



LOMA LINDA UNIVERSITY
BEHAVIORAL MEDICINE CENTER



LOMA LINDA UNIVERSITY
MEDICAL CENTER



LOMA LINDA UNIVERSITY
HEALTH CARE

*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 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:

California Participating Physician (CPP) Application
CPP Addendum's A and B
HIPAA Compliance Acknowledgement Agreement
Medicare Penalty Acknowledgement Statement
Privilege Request Forms located at <http://www.llu.edu/llumc/medicalstaff/forms.html>
Required Items Check List

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. 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, and Rules and Regulations are enclosed or located at www.llu.edu/llumc/medicalstaff/forms.html, "Bylaws, Rules & Regulation" or on the **VIP page** under "Departments", (pull-down menu) "LLUMC-Admin. & Employee Services", "Medical Staff Administration", 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
LLUMC, LLUBMC, LLUHC
Enclosures
SM

LLUMC, LLUHC, LLUBMC
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 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** - Fill in all blanks. If you need additional space, use an extra sheet of paper. ALL TIME MUST BE ACCOUNTED FOR WITH ANY GAPS FULLY EXPLAINED. NOTE: Temporary Privileges may be requested by the Service Chief after all required verifications have been received by Medical Staff Administration, and only awaiting the Committee/Board review process, or in extraordinary circumstances in accordance with the Bylaws.
- CURRICULUM VITAE** - Current copy with chronological history of education, training, and activity, must include month and year.
- DELINEATION OF PRIVILEGES (N/A for UHC)** - Check each privilege you are requesting individually and sign the 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** – An LLUMC employee must copy and initial the copy of your Driver's License or Passport, the likeness on the copy must be identifiable.
- FEE** - The initial application fee must be submitted with the application: \$800 1st facility; \$200 each additional facility; e.g.: (\$1000 for MC & UHC; \$1200 for MC, BMC & UHC); **AHP** \$400 1st facility; \$100 each additional facility; e.g.: (\$500 for MC & UHC; \$600 for MC, BMC & UHC). **Please make check payable to "LLUMC Medical Staff Administration"**.
- DIPLOMAS** - Copy of diploma and/or certificates from all Medical/Dental School, Internship, Residency, Fellowship
- ECFMG Certificate copy, or Proof from the graduating school or fifth pathway.** Applies only to foreign medical graduates.
- WORK PERMIT/GREEN CARD Copy** – If this is a photo ID, the copy must be made and signed by an LLUMC employee, if a photo, the likeness on the copy must be identifiable. Required for non-US Citizens.
- VERIFICATION OF CONTRACTUAL STATUS for Radiology, Pathology, Anesthesiology, Emergency Medicine.**
- CALIFORNIA MEDICAL/DENTAL/AHP LICENSE(S)** - Current copy.
- 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.
- MEDICARE PENALTY STATEMENT** - Provided by LLUMC. Must be **signed and dated**.
- HIPAA CONFIDENTIALITY ACKNOWLEDGEMENT** - Provided by LLUMC. Must be **signed and dated**.
- CME/CE for 2 Past Years-** A list which includes the subject, # of credit hours, and dates is preferred, but copies of certificates will be accepted also.
- DEA** - Current copy, if applicable. DEA Waiver form must be **signed and dated by every applicant**. California requires a DEA with a California address.
- RADIOGRAPHY/FLUOROSCOPY X-RAY SUPERVISOR AND OPERATOR CERTIFICATE** – Indicate by checking and signing the appropriate space on the attached form. If radiography or fluoroscopy are 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.
- SEDATION PRIVILEGES-** If you request Moderate or Deep Sedation, you must complete the appropriate test as indicated on the privilege sheet. Tests and instructions are available on the LLUMC VIP page under "Departments", (pull-down menu) "LLUMC-Admin. & Employee Services", "Medical Staff Administration", Physicians Resource Directory, "LLUMC" **OR** on the LLUMC web site at: <http://www.llu.edu/llumc/medicalstaff/forms.html>
- TUBERCULOSIS SCREENING QUESTIONNAIRE**
- 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

If you have questions, please contact Medical Staff Administration (MSA) at 909/558-6052. MSA is located at 11314 Mountain View Ave., Cambridge Bldg., on the South/West corner of Mountain View Ave. & Barton Road.

Print Applicants Name: _____

CONFIDENTIAL/PROPRIETARY

California Participating Physician Application

This application is submitted to: Loma Linda University Related Facilities, herein, this Healthcare Organization¹

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)

Department/Service: _____ Section: _____

Loma Linda University Behavioral Medicine Center (BMC)

Department/Service: _____ Section: _____

Loma Linda University Health Care (UHC) – PSM from Department Required

Department/Service: _____ Section: _____

Specialty: _____	Sub-Specialty _____
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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:

- State Medical License(s)
- Face Sheet of Professional Liability Certificate
- Photo ID (Drivers License, ID Card, Passport)
- DEA Certificate
- Curriculum Vitae
- Visa (if applicable)
- Board Certification (if applicable)
- ECFMG (if applicable)
- X-Ray Certificate

II. IDENTIFYING INFORMATION

Last Name: _____	First: _____	Middle: _____
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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: _____
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Birth Date: _____ Birthplace (city/state/country): _____	Citizenship (If not a US citizen, please include copy of Alien Registration Card): _____
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Social Security #: _____ Cell Phone #: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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Spouse Name: _____	NPI# _____ UPIN# _____
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III. PRACTICE INFORMATION

Practice Name (if applicable): _____	Department Name (If hospital based): _____
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Primary Office Street Address: _____	City: _____
	State: _____ ZIP: _____

Telephone Number: _____	Fax Number: _____
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Office Manager/Administrator: _____	Telephone Number: _____
	Fax Number: _____

Name Affiliated with Tax ID Number: _____	Federal Tax ID Number: _____
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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. PREMEDICAL 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:

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

Medical School:	Degree Received:	Date of Graduation: (mm/dd/yy)
Mailing Address:	City:	
	State & Country:	Zip:
Medical School:	Degree Received:	Date of Graduation: (mm/dd/yy)
Mailing Address:	City:	
	State & Country:	Zip:

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

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

Print Applicants Name: _____

VII. RESIDENCIES/FELLOWSHIPS

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education since completion of medical school 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:		
Mailing Address:	City: _____		
	Fax #	ZIP:	
State:	Specialty:	From:	To:
	Type of Training (e.g. Residency, etc.):		

Did you successfully complete the program? Yes No (if "No," please explain on separate sheet.)

Institution:	Program Director:		
Mailing Address:	City: _____		
	Fax #	ZIP:	
State:	Specialty:	From: mm/dd/yy	To: (mm/dd/yy)
	Type of Training (e.g. Residency, etc.):		

Did you successfully complete the program? Yes No (if "No," please explain on separate sheet.)

Institution:	Program Director:		
Mailing Address:	City: _____		
	Fax#	ZIP:	
State:	Specialty	From: mm/dd/yy	To: (mm/dd/yy)
	Type of Training (eg. Residency, etc.):		

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:

- 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.

Print Applicants Name: _____

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

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

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

California Sate Medical 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 MEDICAL LICENSES

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.)

Current Insurance Carrier:	Policy #:	Effective Date - Expired Date	
Mailing Address:		City:	
		State:	ZIP:
Per claim amount: \$	Aggregate amount: \$	Expiration Date	
Name of Carrier:	Policy #:	From:	To:
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From:	To:
Mailing Address:		City:	
		State:	ZIP:
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 Admitting Hospital:	City: _____	
	Fax # _____	State: _____ ZIP: _____
Department/Status (active, provisional, courtesy, temporary, etc.)	Appointment Date: From: _____	
Name and Mailing Address of Other Hospital/Institution:	City: _____	
	Fax # _____	State: _____ ZIP: _____
Department/Status:	Appointment Date: From: _____	
Name and Mailing Address of Other Hospital/Institution:	City: _____	
	Fax # _____	State: _____ ZIP: _____
Department/Status:	Appointment Date: From: _____	

B. PREVIOUS HOSPITAL AND OTHER INSITUTION AFFILIATIONS

Name and Mailing Address of Other Hospital/Institution:	City: _____	
	State: _____	ZIP: _____
From: _____	To: _____	Reason for leaving: _____
Name and Mailing Address of Other Hospital/Institution:	City: _____	
	Fax # _____	State: _____ ZIP: _____
From: _____	To: _____	Reason for leaving: _____
Name and Mailing Address of Other Hospital/Institution:	City: _____	
	Fax # _____	State: _____ ZIP: _____
From: _____	To: _____	Reason for leaving: _____
Name and Mailing Address of Other Hospital/Institution:	City: _____	
	Fax # _____	State: _____ ZIP: _____
From: _____	To: _____	Reason for leaving: _____
Name and Mailing Address of Other Hospital/Institution:	City: _____	
	Fax # _____	State: _____ ZIP: _____
From: _____	To: _____	Reason for leaving: _____

Print Applicants Name: _____

XIV. PEER REFERENCES		
Name of Reference:	Specialty:	Telephone Number: _____ Fax # _____
Complete Mailing Address:		City: _____
		State: _____ Zip: _____
Name of Reference:	Specialty:	Telephone Number: _____ Fax # _____
Complete Mailing Address:		City: _____
		State: _____ Zip: _____
Name of Reference:	Specialty:	Telephone Number: _____ Fax # _____
Complete Mailing Address:		City: _____
		State: _____ Zip: _____

XV. WORK HISTORY		
Chronologically list all work history activities since completion of medical 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 _____

Physician Signature _____ Date: _____
(Stamped Signature Is Not Acceptable)

Print Applicants Name: _____

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, 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 state² 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 _____

Physician Signature _____ Date _____
(Stamped Signature Is Not Acceptable)

Print Applicants Name: _____

Addenda Submitting (Please check the following): <input type="checkbox"/> Addendum A - Health Plan and IPA/Medical Group <input type="checkbox"/> Addendum B - Professional Liability Action Explanation	This Application and Addenda A & B were created and endorsed by: <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 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Violated any criminal law (excluding minor traffic violations)?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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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.)

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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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?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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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?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

D. If you answered A, B or C "YES", could accommodations be made to allow you to practice at this Healthcare Organization?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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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:

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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2. Are you on Active Duty Status?
If "Yes," please explain:

<input type="checkbox"/> Yes	<input type="checkbox"/> No
------------------------------	-----------------------------

Print Name Here _____

Physician Signature _____ Date _____
(Stamped Signature Is Not Acceptable)

California Participating Physician Application

Addendum A

Health Plans and IPA's/Medical Groups

This Addendum is submitted to: Loma Linda University Related Facilities, herein, this Healthcare Organization¹

I. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Medical Group(s)/IPA(s) Affiliation:		
Do you intend to serve as a primary care provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you intend to serve as a specialist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No (If yes, please list specialty(s))
Please check all that apply:		
<input type="checkbox"/> Solo Practice	<input type="checkbox"/> Single Practice	
<input type="checkbox"/> Group Practice	<input type="checkbox"/> 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)? Yes No
 If so, which Network? _____

Do you use a practice management system/software: Yes No
 If so, which one? _____

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 covering physicians by name. Attach additional sheets if necessary)

Answering Service Company: _____ Phone Number: () Fax Number: ()

Mailing Address _____ City: _____
 State: _____ ZIP: _____

Covering Physician's Name: _____ Telephone Number: ()

Covering Physician's Name: _____ Telephone Number: ()

Covering Physician's Name: _____ Telephone Number: ()

Covering Physician's Name: _____ Telephone Number: ()

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

VI. FOREIGN LANGUAGES SPOKEN

Fluently by Physician:	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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have a CLIA waiver? <input type="checkbox"/> Yes <input type="checkbox"/> 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
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

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

Print Name Here _____

Physician Signature _____ Date _____

(Stamped Signature Is Not Acceptable)

California Participating Physician Application

Addendum B

Professional Liability Action Explanation

This Addendum is submitted to: Loma Linda University Related Facilities, 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, 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.

Loma Linda University Medical Center

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.**

Physician Signature

Physician Print Name

Physician 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.**

LASER CERTIFICATION INFORMATION

I, _____,
Print Name

do perform procedures requiring the operation of laser equipment
(attach current copy of certificate)

do ***not*** perform procedures requiring the operation of laser equipment

Signature

Date

***ATTACH COPY OF LASER
CERTIFICATION(S)/DOCUMENTATION HERE,
IF APPLICABLE,
AND RETURN THIS FORM TO
MEDICAL STAFF ADMINISTRATION***



LOMA LINDA UNIVERSITY
BEHAVIORAL MEDICINE CENTER



LOMA LINDA UNIVERSITY
MEDICAL CENTER



LOMA LINDA UNIVERSITY
HEALTH CARE

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
BEHAVIORAL MEDICINE CENTER



LOMA LINDA UNIVERSITY
MEDICAL CENTER



LOMA LINDA UNIVERSITY
HEALTH CARE

*Medical Staff 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.



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 Medical Center (LLUMC), Loma Linda University Health Care (LLUHC), and Loma Linda University Behavioral Medicine Center (LLUBMC) herein referred to as Loma Linda University 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 following applicable facility/facilities:

- Loma Linda University Medical Center (LLUMC)
- Loma Linda University Health Care (LLUHC)
- Loma Linda University Behavioral Medicine Center (LLUBMC)

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 signing 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
BEHAVIORAL MEDICINE CENTER



LOMA LINDA UNIVERSITY
MEDICAL CENTER



LOMA LINDA UNIVERSITY
HEALTH CARE

Medical Staff Administration
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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



LOMA LINDA UNIVERSITY

HEALTH CARE

ALTERNATE ADMITTING AGREEMENT

Provider: _____ Specialty(ies): _____

Address: _____

Phone: _____

Admitting Provider: _____ 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 Signature

Date

Alternate Admitting Provider Signature

Date

Alternate Admitter PRINT NAME

LLUHC Medical Director Signature

Date Approved

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) Jejunioileal 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) Jejunioileal 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.

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 California 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

Return this original form to Medical Staff Administration

Category Descriptions and Prerogatives

	Provisional	Active	Courtesy	Consulting	Affiliate	Administrative	Honorary/ Retired
<u>Core Privileges</u>							
<u>Admit</u> – (Serve as Inpatient Attending Physician)	Eligible	Eligible	Eligible (Limit 12 pts per yr)	Not Eligible	Eligible	Not Eligible	Not Eligible
<u>Ambulatory Care</u> - (Serve as Outpatient Attending Physician)	Eligible	Eligible	Eligible (Limit 12 pts per yr)	Eligible	Eligible	Not Eligible	Not Eligible
<u>Provide Consultation</u> - (Includes Radiology Interpretation and Pathology Interpretation)	Eligible	Eligible	Eligible (Limit 12 pts per yr)	Eligible	Eligible	Not Eligible	Not Eligible
<u>Other Prerogatives</u>							
Vote	Not Eligible	Eligible	Not Eligible	Not Eligible	Not Eligible	Not Eligible	Not Eligible
Hold office (Includes Service Chief and MSEC Mbr at large)	Not Eligible	Eligible	Not Eligible	Not Eligible	Not Eligible	Not Eligible	Not Eligible
Chair Committee	Not Eligible	Eligible	Not Eligible	Not Eligible	Not Eligible	Eligible	Not Eligible
Committee Member	Eligible	Eligible	Eligible	Not Eligible	Not Eligible	Eligible	Not Eligible
<u>Responsibilities</u>							
Carry Malpractice Insurance	Required	Required	Required	Required	Required	Not Required	Not Required
Attend Meetings	Required	Required	Not Required	Not Required	Required	Not Required	Not Required
Pay Fees	Required	Required	Required	Required	Required	Required	Not Required
Apply for Reappointment	Required	Required	Required	Required	Must Qualify w/Pt Activity	Required	Not Required



LOMA LINDA
UNIVERSITY
MEDICAL CENTER

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

NAME OF PHYSICIAN/AHP (Please Print) _____, _____, _____

Add Sign-On(s) Modify from Res to Phys Last _____ First _____ MI _____

Disable All Sign-On(s) Physician/AHP Specialty _____

User Name Change (Marriage, legal name change) (Previous name) _____

(MSA Use Only) Facilities: _____ Email Group: MC BMC _____

EID# _____ Faculty Community

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.*

Employee/Staff Signature: _____ **Date:** ____/____/____

Title: Physician Allied Health Professional **Department:** _____

Dictation #: _____ **For VPN ONLY:** **Cost Center:** _____ **Service Chief Initials:** _____

Admin Asst Contact Name: _____ **Ext:** _____ **Bldg/Room:** _____

CHAIS/CICS <input type="checkbox"/> DHIS <input type="checkbox"/> SUPERSESSION <input type="checkbox"/> TSO		<input type="checkbox"/> Web Insurance	<input type="checkbox"/> Passport
You must provide the name of an employee who has the same access _____		<input type="checkbox"/> TRAC / On-TRAC	<input type="checkbox"/> Optime
		<input type="checkbox"/> Charms	<input type="checkbox"/> AGFA RIS* (Radiology Only)
		<input type="checkbox"/> MIDAS+	<input type="checkbox"/> Computation
<input type="checkbox"/> TSO	<input type="checkbox"/> T&A (TSO required)	<input type="checkbox"/> DataEase/Transplant DB	<input type="checkbox"/> Periop: Surgery Schedule
<input type="checkbox"/> LLUCIS (LLEMR-Pwr Cht)	<input type="checkbox"/> FirstNet* (EM, Med Only)	<input type="checkbox"/> Decision Support Portal	<input type="checkbox"/> VPN Access Cost center # _____
<input type="checkbox"/> Outlook	<input type="checkbox"/> Bed Management		<input type="checkbox"/> HCMS
<input type="checkbox"/> OWL Portal	<input type="checkbox"/> Acustaf	<input type="checkbox"/> PMM	<input type="checkbox"/> ClinDoc
<input type="checkbox"/> IMPAX	<input type="checkbox"/> MestaMed	<input type="checkbox"/> No Internet Access	<input type="checkbox"/> TOROL/Quest Diagnostics
<input type="checkbox"/> Novell	<input type="checkbox"/> DTS	<input type="checkbox"/> ProgNotes (Peds & FM Only)	<input type="checkbox"/> CDL Apps (Cardiology Only)
<input type="checkbox"/> DocuSys (Anesthesiologists only)			
<input type="checkbox"/> Shared Drive (provide folder name): _____		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> HPF* <input type="checkbox"/> Physician		<input type="checkbox"/> MedQuest (All UHC) <input type="checkbox"/> Allied Health/Student/Nurse Practitioner/Phys Asst/Clinical Psychologist, etc	
(FOR PHYSICIANS/AHP ONLY) Additional signature required for PIN number/electronic signature			
<i>In addition to the above said statement under "Confidentiality Warranty", I am being issued a security code password that is my responsibility to maintain in a confidential manner. This password is for entering and using on-line Medical Center Information Systems and is my electronic legal signature. I have received a unique code in order to authenticate patient records at LLUMC. This code is functional for the HPF system. I understand that my use of this code is the same as my written signature. I will be the sole user of this code. I will not share this code with anyone else. I will not use anyone else's code. If anyone should obtain information, which would allow him or her to use my code, I will immediately notify the Help Desk at ext. 48889.</i>			
Signature: _____		Date: ____/____/____	

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 66053

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