

California Participating Physician Application

This application is submitted to: PACIFIC HOSPITAL OF LONG BEACH herein, this Healthcare organization.¹

I. INSTRUCTIONS		
<p>This form should be typed or 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. Current copies of the following documents must be submitted with this application:</p>		
<ul style="list-style-type: none"> - State Medical License(s) - DEA Certificate - Board Certification (if applicable) 	<ul style="list-style-type: none"> - Face Sheet of Professional Liability Policy or Certification - Curriculum Vitae - ECFMG (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/Cell Number:	
Birth Date: Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include copy of Alien Registration Card):	
Social Security No:	Gender:	
Specialty:	Race/Ethnicity (voluntary):	
Subspecialties:		
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:	

¹ As used in the information Release/Acknowledgments Section of this application, the term “this Healthcare Organization” shall refer to the entity to which this application is submitted as identified above

² This information will be used for consumer information purposes only.

PRINT 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. PREMEDICAL EDUCATION: (Attach additional sheets if necessary. Reference this section Number and Title)

College or University Name:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	Telephone Number:	
	Fax Number:	
	City:	
	State: ZIP:	

V. MEDICAL/PROFESSIONAL EDUCATION: (Attach additional sheets if necessary.

Reference this section Number and Title)

Medical School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	Telephone Number:	
	Fax Number:	
	City:	
	State & Country: ZIP:	
Medical/Professional School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	Telephone Number:	
	Fax Number:	
	City:	
	State & Country: ZIP:	

POSTGRADUATE TRAINING AND EXPERIENCE

VI. INTERNSHIP/PGYI (Attach additional sheets if necessary. Reference this section Number and Title)

Institution:	Program Director:	
Mailing Address:	Telephone Number:	
	Fax Number:	
	City:	
	State & Country: ZIP:	
Type of Internship:		
Specialty:	From:(mm/yy)	To:(mm/yy)

VII.RESIDENCIES/FELLOWSHIPS: (Attach additional sheets if necessary. Reference this section Number and Title)

Include residencies, fellowships, preceptorship, teaching appointments (indicate whether clinical or academic), and postgraduate education in chronological order, giving name, address, city and ZIP code, and dates. Include **all** programs you attended, whether or not completed.

Institution:	Program Director:	
Mailing Address:	Telephone Number:	
	Fax Number:	
	City:	
	State: ZIP:	

Type of Training (e.g. residency, etc.):	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," please explain on separate sheet.)			
Institution:		Program Director:	
Mailing Address:		Telephone Number:	
		Fax Number:	
		City:	
		State:	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," please explain on Separate sheet.)			
Institution:		Program Director:	
Mailing Address:		Telephone Number:	
		Fax Number:	
		City:	
		State:	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)			

VII. BOARD CERTIFICATION

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

- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with equivalent requirements approved by the Medical Board of California
- a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic association approved postgraduate training that provides complete training in that specialty or subspecialty

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.

IX. OTHER CERTIFICATIONS: (E.G. Fluoroscopy, Radiography, Etc.)
 (Attach additional sheets if necessary. Reference this section Number and Title)

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

X. MEDICAL LICENSURE/REGISTRATIONS: (remember to attach copies of documents.)

California State Medical License Number:	Issue Date:	Expiration Date:
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Date Issued: Valid Through:
Medicare UPIN/National Physician Identifier NPI:		MediCal/Medicaid Number:

XI. ALL OTHER STATE MEDICAL LICENSES. List All Medical Licenses Now or Previously Held.
 (Attach additional sheets if necessary. Reference This Section Number and Title)

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

XII. PROFESSIONAL LIABILITY (Remember to attach copy of professional liability policy or certification face sheet.)

Current Insurance Carrier:	Policy No:	Original effective date:
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Mailing Address:	City:
	State: ZIP:

Per Claim Amount:	Aggregate Amount:	Expiration Date:
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Please explain any surcharges to your professional liability coverage on a Separate sheet. Reference This Section Number and Title.

Please list all of your professional liability carriers within the past seven years, other than the one listed above:

Name of Carrier:	Policy No:	From: (mm/yy)	To: (mm/yy)
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Mailing Address:	City:
	State: ZIP:

Name of Carrier:	Policy No:	From: (mm/yy)	To: (mm/yy)
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Mailing Address:	City:
	State: ZIP:

Name of Carrier:	Policy No:	From: (mm/yy)	To: (mm/yy)
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Mailing Address:	City:
	State: ZIP:

Name of Carrier:	Policy No:	From: (mm/yy)	To: (mm/yy)
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Mailing Address:	City:
	State: ZIP:

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 affiliations (A) and have had previous hospital privileges (B) during the past ten years. This includes hospitals, 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 Admitting Hospital:	Telephone:
	City:
	State: ZIP:

Department/Status (active, provisional, courtesy, etc.):

Name and Mailing Address of other Hospital/Institution:	Telephone:
	City:
	State: ZIP:

Department/Status (active, provisional, courtesy, etc.):

Name and Mailing Address of other Hospital/Institution:	Appointment Date:
	Telephone:
	City:
State: ZIP:	

Department/Status (active, provisional, courtesy, etc.):

If you do not have hospital privileges, please explain on Addendum A.

B. PREVIOUS AFFILIATIONS During Last Ten Years. (Attach additional sheets if necessary. Reference This Section Number and Title)

Name and Mailing Address of other Hospital/Institution:	Telephone:
	City:
	State: ZIP:

From: (mm/yy) To: (mm/yy) Reason for leaving:

Name and Mailing Address of other Hospital/Institution:	Telephone:
	City:
	State: ZIP:

From: (mm/yy) To: (mm/yy) Reason for leaving:

Name and Mailing Address of other Hospital/Institution:	Telephone:
	City:
	State: ZIP:

From: (mm/yy) To: (mm/yy) Reason for leaving:

Name and Mailing Address of other Hospital/Institution:		Telephone	
		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for leaving:	

XIV. PEER REFERENCES

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

Name of Reference:	Specialty:	Telephone Number:
Mailing Address:		Fax Number:
		City:
		State: ZIP:
Name of Reference:	Specialty:	Telephone Number:
Mailing Address:		Fax Number:
		City:
		State: ZIP:
Name of Reference:	Specialty:	Telephone Number:
Mailing Address:		Fax Number:
		City:
		State: ZIP:

XV. WORK HISTORY (Attach additional sheets if necessary. Reference This Section Number and Title)

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

Current Practice:	Contact Name	Telephone Number:
Mailing Address:		Fax Number:
		City:
		State: ZIP:
From: (mm/yy)	To: (mm/yy)	
Name of Practice Employer: #	Contact Name:	Telephone Number:
Mailing Address:		Fax Number:
		City:
		State: ZIP:
From: (mm/yy)	To: (mm/yy)	
Name of Practice Employer:	Contact Name:	Telephone Number:
Mailing Address:		Fax Number:
		City:
		State: ZIP:
From: (mm/yy)	To: (mm/yy)	

XVI. ATTESTATION QUESTIONS

If your answer to questions A through K is "Yes", or if your answer to L is "No", please provide full details on a 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 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), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, 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 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 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/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)?

[] Yes [] No

H. Have you ever been 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 within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you 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

M. Have you ever voluntarily or involuntarily had your membership or clinical privileges at any healthcare institution terminated, limited, relinquished or reduced.

[] Yes [] No

N. Have you had any previous or current pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or voluntarily relinquished such licensure or registration?

[] 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 application or termination of my privileges, employment or physician participation a

Print Name : _____

Physician Signature: _____
(Stamped Signature Is Not Acceptable)

Date: _____

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, for the purpose of evaluating this application and any recertification application regarding my professional training, experience, character, conduct and judgment ethics, and ability to work with others. 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 state³ 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, 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 participation, 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 nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal 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 but 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, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges; 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 application or termination of my privileges, employment or physician participation agreement. A photocopy of this document shall be as effective as the original.

Print Name: _____

Physician Signature: _____ Date _____

³The intent of this release is to apply at minimum, protections comparable to those available in California to any action, regardless of where such action is brought

<p>Addenda Submitting (Please check the following):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Addendum A - Health Plan and IPA/Medical Group <input type="checkbox"/> Addendum B - Professional Liability Action Explanation 	<p>This Application and Addenda A and B were created and are endorsed by:</p> <ul style="list-style-type: none"> · 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)
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Individual healthcare organizations may request additional information or attach supplements to this form. They are not part of the California Participation Physician Reapplication 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.

**California Participating Physician Application
Addendum B
Professional Liability Action Explanation**

This Addendum is submitted to: _____, herein, this Healthcare Organization¹

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 in the past seven (7) years, 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, 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: _____

¹As 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.

SUMMARY

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 attorneys listed on Page 1 to discuss any information regarding this case with this Healthcare Organization.

Print Name : _____

Physician Signature: _____

(Stamped Signature Is Not Acceptable)

Date: _____

Name: _____



Medical Staff Services Department
Telephone # (562) 997-2330
Fax: (562) 595-6985

ADDENDUM: SUPPLEMENTAL ACKNOWLEDGMENT

MEDICAL STAFF CODE OF CONDUCT

I hereby acknowledge and agree to be bound by the Medical Staff Code of Conduct Policy and Procedures as adopted by the Medical Staff of Pacific Hospital of Long Beach.

Signature

Date

Printed Name



2776 Pacific Avenue
Long Beach, CA 90806
(562) 595-1911

Medical Staff Services Department

Telephone: # (562) 997-2330

FAX: # (562) 595-6985

BYLAWS AGREEMENT

The following is a brief outline of items, but not inclusive of all, contained in the Medical Staff Bylaws, Rules and Regulations that each practitioner must agree to abide by and be bound to:

I.	MEMBERSHIP	
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VII.	RULES AND REGULATIONS	

- Physicians must visit their patients every 24 hours and document their visit
- H&P's must written or dictated within 24 hours of admission
- H&P's must be on the chart prior to surgery or a detailed written progress note
- All verbal and telephonic orders must signed, dated and timed within 48 hours
- Operative reports must be dictated immediately following surgery
- Informed consent must be documented on the chart prior to surgery
- Office H&P's must be updated prior to surgery
- Supervising physicians must countersign all charts within 48 hours
- Hysterectomies must have state-mandated consent on the chart prior to surgery
- All documentation in the chart must be legible in writing, printing or by dictation
- All surgeons must document a post-operative progress note immediately following surgery
- Ambulatory charts must contain documentation of 1) significant diagnosis, 2) allergies, 3) medications and 4) significant operative/invasive procedure

I have received, read and agree to abide by the Pacific Hospital of Long Beach Medical Staff Bylaws, Rules and Regulations and applicable Department Rules and Regulations.

SIGNATURE

DATE

PRINTED NAME



Medical Staff Services Department

Telephone: # (562) 997-2330

FAX: # (562) 595-6985

PHYSICIAN ACKNOWLEDGEMENT STATEMENT

“Notice to Physicians: Medicare payment to hospitals is based 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.

PHYSICIAN SIGNATURE

DATE

PRINTED NAME



Medical Staff Services Department

Telephone # (562) 997-2330

Fax # (562) 595-6985

CME ATTESTATION FORM

I attest to the fact that I have attended CME courses relating to my specialty in the last two years, and have obtained fifty (50) hours of CME, as required by the Medical Board of California for re-licensure. I understand I am not to send copies of these CME documents, but I must keep them on file and have them ready for submission when requested.

Physician Signature

Date

Print Name



**Medical Staff Services
Department**

Telephone: # (562) 997-2330

**MEDICAL STAFF
CONFIDENTIALITY AGREEMENT**

As a member of the Medical Staff of Pacific Hospital of Long Beach, I may be involved in the evaluation and improvement of the quality of patient care. I recognize that confidentiality is vital to the free and candid discussions necessary for effective monitoring and evaluation activities conducted by the Medical Staff. Therefore, I agree to respect and maintain the confidentiality of all discussions, deliberations, records and other information generated in connection with these activities, and to make no voluntary disclosures of such information except to persons authorized to receive it in the conduct of the Medical Staff of Pacific Hospital.

Furthermore, my participation in monitoring and evaluation and other performance improvement activities is in reliance on my belief that the confidentiality of these activities will be similarly preserved by every other member of the Medical Staff or other individuals involved. I understand that the Medical Executive Committee of Pacific Hospital is entitled to undertake such action as is deemed appropriate to ensure that this confidentiality is maintained, including action necessitated by any breach or threatened breach of this agreement.

Signature

Date

Please print your name



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**PHARMACY
PHYSICIAN SIGNATURE VERIFICATION**

This form will be maintained on file in the Pharmacy as a tool to verify your signature.

DEA Registration Number

DEA Schedules

License Number

Date Expires

Signature

Date

Print Name



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Long Beach, CA 90806
(562) 595-1911

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Telephone: # (562) 997-2330
FAX: # (562) 595-6985

PLEDGE TO PROVIDE CONTINUOUS CARE

As an applicant for membership and clinical privileges to the Medical Staff of Pacific Hospital of Long Beach, I pledge to provide continuous care to my patients.

Applicant Signature

Date

Printed Name



AUTHENTICATION OF WRITTEN SIGNATURE

Physician Name: _____

Subject: Authentication of Written Signature

All written signatures and initials for all physicians who document in the medical record will be readily available and maintained under adequate safeguards within the Health Information Management Department.

Please sign TWICE below, initial, and return to us promptly using the enclosed self-addressed envelope.

Signature

Signature

Initials



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Long Beach, CA 90806
(562) 595-1911

Medical Staff Services Department

Telephone # (562) 997-2330

Fax # (562) 595-6985

TB SCREENING/TUBERCULIN (PPD) SKIN TESTING

(For Medical Staff and Allied Health Professionals)

1. Date PPD placed: (mm/dd/yy) _____
(Must be within one year from date requested)
2. Date PPD read: (mm/dd/yy) _____
3. Result: (#millimeters induration) _____
(A baseline chest X-Ray report will be required for a PPD reaction >10mm.)
4. Read by: _____
Must be read within 48-72 hours. (Practitioners may NOT read their own tests).
5. Please answer all questions below, sign and date the form. **(required regardless of PPD history)**

Do you currently have symptoms of:	Yes	No
a. Unusual fatigue	<input type="checkbox"/>	<input type="checkbox"/>
b. Weight Loss (unrelated to dieting)	<input type="checkbox"/>	<input type="checkbox"/>
c. Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>
d. Persistent cough (>2 weeks of duration)	<input type="checkbox"/>	<input type="checkbox"/>
e. Blood streaked sputum	<input type="checkbox"/>	<input type="checkbox"/>
f. Fever associated with cough for more than one week	<input type="checkbox"/>	<input type="checkbox"/>
g. Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
h. Have you previously had a positive PPD?	<input type="checkbox"/>	<input type="checkbox"/>

(If Yes, please answer the following:

- Have you received INH or other prophylaxis or treatment for TB? Yes No
- Have you ever received BCG2 vaccine? Yes No

Signature

Date

Print Name