VCMC Ventura County Medical Center

Associated with the UCLA School of Medicine

A Division of the Ventura County Health Care Agency

# MEDICAL STAFF SUPPLEMENTAL APPLICATION

## I. PRESENT STATUS

What is your present status? (Check One) ❑ Full-time Practice ❑ Part-time Practice

If you are not currently in practice, when do you intend to begin your practice? _____.

Practice Associates: _____.

Are you currently practicing in Ventura County? ❑ Yes ❑ No

If not, do you plan to relocate your clinical practice to this area? ❑ Yes ❑ No When: _____.

Are you currently living in Ventura County? ❑ Yes ❑ No

If not, do you plan to relocate to this area? ❑ Yes ❑ No When: _____.

## II. VCMC PAST AFFILIATION

Have you ever been affiliated with the Ventura County Medical Center? ❑ Yes ❑ No

Affiliation Dates: _____ (month/year) to _____ (month/year) Location: _____ (hospital area or name of clinic).

## III. CPR CERTIFICATION

VCMC Rules and Regulations Section 5B states, *"Physician members of the active, courtesy and consulting staff shall be proficient in CPR. Completion of formal training in CPR is desirable, but not mandatory for completion of this criterion."*

| | PALS *Pediatrics* | NRP *Neonatal* | BLS *Basic* | ACLS *Advanced* ER required | OTHER |
|---|---|---|---|---|---|
| DATE:➔ | | | | | |

❑ I am currently proficient in CPR. Initials: ➔ _____.

## IV. CONTINUING MEDICAL/PROFESSIONAL EDUCATION

Please submit documentation of your continuing medical/professional education credits and course topics acquired during the last two years. Emphasis should be placed on those programs most relevant to your current specialty and the privileges you are requesting. A report of total hours only will not suffice.

❑ CMA or AMA Reporting form with course titles/credit hours

❑ Course certificates and/or other documentation attached

## V. PREVIOUS HOSPITAL AND OTHER INSTITUTION AFFILIATIONS

VCMC requires verification from all hospitals where you have requested privileges, including applications that were denied, withdrawn, or discontinued in any manner, whether voluntary or in anticipation of rejection. This information is to be provided for all years since completion of residency.

❑ The list provided in section 13A and 13B of the application reflects all hospitals where I have requested privileges (including applications that were denied, withdrawn or discontinued in any manner) since completion of residency.

Signature: _____ Date: _____

## VI. ADDITIONAL QUESTIONS

If your answer to questions A, B, C is "yes", or if your answer to D is "no", please provide full details on a separate sheet.

| | Circle One | |
|---|---|---|
| A. Have you ever been denied an application for membership and privileges, or have you ever withdrawn an application in anticipation of rejection of your application? | YES | NO |
| B. Are you engaged in the use of illegal drugs, or the use of controlled substances not under the supervision of a licensed health care professional (including self administration of such drugs)? | YES | NO |
| C. If you use alcohol, does your use prevent you from exercising the privileges you have requested according to accepted standards of professional performance or without posing a danger to yourself or others? ❑ n/a | YES | NO |
| D. Does your professional liability insurance extend to all privileges you have requested? | YES | NO |

Initial and Date: ➔ _____

## VII. 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.

| | Circle One | |
|---|---|---|
| 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, statutes, regulations, or other legal requirements that may be applicable to the practice of your profession or to your rendition of service to patients? | YES | NO |
| 2. Violated any criminal law (excluding minor traffic violations)? | YES | NO |
| B. Are there any prior or pending government agency or third party payor proceedings or litigation challenging or sanctioning your patient admission, treatment, discharge, charging, collection, or utilization practices, including but not limited to Medicare and Medicaid fraud and abuse proceedings or convictions? | YES | NO |

Initial and Date: ➔ _____

## VIII. APPLICANT'S AGREEMENT

I understand that the hospital will abide by State law and issue reports to the Medical Board of California for the following: Medical Staff actions, removal or suspension of staff privileges.

I acknowledge that I am required to submit any reasonable evidence of current health status that may be requested by the Executive Committee of the Medical Staff.

I pledge to provide continuous care for my patients. I hereby designate _____, a member of the staff of VCMC to be called on any of my cases if I am out of town or the hospital is unable to reach me. I have contacted the designated practitioner and she/she has accepted this responsibility.

I agree that my activities as a Medical Staff member will be bound by the Medical Staff Bylaws, Rules and Regulations and I accept the responsibilities of membership outlined therein.

I will not participate in any form of fee splitting.

In accordance with the bylaws, I agree to notify the hospital of all malpractice actions and their eventual outcomes.

I agree to abide by the Code of Ethics adopted by the American Medical Association (AMA).

By applying for appointment to the Medical Staff of the Ventura County Medical Center, I hereby signify my willingness to appear for interviews in regard to my application if requested.

Signature: _____ Date: _____

## IX. SUPPLEMENTAL ACKNOWLEDGMENTS AND AGREEMENTS

1. I acknowledge that I have received or have been given access to a copy of the Healthcare Organizations' bylaws, policies and rules and an explanation for the requirements they establish.
2. I agree to appear, if requested before Healthcare Organization officers, department officers and committees for interviews or inquiries regarding this appointment application.
3. I consent to the inspection of all records and documents that may be material to the evaluation of my application and direct individuals who have custody of such records and documents to permit inspection and/or copying.
4. I agree to provide copies of patient's records from another health facility or my private office upon the request of the Healthcare Organization, if in the course of evaluation of my application, my practice at the facility or office is deemed relevant.
5. I agree to submit to a physical or mental health examination acceptable to the Healthcare Organization upon request by any authorized representative or committee, as necessary, to determine compliance with healthcare Organization requirements pertaining to health status.
6. I agree to be bound by the terms of the Healthcare Organization bylaws, policies, and rules in all matters relating to the consideration of this appointment application, and to agree that I will complete all hearings and appeals for any adverse membership, privileges, and employment or participation action before resorting to court.
7. I agree to abide by any Healthcare Organization bylaws, policies or rules requirements for release and immunity from civil liability. I further agree to release from liability any persons or entities which request or provide information in connection with peer review or credentialing conducted by the Healthcare Organization, whether or not such release is specifically required by the bylaws, policies or rules. I further release from liability any persons or entities that take any action on my application or on my privileges or membership, whether or not such release is specifically required by the bylaws, policies or rules so long as the action was taken in good faith, after a reasonable investigation.
8. If granted membership and privileges, I agree to maintain an ethical practice to provide for continuous care of all my patients, and to abide by the Healthcare Organization bylaws, rules and policies and to discharge Healthcare Organization functions for which I will be responsible due to my membership, privileges, employment or participation.

I FULLY UNDERSTAND THAT ANY SIGNIFICANT MISSTATEMENT IN OR OMISSIONS FROM THIS APPOINTMENT APPLICATION WILL CONSTITUTE CAUSE FOR DENIAL OF MY APPLICATION FOR APPOINTMENT, AND TERMINIATION OF MEMBERSHIP, PRIVILEGES, EMPLOYMENT OR PARTICIPATION. I HEREBY AFFIRM THAT THE INFORMATION I HAVE FURNISHED TO THE HEALTHCARE ORGANIZATION IN THIS APPLICATION AND IN THE ACCOMPANYING CALIFORNIA PARTICIPATING PHYSICIAN APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ _____

Signature Date

## X. MEDICARE ATTESTATION

By my signature below, I acknowledge receipt of the following notice:

NOTICE TO PHYSICIANS: *Medicare payments to hospitals are based in part on each patient's principle and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his/her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information, required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.*

_____ _____

Signature Date