Agreement.

Print Name Here: ____

Signature: ____ Date:_________________________
(Stamped Signature Is Not Acceptable)

This Agreement shall be maintained in the Allied Health Professional's credential file as part of the process of medical staff matters conducted within Loma Linda University Related Facilities.

LOMA LINDA UNIVERSITY
HEALTH SYSTEM

Re: Privacy and Security Regulations Compliance Acknowledgement/Agreement

Dear Practitioner:

The enactment of federal and state level regulations such as the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules, the Health Information Technology for Economic and Clinical Health (HITECH), and California Privacy Laws, (collectively "Regulations"), established privacy and security standards to protect the use and disclosure of protected health information (PHI).

The Regulations provide a range of penalties for non-compliance depending on the context of the violation and the offender's intent. For individuals who knowingly and willfully obtain, disclose, or use medical information in violation of the Regulations' provisions, the penalties could include incarceration, loss of licensure, and/or significant financial penalties.

Loma Linda University and its Related Facilities (LLURF), and each member of the respective Medical/Allied Health Professional (AHP) staff are bound by these Regulations. LLURF is adopting policies and procedures that comply with these Regulatory requirements, including distribution of the Notice of Privacy Practices (NPP) during the admission process.

We are asking each member of the Medical/AHP Staff to sign this letter to acknowledge their recognition that LLURF must meet its Privacy and Security obligations with respect to patients of the facility and to agree that each member of the Medical/AHP Staff will cooperate with and abide by any LLURF policies and procedures required by the Regulations.

Additionally, you are asked to acknowledge that you understand your responsibility for complying with the requirements of these Regulations in your office practice. This may be done either by you as an individual, as part of a group practice, or as part of the Organized Health Care Arrangement (OHCA) being established between LLURF and faculty members of the Loma Linda University School of Medicine.

As a member of a respective Medical/AHP Staff, we ask that you acknowledge that you understand that these private practice obligations must be met and that the policies and procedures implemented at LLURF for inpatients will not apply to your office practices. Therefore, you are responsible for developing applicable policies and procedures and for complying with the Privacy and Security Regulations for services provided in your office practice.

Finally, you understand that your obligations with respect to your inpatients at LLURF will end only upon termination of your Medical/AHP Staff membership at the applicable facility/facilities:

Loma Linda University Medical Center (LLUMC)
Loma Linda University Health Care (LLUHC)
Loma Linda University Behavioral Medicine Center (LLUBMC)
Loma Linda University Children's Hospital (LLUCH)

We anticipate that the LLURF policies and procedures will be an efficient way for you and for LLURF to deliver health care to our mutual patients, help maintain high standards of patient care, and comply with the Regulations. If you have any questions regarding this letter, please contact the Compliance Department at (909) 651-4200. Otherwise, please acknowledge your agreement as set forth in the body of this letter by singing below.

____
Date (not valid unless dated)

____
Signed (stamped signature is not acceptable)

____
Print Name

*Please return the signed acknowledgement/agreement to Medical Staff Administration.

Loma Linda University Related Facilities

SUBJECT: XRAY SUPERVISOR/FLUOROSCOPY CERTIFICATE WAIVER

Any physician who Supervises Technologists or Operates Fluoroscopy or Radiography equipment in the course of his/her practice is required by the State of California, Title 17, to maintain the appropriate permit.

Supervise/Operate consists of any of the following activities:

1. Physician activates or energizes the equipment personally
2. Physician directly controls radiation exposure to the patient during the fluoroscopy procedure
3. Physician supervises one or more persons who hold a radiologic technologist fluoroscopy permit. Includes such activities as:
   a. Physician directs the technologist to activate the equipment
   b. Physician positions the equipment or the patient personally
   c. Physician directs the technologist to position the equipment or patient

To Supervise and/or Operate the equipment, you must have the privilege to do so. You must:

1. request the privilege on your appropriate privilege request form **and**
2. sign and attach this form **and**
3. attach a current copy of your Permit

These forms must be submitted to Medical Staff Administration for processing.

In general, Radiologist, Urologists, Gastroenterologists, Pulmonologists, Orthopedists, Podiatrists, Surgeons, and Cardiologists are required to maintain a permit unless the use of such equipment is waived.

****

Please mark the appropriate box and sign the form.

☐ **I plan to OPERATE AND/OR SUPERVISE fluoroscopy or radiography equipment and I have attached a copy of my current permit.**

☐ **I AM IN THE PROCESS of applying for a certificate to Supervise Technologists or Operate Fluoroscopy and/or Radiography equipment. When I have received it I will provide you with a copy and a request for that privilege. Until that privilege is granted to me I will not supervise radiology technologists or operate fluoroscopy or radiology equipment.**

☐ **I DO NOT operate or supervise fluoroscopy or radiography equipment and I waive that privilege.**

______________________________ Applicant Signature

______________________________ Applicant Print Name

______________________________ Applicant Primary Specialty

______________________________ Date

Return this signed form to Medical Staff Administration
11314 Mountain View Ave-Cambridge Bldg
Loma Linda, CA 92354
or Fax 909/558-6053 or Fax 66053.

LOMA LINDA UNIVERSITY
HEALTH SYSTEM

Medical Staff Administration
11314 Mountain View Avenue
Cambridge Building
Loma Linda, CA 92354
(909) 558-6052 Fax (909) 558-6053

DEA WAIVER

I, ____ agree that during any time that I do not have a current/valid DEA Certificate, I will not write prescriptions for drugs that require a DEA Certificate.

I do not have a current/valid DEA Certificate because ____________________________________

____

____

____

____   ________________________

Signature   Date

You can quickly update/change your DEA address and/or Schedules online at
http://www.deadiversion.usdoj.gov/drugreg/reg_apps/index.html

LLUMC Medical Staff Policy MS-#1

Policy Title: Tb Screening Requirements for Medical Staff Members and for other Health Care Workers granted privileges by the Medical Staff.

Background:

Tb screening is an effective tool for detecting tuberculosis in "High Risk" populations. Tb screening is less useful for populations that are not at "High Risk" or when applied without prior risk assessment. The low Tb Skin Test (TST) conversion rate among LLUMC employees (where screening is mandated), particularly among LLUMC employees involved in direct patient care, is evidence that LLUMC is not in general a "High Risk" occupation site. Therefore it is prudent to implement a screening program for Medical Staff Members and other Health Care Workers granted privileges by the Medical Staff that includes a "Risk Assessment" component.

Policy:

1. Medical Staff members and others granted privileges by the Medical Staff shall undergo Tb screening at the time of appointment and at the time of each reappointment. For those found to be at "High Risk", a TST (or equivalent) shall be required at least yearly and may be required more frequently if exposure has occurred. For those not at "High Risk" a TST at the time of initial appointment shall be required and any additional TST shall be guided by the Risk Assessment required for each reappointment.
2. An individual shall be considered "High Risk" if any of the following are applicable:
   a. They immigrated to the US from a country or region with increased prevalence of infectious tuberculosis.
   b. They live with a person with infectious tuberculosis.
   c. They have within the previous 12 months had exposure to a patient with infectious tuberculosis:
      1) They have occupied the same room as a patient with infectious tuberculosis for one hour or more without the use of respiratory protection.
      2) They have performed an examination or procedure without respiratory protection that brought them into proximity of the patient's airway on a patient with infectious tuberculosis.
      3) They are part of a group in which individual members of the group have experienced TST conversion.
   d. They have a recognized Medical Risk Factor:
      1) HIV Infection
      2) Diabetes
      3) Prolonged (> 4 weeks) high dose (> 20 mg prednisone equivalent) corticosteroid therapy or similar immune modulating therapy during the previous 12 months.
      4) Chronic renal failure
      5) Leukemia or lymphoma
      6) Carcinoma of head or neck
      7) Weight less than 90% of ideal body weight
      8) Silicosis
      9) Gastrectomy
      10) Jejunoileal bypass
      11) Chronic fibrotic changes on chest X-Ray
   e. They are or within the prior 12 month have been a resident or an employee of High-Risk Congregate Setting such as prison, jail, nursing home, homeless shelter, HIV residential shelter.
   f. They have any combination of two or more of the following:
      1) Productive or persistent cough (lasting more than 3 weeks)
      2) Blood in sputum
      3) Undiagnosed fever lasting more than 5 days
      4) Soaking night sweats
      5) Unexplained weight loss
      6) Unexplained loss of appetite

References:

- Morbidity and Mortality Weekly Report - CDC (MMWR) 1995: 44 (RR-11)
- MMWR 2000; 49 (RR-6)

Tuberculosis Screening Questionnaire

Name________________________________ Specialty________________________

Read each of the following questions and mark your response at the bottom of this page.

1. Have you immigrated to the US from a country or region with increased prevalence of tuberculosis?
2. Do you live with someone who has infectious tuberculosis?
3. Within the past 12 months, have you occupied the same room as a patient with infectious tuberculosis for one hour or more without the use of respiratory protection?
4. Within the past 12 months, have you performed an examination or procedure that brought you into proximity of the patient's airway on a patient with infectious tuberculosis without the use of respiratory protection?
5. Within the past 12 months have any friends, family members or fellow workers had a Tb Skin Test conversion?
6. Do you have any of the following recognized Medical Risk Factor(s) for tuberculosis?
   a. HIV Infection
   b. Diabetes
   c. Prolonged (> 4 weeks) high dose (> 20 mg prednisone equivalent) corticosteroid therapy or similar immune modulating therapy
   d. Chronic renal failure
   e. Leukemia or lymphoma
   f. Carcinoma of head or neck
   g. Weight less than 90% of ideal body weight
   h. Silicosis
   i. Gastrectomy
   j. Jejunoileal bypass
   k. Chronic fibrotic changes on chest X-Ray
7. Have you within the past 12 month been a resident or an employee of a High-Risk Congregate Setting such as prison, jail, nursing home, homeless shelter, HIV residential shelter?
8. Do you have any of the following?
   a. Productive or persistent cough (lasting more than 3 weeks)
   b. Blood in sputum
   c. Undiagnosed fever lasting more than 5 days
   d. Soaking night sweats
   e. Unexplained weight loss
   f. Unexplained loss of appetite

____ My answer to all of the above questions is NO.

If your answer to all of the above questions is NO then sign below; you have passed Tb Screening; you will again be subject to Tb screening at next re-appointment date. (Initial applicants must submit results of your recent TST with this form.)

____

Signature Date

If you answered YES to any of the above questions continue to the next page.

Return this original form to Medical Staff Administration

Tuberculosis Screening Questionnaire

Name______________________________________ Specialty_____________________________

If your answer to any of the questions on the previous page is "Yes" then continue. These questions must be answered by circling Yes or No.

1.	I have had a positive TST in the past	Yes	No
2.	I have received BCG in the past	Yes	No
3.	I have had an allergic reaction to TST in the past	Yes	No
4.	I have had a "false positive" TST in the past	Yes	No

You must now go to LLUMC Employee Health Service (EHS) or to a U.S. licensed physician and have the following attestation completed:

If LLUMC EHS: Results of Tuberculin Skin Test ____________________________________

____________________________________ ____________

(Signed) – EHS Nurse Date

If Personal Physician:

I have reviewed the history provided in this document and any other information the patient may have provided. I have performed a pertinent physical examination. Using my professional judgment, I have or have not performed a Tb Skin Test, and Chest X-Ray. Based on the entirety of my evaluation I find:

The patient is free of Infectious Tuberculosis ______

The patient needs additional evaluation for Infectious Tuberculosis ______

____________________________________ ____________

Examining Physician Signature Date

____

Print Examining Physician Name

<u>Return this original form to Medical Staff Administration</u>

ALTERNATE ADMITTING AGREEMENT

Provider: ______________________ *Specialty(ies):* ______________________

Address: ____

______________________ *Phone:* ______________________

Supervising Phys: ______________________ *Specialty(ies):* ______________________

____

______________________ *Phone:* ______________________

Admitting Hospital(s): Loma Linda University Medical Center

____

Comments/Special Arrangements: The above Admitting Provider shall provide hospital services for patients that need care at LLUMC

____

____

Admitter agrees to provide hospital services for members assigned to the above provider at the hospital indicated. For such services, bills will be submitted to and paid by the IPA.

**** THIS AGREEMENT IS CURRENT AND VALID UNTIL THE PROVIDER TERMINATES FROM LLUHC OR OBTAINS HIS/HER OWN PRIVILEGES AT LLUMC.***

______________________ ______________________
Provider (AHP) Signature *Date*

______________________ ______________________
Alternate Admitting Physician Signature (Supervising Phys) *Date*

____
Alternate Admitter Physician PRINT NAME

______________________ ______________________
LLUHC Medical Director Signature *Date Approved*

STATEMENT OF APPROVAL AND AGREEMENT
For Nurse Practitioners

These standardized procedures, policies and protocols have been jointly developed and approved by the nurse practitioners and physicians of Loma Linda University Related Facilities. By signing this document, we approve and agree to abide by all that is contained in these documents.

Supervising Physician

______________________	______________________	____________
Physician Signature	Print Name	Date
______________________	______________________	____________
Physician Signature	Print Name	Date

Nurse Practitioner

______________________	______________________	____________
Nurse Practitioner Signature	Print Name	Date

S:/Medstaff /Forms-AHP/F-NP Statement of Approval and Agreement 4-16-12.doc

DELEGATION OF SERVICES AGREEMENT
BETWEEN
A SUPERVISING PHYSICIAN AND A PHYSICIAN ASSISTANT

and

SUPERVISING PHYSICIAN'S RESPONSIBILITY FOR SUPERVISION
OF A PHYSICIAN ASSISTANT

Title 16, Section 1399.540 of the Physician Assistant Regulations states, in part, "A physician assistant may only provide those medical services which he or she is competent to perform and which are consistent with the physician assistant's education, training, and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant. b) The writing which delegates the medical services shall be known as a delegation of services agreement. A delegation of services agreement shall be signed and dated by the physician assistant and each supervising physician. A delegation of services agreement may be signed by more than one supervising physician only if the same medical services have been delegated by each supervising physician. A physician assistant may provide medical services pursuant to more than one delegation of services agreement."

The following two sample documents are attached to assist you with meeting this legal requirement:

- Delegation of Services Agreement (DSA) Between Supervising Physician and Physician Assistant; and,
- Supervising Physician's Responsibility for Supervision of Physician Assistant Agreement.

These are sample documents. They are for your convenience, information, and use. Please feel free to duplicate or modify them as appropriate and consistent with law.

If you choose not to use the sample documents, please be aware that you are still required by law to execute a DSA with your supervising physician. The DSA must be signed and dated by you and your supervising physician. The original or a copy of this document should be maintained at all practice sites where the physician assistant practices, and should be readily accessible. It is recommended that you retain prior DSAs for one to three years after the DSA is no longer current or valid.

While every practicing physician assistant is required to have a DSA, you are **not** required to submit it to the Physician Assistant Committee. If requested, you must make a copy of your DSA available to any authorized agent of the Medical Board of California, the Osteopathic Medical Board of California, or the Physician Assistant Committee who may request it.

Failure to have a current DSA constitutes a violation of the Physician Assistant Regulations and is grounds for disciplinary action against a physician assistant's license. In addition, failure by the physician assistant and supervising physician to comply with the supervision requirements specified in the Physician Assistant Regulations and in the Delegation of Services Agreement is ground for disciplinary action.

rev 11/08

DELEGATION OF SERVICES AGREEMENT BETWEEN SUPERVISING PHYSICIAN AND PHYSICIAN ASSISTANT (Title 16, CCR, Section 1399.540)

PHYSICIAN ASSISTANT ____

(Name)

Physician assistant, graduated from the ____

(Name of PA Training Program)

physician assistant training program on ______________________________.

(Date)

He/she took (or is to take) the licensing examination for physician assistants recognized by the State of California (e.g., Physician Assistant National Certifying Examination or a specialty examination given by the State of California) on ________________________.

(Date)

He/she was first granted licensure by the Physician Assistant Committee on ______________________ (Date), which expires on ____________________ (Date), unless renewed.

SUPERVISION REQUIRED. The physician assistant named above (hereinafter referred to as PA) will be supervised in accordance with the written supervisor guidelines required by Section 3502 of the Business and Professions Code and Section 1399.545 of the Physician Assistant Regulations. The written supervisor guidelines are incorporated with the attached document entitled, "Supervising Physician's Responsibility for Supervision of Physician Assistants."

AUTHORIZED SERVICES. The PA is authorized by the physician whose name and signature appear below to perform all the tasks set forth in subsections (a), (d), (e), (f), and (g) of Section 1399.541 of the Physician Assistant Regulations, when acting under the supervision of the herein named physician. (In lieu of listing specific lab procedures, etc. the PA and *supervising* physician may state as follows: "Those procedures specified in the practice protocols or which the supervising physician specifically authorizes.")

The PA is authorized to perform the following laboratory and screening procedures:

____

____

The PA is authorized to assist in the performance of the following laboratory and screening procedures:

____

____

The PA is authorized to perform the following therapeutic procedures:

____

____

The PA is authorized to assist in the performance of the following therapeutic procedures:

____

____

The PA is authorized to function as my agent per bylaws and/or rules and regulations of (name of hospital):

____

____

a) The PA is authorized to write and sign drug orders for Schedule: II, III, IV, V without advance approval (circle authorized Schedule(s). The PA has taken and passed the drug course approved by the PAC on __________ (Date) (attach certificate). DEA #:______________________________.

or

b) The PA is authorized to write and sign drug orders for Schedule: II, III, IV, V with advance patient specific approval (circle authorized Schedule(s). DEA #:______________________________.

CONSULTATION REQUIREMENTS. The PA is required to always and immediately seek consultation on the following types of patients and situations (e.g., patient's failure to respond to therapy; physician assistant's uncertainty of diagnosis; patient's desire to see physician; any conditions which the physician assistant feels exceeds his/her ability to manage, etc.)

____

(List Types of Patients and Situations)

____

MEDICAL DEVICES AND PHYSICIAN'S PRESCRIPTIONS. The PA may transmit by telephone to a pharmacist, and orally or in writing on a patient's medical record or a written prescription drug order, the supervising physician's prescription in accordance with Section 3502.1 of the Business and Professions Code.

The supervising physician authorizes the delegation and use of the drug order form under the established practice protocols and drug formulary. ________ YES _________ NO

The PA may also enter a drug order on the medical record of a patient at _________________________________
(Name of Institution)
in accordance with the Physician Assistant Regulations and other applicable laws and regulations.

Any medication handed to a patient by the PA shall be authorized by the supervising physician's prescription and be prepackaged and labeled in accordance with Sections 4076 of the Business and Professions Code.

PRACTICE SITE. All approved tasks may be performed for care of patients in this office or clinic located at
____ and, in _______________________________ hospital(s) and
(Address / City) (Address / City)
____ skilled nursing facility (facilities) for care of
(Name of Facility)
patients admitted to those institutions by physician(s) ____ .
(Name/s)

EMERGENCY TRANSPORT AND BACKUP. In a medical emergency, telephone the 911 operator to summon an ambulance.

The ____ emergency room at ________________________
(Name of Hospital) (Phone Number)

is to be notified that a patient with an emergency problem is being transported to them for immediate admission. Give the name of the admitting physician. Tell the ambulance crew where to take the patient and brief them on known and suspected health condition of the patient.

Notify _____________________________________ at ___________________________________ immediately
(Name of Physician) (Phone Number/s))
(or within ________________ minutes).

PHYSICIAN ASSISTANT DECLARATION

My signature below signifies that I fully understand the foregoing Delegation of Services Agreement, having received a copy of it for my possession and guidance, and agree to comply with its terms without reservations.

_______________________________ ____
Date Physician's Signature (Required)

____
Physician's Printed Name

________________________________ ____
Date Physician Assistant's Signature (Required)

____
Physician Assistant's Printed Name

PHYSICIAN'S RESPONSIBILITY
FOR SUPERVISION OF PHYSICIAN ASSISTANT

SUPERVISOR____, M.D./D.O. is licensed to practice in California as a physician and surgeon with medical license number _________________. Hereinafter, the above named physician shall be referred to as the supervising physician.

SUPERVISION REQUIRED. The physician assistant (PA) named in the attached Delegation of Services Agreement will be supervised by the supervising physician in accordance with these guidelines, set forth as required by Section 3502 of the Business and Professions Code and Section 1399.545 of the Physician Assistant Regulations, which have been read by the physician whose signature appears below.

The physician shall review, countersign, and date within seven (7) days the medical record of any patient cared for by the physician assistant for whom the physician's prescription for Schedule II medications was transmitted or carried out.

REPORTING OF PHYSICIAN ASSISTANT SUPERVISION. Each time the physician assistant provides care for a patient and enters his or her name, signature, initials, or computer code on a patient's record, chart or written order, the physician assistant shall also enter the name of his or her supervising physician who is responsible for the patient. When the physician assistant transmits an oral order, he or she shall also state the name of the supervising physician responsible for the patient.

MEDICAL RECORD REVIEW. One or more of the following mechanisms, as indicated below, by a check mark (x), shall be utilized by the supervising physician to partially fulfill his/her obligation to adequately supervise the actions of the physician assistant named ____.
(Name of PA)

_______ Examination of the patient by a supervising physician the same day as care is given by the PA.

______ The supervising physician shall review, audit, and countersign every medical record written by the PA within ___________________________________ of the encounter.
(Number of Days May- Not Exceed 30 Days)

______ The physician shall audit the medical records of at least 5% of patients seen by the PA under any protocols which shall be adopted by the supervising physician and the physician assistant. The physician shall select for review those cases which by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

______ Other mechanisms approved in advance by the Physician Assistant Committee may be used. Written documentation of those mechanisms is located at ____.
(Give Location)

______ INTERIM APPROVAL. For physician assistants operating under interim approval, the supervising physician shall review, sign, and date the medical records of all patients cared for by the physician assistant within seven (7) days if the physician was on the premises when the physician assistant diagnosed or treated the patient. If the physician was not on the premises at that time, he or she shall review, sign, and date such medical records within 48 hours of the time the medical services were provided.

BACK UP PROCEDURES: In the event this supervising physician is not available when needed, the following physician(s) has (have) agreed to be a consultant(s) and/or to receive referrals:

____ Phone: __________________________
(Printed Name and Specialty)

____ Phone: __________________________
(Printed Name and Specialty)

PROTOCOLS NOTE: This document **does not** meet the regulation requirement to serve as a protocol. Protocols, if adopted by the supervising physician, must fully comply with the requirements authorized in Section 3502 (c) (1) of the Business and Professions Code.

_________________ ____
Date Physician's Signature

Loma Linda University Related Facilities
MEDICAL STAFF
COMPUTER ACCESS REQUEST/DELETE FORM

NAME OF PHYSICIAN/AHP ***(Please Print)*** ______________________, ______________________, __________
Last First MI

☐ Add Sign-On(s) ☐ Modify from Resident to Physician

☐ Disable All Sign-On(s) Specialty: ______________________

☐ User Name Change (Marriage, legal name change)

(Previous name)______________________

(MSA Use Only) Facilities: ______________ Email Group: ☐ MC ☐ BMC ☐ Children's Hosp

EID#: ______________ ☐ Faculty ☐ Community ☐ LLUMC Employed NP

Faxed Date: ______________ Degree: __________ **Effective Date:**______________

Confidentiality Warranty

I understand and agree that I am being issued a computer security code password. I hereby accept full responsibility of the use of this password and agree to adhere to, in accordance with, but not limited to, the requirements of LLUMC Policy A-34, "Computer Systems Security". In addition, I understand and agree to adhere to, in accordance with, but not limited to, the requirement of LLUMC Policy A-43, "Use of Computer Internet Services." Furthermore, I agree that I will not share this password with any other individual, nor will I use any other individual's password. In addition, I understand and agree that I assume full responsibility for all transactions and information available through the use of this password. I also agree to immediately notify the IS Help Desk at ext. 48889 if I learn that any other person obtained information which may provide them the opportunity to use my password. Furthermore, in accordance with, but not limited to, the requirements of LLUMC Policies A-10, "Classification and Protection of Information" and I-25 "Personnel Records", I understand and agree that I will have access to confidential information pertaining to patients, employees and business data which is the property of LLUMC. I also agree to be responsible for maintaining the confidentiality of such information. In addition to the above, for systems listed (denoted by an asterisk *) that allow for an electronic signature, I understand that the use of this password represents my electronic legal signature so that the use of this code is the same as my written signature. Finally, I understand and agree that any breach of confidentiality as stated herein and/or in accordance with LLUMC Policy or applicable law shall be grounds for disciplinary action, which may include immediate termination.

Physician/AHP Signature: ______________________ **Date:** ____/____/_____ SIGN HERE

Title: ☐ **Physician** ☐ **Allied Health Professional** **Department:**______________________

Dictation #: ____________ **For VPN ONLY: Cost Center:** __________ **Service Chief Initials:** ________

Admin Asst Contact Name: ______________________ ***Ext:*** __________***Bldg/Room:*** ______________

☑ **LLEAP**	☐ **Web Insurance**
☑ **Outlook**	☐ **TRAC / On-TRAC**
☐ **IMPAX**	☐ **Charms**
☐ **DTS**	☐ **MIDAS+**
☐ **VPN Access** **Cost center #**__________	☐ **Decision Support Portal**
☐ **MedQuest** ***(All UHC)***	☐ **MUSE** (*Emerg Med only)*
☐ **No Internet Access**	☐ **PMM**
☐ **CDL Apps** ***(Cardiology Only)***	☐ **Other:**
☐ **LLUCIS (LLEMR Pwr-Chart)** *Pathology*	
☐ **Shared Drive** (provide folder name): ______________________	

AUTHORIZED BY: ***(Signature)***______________________ ***(Print name)***______________________

(***Authorization from Medical Staff Administration Only***. ***All other signatures will cause a delay.***)

Ext: ______________ **Date:** _____/______/_____

FAX TO: Medical Staff Administration for Authorization and Processing (Fax x66053)

Office use only: USER ID ______________ ANALYST INIT __________ DATE ____/_____/_______