Los Angeles County + University of Southern California
ATTENDING STAFF ASSOCIATION
INITIAL APPOINTMENT APPLICATION

IDENTIFYING INFORMATION

_____ _____ _____

***** LAST NAME (Please Print) ***** FIRST NAME INITIAL

Is there any other name under which you have been known? Name(s) _____

Do you ☐ speak ☐ read ☐ write any language other than English? * Languages A_____ B_____

*** Refer to the bottom of this page**

DEPARTMENT (Specialty)	DIVISION (Subspecialty)
_____	_____

*** OFFICE**	**HOME**
_____ Address	_____ Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ Telephone Number (Area Code)	_____ Telephone Number (Area Code)
_____ Email Address	_____ Email Address
_____ _____ Beeper Number (Area Code) FAX Number	_____ _____ Beeper Number (Area Code) FAX Number
Office Manager or Designee: _____	Cell Phone: _____

BIRTHDATE	PLACE OF BIRTH	Please provide: C # _____ or E #_____	MARITAL STATUS ☐ Married ☐ Single

CURRENT LICENSES

	NUMBER	**DATE ISSUED**	**STATE**	**EXP. DATE**
* PROFESSIONAL LICENSE (M.D., D.D.S., D.P.M., D.O.)			California	
*DEA CERTIFICATE				
Submit copy if require by the Department CPR CERTIFICATES: (i.e., ACLS, BLS, PALS, etc.)				
OTHER STATE MEDICAL LICENSES				
Other Certifications: (i.e., Fluoroscopy, Radiography, P.A. Supervisor, etc.)				
*NPI (National Provider Identification) #		ECFMG #		

*** This information will be released to the public, managed care organizations and/or governmental agencies: Name, Professional Address, Training Year Graduated Professional School, Medical License Number, DEA, NPI, Board Certification, and Languages spoken other than English.**

*EDUCATION AND DEGREES:		
CONFERRED BY	DEGREE	DATE
A.		
B.		
C.		

INTERNSHIP OR POSTGRADUATE YEAR 1		
NAME OF HOSPITAL (City, State)	DATES MO/YRS	SPECIALTY
A.		
B.		

RESIDENCY OR POSTGRADUATE YEARS 2-7		
NAME OF HOSPITAL (City, State)	DATES MO/YRS	SPECIALTY
A.		
B.		

FELLOWSHIP TRAINING		
NAME OF HOSPITAL (City, State)	DATES MO/YRS	SPECIALTY
A.		
B.		

CONTINUING TRAINING:

(50 CREDITS REQUIRED)
Please include copies of official program attendance certificates with your application. For Staff who participate in CME activity at the Medical Center (grand rounds, conferences, etc.), the Attending Staff Office is working directly with the Office of Graduate Medical Education to obtain verification and a printout will be included with the completed application. Copies of program certificates or information submitted with a license renewal application when CME's are required by the state need to be provided upon request. **NUMBER OF CREDITS: _____**

CURRENT HOSPITAL STAFF AFFILIATIONS & PREVIOUS AFFILIATIONS DURING LAST 10 YEARS (Attach additional sheets as necessary)		
NAME OF HOSPITAL	STATUS	DATE OF APPOINTMENT
A.		
B.		

WORK HISTORY (Attach additional sheets as necessary) Provide chronological listing beginning with completion of training. If you have practiced fewer than five years from the date of credenatiling, the history begins with initial licensure. Provide detailed explanation of gaps six (6) months

NAME OF ORGANIZATION, HOSPITAL, OR OFFICE PRACTICE	POSITION	MM/YY – MM/YY
A.		
B.		

***BOARD CERTIFICATION (Attach copy of certificates)**

BOARD STATUS	NAME OF BOARD	ELIGIBLE-NOT CERTIFIED	DATE CERTIFIED	RECERTIFICATION DATE
Specialty/Subspecialty				
Specialty/Subspecialty				

Have you ever 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.

PROFESSIONAL PEER REFERENCES:

Please give names of three (3) persons (two of whom should be in the same specialty as yours) who can provide adequate references pertaining to your current professional competence and ethical character. Note: References will be evaluated primarily by the extent of direct clinical observation and other work with the applicant.

DR._____ ADDRESS:_____

DR._____ ADDRESS:_____

DR._____ ADDRESS:_____

ATTESTATION QUESTIONS

Please answer the following questions "YES" or "NO" If your answer to any of the questions is "YES" 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 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 minor traffic violation)? YES ☐ NO ☐

I. 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 ☐

J. 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 insurance or its coverage of any procedures?

YES ☐ NO ☐

Professional Liability Insurance Carrier_____

Policy Number_____

PHYSICAL AND MENTAL HEALTH STATUS

If your answer to questions **A** through **D** is "Yes" give full details on a separate sheet of paper.

A. Are you aware of or have you been advised that you have any temporary or permanent physical, mental, or emotional condition or impairment, or substance abuse problem which, by it's nature, or as a result of its treatment, might interfere with your ability to practice your profession or exercise the clinical privileges requested with reasonable skill, competency and safety?

YES ☐ NO ☐

B. Have you ever become aware of or were you ever advised that you had any temporary or permanent physical or mental condition or impairment which might interfere with your ability to practice your profession with reasonable skill and safety, other than any such condition or impairment which you have indicated in response to the previous question?

YES ☐ NO ☐

C. Are you, or have you been addicted to the use of narcotics, barbiturates, alcohol or other drugs\or are you currently using any illegal substances:

YES ☐ NO ☐

D. Are you, or have you in the past five years, been in any voluntary treatment program for substance abuse?

YES ☐ NO ☐

E. Are you able to perform all the procedures for which you have requested privileges with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients?

YES ☐ NO ☐

F. Do you require reasonable accommodation in order to exercise those privileges requested? Please use a separate sheet to describe the accommodation(s) which will enable you to perform the privileges you have requested.

YES ☐ NO ☐

(If you will require reasonable accommodation, please use a separate sheet to describe the accommodation(s) which will enable you to perform the privileges you have requested.)

ATTENDING APPOINTMENT AND PRIVILEGES:

I hereby apply for appointment to the LAC+USC Medical Center Attending Staff Association and with privileges as indicated on the attached privilege forms. Upon making this application for appointment, I agree to comply with the Bylaws, Rules, and Regulations of the LAC+USC Medical Center Attending Staff Association and Healthcare Network Principles of Practice.

I hereby affirm that the information submitted in the Attestation and Physical & Mental Health questions above, 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 agreement.

_____

PRINT NAME

_____ _____

APPLICANT'S SIGNATURE DATE

Following section to be completed by Department:

STAFF MEMBERSHIP AND PRIVILEGES

APPLICANT'S NAME:_____

Recommended for appointment to the following department: _____

Recommended as a member of the PROVISIONAL STAFF membership classification.

Please indicate the appropriate category:

Full Time Staff ☐
Per Diem ☐
Voluntary Staff ☐
Other: _____

Academic Rank (if applicable:_____

I have reviewed applicant's qualifications, credentials, and health status and recommended staff appointment with privileges as noted on attached privilege forms.

_____

Department Chairman or Designee Approval **Date**

Approved by The Credentials and Privileges Advisory Committee on: _____

Approved by The Medical Executive Committee on: _____

GOVERNING BOARD APPROVAL

Approved by The Governing Board on: _____

For period ending: _____

Upon acceptance of this application, membership in the Health Research Association (affiliated research organization) is automatic, unless accompanied by a letter requesting ASA membership only. (Applies to members of LAC+USC Attending Staff Association only)

LAC+USC HEALTHCARE NETWORK ATTENDING STAFF ASSOCIATION

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 the LAC+USC Healthcare Network Attending Staff Office 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 application and any other credentialing 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 states 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 the LAC+USC Healthcare Network Attending Staff Office, engaged in quality assessment, peer review and credentialing on behalf of the LAC+USC Healthcare Network Attending Staff Office, and all persons and entities providing credentialing information to such representatives of the LAC+USC Healthcare Network Attending Staff Office from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation 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 the LAC+USC Healthcare Network Attending Staff Office 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 current 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 this 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 the LAC+USC Healthcare Network Attending Staff Office 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 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 the LAC+USC Healthcare Network Attending Staff Office 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 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 application 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 and current dates are required on the application.

In making this application for appointment/reappointment to the LAC+USC Attending Staff Association (if applicable), I acknowledge my obligation to provide continuous care and supervision of my patients, accept committee assignments, to accept consultation assignments and to participate in staffing the emergency service area and other special care units.

I acknowledge that I have received and read the Bylaws of the LAC+USC Medical Center Attending Staff Association and/or Healthcare Network Principles of Practice and agree to be bound by the terms thereof if I am granted membership or clinical privileges in all matters relating to the consideration of my application for appointment/reappointment.

I further acknowledge that I am familiar with the principles and standards of the Joint Commission and will cooperate with the LAC+USC Medical Center and Healthcare Network in acquiring and maintaining accreditation for the Medical Center and the Healthcare Network. I also agree to conduct my practice in accordance with high ethical traditions. Specifically, I will not participate in any form of fee-splitting. In complying with this principle, I understand that I am not to collect fees for others referring patients to me, nor permit other physicians and surgeons to collect fees from me, nor to make joint fees nor permit any associate of mine to do so. I also agree that I shall not receive any direct pecuniary gain from patient or similar sources as a result of research financed or sponsored by this association.

I particularly agree to subject my clinical performance to, and faithfully participate in the Attending Staff Association's quality improvement programs as the same shall from time-to-time be in effect, and I agree to hold members of the attending staff and other authorized representatives of the LAC+USC Medical Center and Healthcare Network engaged in these quality activities free from liability for their actions performed in good faith in connection therewith.

Print Name Here_____ Date: _____

Physician Signature_____
(Stamped Signature Is Not Acceptable)

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CONFIDENTIALITY OF SOCIAL SECURITY NUMBER

In order to generate a unique staff identification number (SID #) we required the initial use of your Social Security Number.

The Social Security Number will be used to ONLY ONCE to create an encrypted number.

This page will then be removed immediately from the application and ***shredded***.

The SSN will not be stored in any manner, neither electronically or paper.

Social Security Number:

_____

THIS PAGE SHALL BE SHREDDED IMMEDIATELY AFTER ENCRYPTION