

ATTACH	Lakewood Regional ID# Medical Center	
SMALL		For MSO use:
PHOTO	Tenet California Health System	Data Dassived/Daturned incomplete
HERE	3700 E. South St. Lakewood, CA 90712	Date Received/Returned incomplete
(MANDATORY)	(562)602-6811 (562)634-6303 fax	Date Received Complete/Processing Started

APPLICATION FOR APPOINTMENT TO MEDICAL STAFF INSTRUCTIONS: 1. Non-Refundable Application Fee must accompany this application.

2. Please type or print legibly.

					MD		DPM
LAST NAME		FIRST NAME		INITIAL	TITL	-E	
OFFICE ADDRESS	CITY	STATE	ZIP	TELEPHONE	F	AX	
	2.55						
HOME ADDRESS	CITY	STATE	ZIP	TELEPHONE	<u> </u>	PAGER	
				M S D W			
BIRTHDATE BIRT	THPLACE	CITIZENSHIP		MARITAL STATUS	NAME OF SE	POUSE	
CDECIAL TV		OCIAL SECUDITY #/TAX	/ ID#	NDI #		- Mail Addraga	
SPECIALTY	5	OCIAL SECURITY #/TA>	( ID#	NPI #		E-Mail Address	
PRACTICING WITH WH	OM AND NATUR	E OF AFFILIATION/ NAM	/E OF GR	OUP/ORGANIZATION/COF	RPORATION.		
				<u> </u>			
IF YOU ARE OUT OF TH	IE IMMEDIATE A	REA DO YOU PLAN TO	RELOCAT	TE TO THIS AREA? YES			
PRE-MEDICAL					IF YES, V	NHEN?	
EDUCATION							
	COLLEGE OR	UNIVERSITY			DEG	BREE	DATES
MEDICAL							
EDUCATION	MEDICAL SCH	00L		ADDRESS	DAT	E OF GRADU	ATION
POST GRADUATE TRAINING:							
TRAINING.	TYPE OF INTE	RNSHIP		SPECIALTY		DATES	
INTERNSHIP	HOSPITAL			ADDRESS		FAX#	
	TIOOTITAL			ADDICESS		170	
DECIDENCIES							
RESIDENCIES FELLOWSHIPS	TYPE OF RESI	DENCY		SPECIALTY		DATES	
	HOSPITAL			ADDRESS		FAX#	
	HOSPITAL			ADDRESS		FAA#	
	TYPE OF RESI	DENCY/FELLOWSHIP		SPECIALTY		DATES	
	HOSPITAL			ADDRESS		FAX#	
	TYPE OF RESI	DENCY/FELLOWSHIP/C	THER	SPECIALTY		DATES	
	HOSPITAL			ADDRESS		FAY#	
	HOSPITAL			ADDRESS		FAX#	



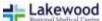
## **Lakewood Regional Medical Center < Medical Staff Membership Application**

POST GRADUATE	(Account for all time since graduation from medical school, including office, clinic and military experience.)			
PRACTICE	Location	Address	Dates	
	Location	Address	Dates	
	Location	Address	Dates	
HOSPITAL AFFILIATIONS		iations with Lakewood Regional Medica		
Use separate	arrangements and pending a			
sheet if necessary	Name and Address of Hospital		Type of Affiliation/Status Dates	
	(List all past and present lice	nses.)		
	State	Date Issued License	Number Expiration Date	
LICENSURE	State	<u> Date Issued</u> <u>Licerise</u>	<u>Expiration Date</u>	
Please attach copies of all				
current licensure and/or certification				
and, or commodition	ECFMG NUMBER (if applicable	2)	Please attach copy of certificate.	
	CURRENT DEA NUMBER	E	XPIRATION DATE	
	FLUOROSCOPY CERTIFICAT	E	XPIRATION DATE	
	Are you certified by an AB	MS Specialty Board? Yes	]No	
CERTIFICATION				
Please attach copy	Name of Board	Original Date of Certificat	ion and Recertification	
of certificate	Name of Board Original Date of Certification and Recertification			
	If not Board Certified, have you applied? Yes No			
	Name of Board:	Anticipated	Date of Certification:	
	Have you ever been Board Cer	ified? Yes No		
Use separate sheet if necessary	If you did not re-certify with an A	ABMS Specialty Board, please explain v	vhy:	



### **Lakewood Regional Medical Center < Medical Staff Membership Application**

PROFESSIONAL	least one year, and have	ans who are in your discip e current, direct knowledo erform the privileges you a	ge of your training ar			
REFERENCES						
	Name	Address	Phone & Fa	x Number		
	Name	Address	Phone & Fa	x Number		
	Name	Address	Phone & Fa	x Number		
	Please list all previous In	surance Companies you h	nave been covered by	in the last 10 years		
	ricuse hist an previous in		iave been covered by	in the last to years.		
PROFESSIONAL LIABILITY	Insurance Carrier	Coverage Amount	Policy Number	Expiration		
COVERAGE						
Please continue	Insurance Carrier	Coverage Amount	Policy Number	Expiration		
on separate sheet of paper if	Have any liability insurance carriers canceled, refused coverage or rated up because of unusual					
necessary.	Risk? Yes No Nam	ne of Carrier				
STATEMENT OF APPLICANT						
hospital policy as now wri interviews or inquiries in r members of medical staffs	tten and as may be amended. By egard to my application. I authori, s and other hospitals or institution; om liability all individuals and entit	of this hospital, I have read and ag or applying for appointment to the N ze the hospital, its medical staff ar is who may have information bearing tes who provide information in good	ledical Staff, I hereby signify nd their representatives to co ng on my professional compe	my willingness to appear for nsult with administrators and etence, character and ethical		
I agree to provide for continuous coverage for my patients.						
I have authorized and consent to the release of information by this hospital or its medical staff to other hospitals, medical associations and other interested persons on request regarding any information the hospital or medical staff may have concerning me so long as such release of information is done in good faith and without malice, and hereby release from liability this hospital, its medical staff and their designated agents for doing so.						
I understand and agree that I, as an applicant for Medical Staff membership have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. I understand and agree that it is my obligation to provide any such information necessary to update my application after it has been submitted. This burden may include submission to a medical or psychological examination at my expense if deemed appropriate by the executive committee which may select the examining physician.						
I fully understand and agree that any significant misstatement or omission from this application shall constitute cause for summary dismissal from the staff or a denial, modification or revocation of my Medial Staff membership and/or privileges.						
I agree to report any changes in my physical or mental health, any changes to my license, and any changes in my staff membership status at other hospitals after this application has been submitted.						
I understand that the comp	pletion of this application is my sol	e responsibility.				
I declare that the information furnished by me is true to the best of my knowledge. I hereby apply for appointment to the Medical Staff of Lakewood Regional Medical Center.						
SIGNATURE:		D	DATE:			
			-			



# LAKEWOOD REGIONAL MEDICAL CENTER SUPPLEMENT TO APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES" GIVE FULL DETAILS ON A SEPARATE SHEET OF PAPER

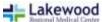
	Has any professional license of yours, in any jurisdiction, or your DEA registration or any applicable narcotic registration in any jurisdiction Ever been denied, (upon application), limited, suspended, revoked or Voluntarily suspended or otherwise acted upon – or is any such action Pending?	Yes No
	Have your privileges at any healthcare facility ever been limited, Suspended, diminished, denied, revoked, voluntarily relinquished or Not renewed or otherwise acted against – or is any such action pending?	Yes No
	Have you ever been denied or voluntarily relinquished membership or Renewal thereof or been subject to disciplinary action in any medical Or professional organization, healthcare facility, or licensing agency – Or is any such action pending?	Yes No
Have	you ever been suspended, fined, disciplined, plate Probation, restricted, excluded, or otherwise sanctioned by, or have you Voluntarily or involuntarily relinquished eligibility to participate in, Any federal or state health program, or is such action pending? (Examples Of such programs include, but are not limited to: Medicare, Medi-Cal, Tri-Care (formerly CAMPUS), California Children's Services, Maternal And Child Health Services block grant, block grants to State Children's Health insurance programs.)	eced on
	Have you ever been notified to appear before any licensing agency for? A hearing or a complaint of any nature?	Yes No
Have	you ever surrendered, voluntarily withdrawn, or Or compelled to relinquish your status as a student in good standing in Any internship, residency, fellowship, preceptorship, or other clinical Education program?	been requested  Yes No
Have	you ever been denied certification/recertification	n by a specialty
	Board, or has your eligibility, certification or recertification status changed (Other than changing from eligible to certified?)	Yes No
	Have you ever been convicted of a felony or misdemeanor (other than? Minor traffic offenses)?	Yes No
	Within the past 5 years, have you ever been treated for a psychiatric, drug? Alcohol or behavioral problem? (If so, please indicate on a separate sheet Of paper, the rehabilitation program completed and dates).	Yes No
Are y	ou presently using any illegal drugs or illegally odrugs?	obtained DEA Class 1-5
	<b>-9-</b> -	Yes No
K.	Do you have any physical or mental limitations impairing your ability? To practice competent medicine or the privileges you are requesting?	Yes No
L.	Have any judgments or settlements been made against you in Professional liability cases? (If so, please complete the attached Professional Liability Form for each case).	Yes No



### SUPPLEMENT TO APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF

M.	Are there any professional liability cases pending against you?
	(If so, please complete the attached Professional Liability form for each case).
PROF	ESSIONAL LIABILITY FORM
PRINT	NAME
	answered "Yes" to: "Have any judgments or settlements been made against you in professional liability cases?", or "Yes" to: "Are any professional liability cases pending against you?" please complete the following for <b>each</b> case and/or claim:
	choose to not complete this form, you must submit written details regarding your affirmative answers with e following questions answered.
1.	Complete Name of the Case/Claim:
2.	Name of Court in which the Case was Filed (if applicable)
3.	Date of Loss or Incident:
4.	Date You First Received Notice of the Claim:
5.	Relationship to the Plaintiff/Patient:
6.	Allegation:
7.	Date and Type of Resolution (if applicable)_
8.	Current Status of Case/Claim (if applicable):
9.	Amount of Judgment or Settlement (if applicable):
10.	Name of Your Insurance Company that handled or is handling the claim:
11.	Description of the Case/Claim:
Signati	ure of Applicant Date

**Note:** Additional information may be requested after review of the above information.



5.

### CONSENT AND RELEASE FROM LIABILITY FORM

By applying for appointment/reappointment and clinical privileges, and in consideration of the Medical Staff's evaluation of my qualifications, I accept the following conditions and intend to be legally bound by them, regardless of whether or not I am granted appointment/reappointment and/or clinical privileges. These conditions shall be effective as of the date set forth below and shall remain in effect for the duration of any appointment or clinical privileges I may be granted.

- 1. To the fullest extent permitted by law, I extend absolute immunity to, release from any and all liability, Lakewood Regional Medical Center (the "Hospital"), its Medical Staff, and all their representatives, for any matter relating to appointment, reappointment, clinical privileges, or my ongoing qualifications for the same. This includes, but is not limited to, any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken, or received, by the Hospital, the Medical staff, or any of their representatives.
- 2. I authorize the Hospital, its Medical Staff, and their representatives to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, ability to practice competently, ethics, behavior, or any other matter that the Hospital Medical Staff or their representatives determine are related to my qualifications for initial and continued appointment to the Medical Staff and/or clinical privileges. This authorization includes the right to inspect or obtain any and all communications, reports, records, medical records, statements, documents, recommendations or disclosures of third parties that the Medical Staff or its representatives determine are relevant to such questions. In addition, I authorize third parties to release the information to the Hospital, its Medical Staff, and their authorized representatives.
- 3. I authorize hospitals, medical staffs, insurers, other third parties and their representatives to release information and documents to the Hospital, its Medical Staff, and their authorized representatives. To the fullest extent permitted by law, I grant absolute immunity to, and release from any and all liability, individuals and organizations which provide information or documents to the Hospital or its Medical Staff concerning my professional competence, ethics, character and other qualifications for Medical Staff appointment or clinical privileges.
- 4. I authorize the sharing of information and documents between the Hospital, its Medical Staff, and their representatives and other medical staffs and peer review bodies or organizations, such as other hospitals, health care facilities, managed care entities, and their agents, for the purpose of evaluating my qualifications. To the fullest extent permitted by law, I grant absolute immunity to, and release from liability each of the foregoing as the result of such sharing of information and documents.

	sole and exclusive remedy with respect to any professional review actions taken at the Hospita			
DATE:				
		Signature of Practitioner		
		Printed or Typed Name of Practitioner		

I agree that the hearing and appeal procedures set forth in the Medical Staff Bylaws shall be my



### **HIPAA Compliance Agreement**

A fundamental HIPAA tenant is that only the minimum necessary amount of information needed to complete a particular task should be collected, used or divulged in the process. <u>Fortunately, the minimum necessary principle does not apply in direct treatment situations</u>. Thus, all the health professionals within a health care entity who are treating a patient have access to the entire medical record. However, physicians are often asked to provide medical information for purposes other than treatment, such as disability forms, life insurance and sports physical reports, and certifications for drivers and pilots. When releasing information of this type, only the minimum necessary should be divulged. (The patient's authorization would also be required in these examples or any other release of information that is not TPO.)

#### The minimum necessary principle does not apply in:

- Direct treatment situations in communications with another professional treating the patient.
- Disclosing medical information to the patient himself/herself
- Disclosing medical information to the patient's legal representative.
- Disclosing information authorized for release by the patient
- · Certain disclosures required by law.

BY SIGNING BELOW, I UNDERSTAND THAT I AGREE TO ABIDE BY THE HIPAA RULES AND ALL RELATED PATIENT INFORMATION IS TO BE TREATED WITH UTMOST CONFIDENTIALITY. COMPUTERS, COMPUTER FILES, THE E-MAIL SYSTEM, THE VOICE-MAIL SYSTEM, AND SOFTWARE FURNISHED TO ME ARE TENET PROPERTY INTENDED FOR BUSINESS USE. VOICE-MAIL SYSTEM, AND E-MAIL SYSTEM, NUMEROUS COMPUTERS, INCLUDING PORTABLE COMPUTERS, COMPUTER TERMINAL, SOFTWARE, AND NUMEROUS INTERNET-CONNECTED TERMINALS ARE AVAILABLE TO ASSIST TENET IN CONDUCTING BUSINESS, INTERNALLY AND EXTERNALLY. THESE SYSTEMS, INCLUDING THE EQUIPMENT AND THE DATA STORED IN THE SYSTEMS AND ALL INFORMATION AND MATERIALS DOWNLOADED INTO TENET COMPUTERS ARE AND REMAIN THE PROPERTY OF TENET. I WILL NOT USE A PASSWORD, ACCESS A FILE, OR RETRIEVE ANY STORED COMMUNICATION WITHOUT AUTHORIZATION. TO ENSURE COMPLIANCE WITH POLICY COMPUTER AND E-MAIL USAGE MAY BE MONITORED.

PHYSICIAN SIGNATURE:	DATE
Print Physician Name:	



### **DRG Validation Statement**

This DRG Validation Statement is to be signed by all medical staff members (physicians, dentists, podiatrists, psychologists, and all affiliate staff members) on initial appointment to the staff.

#### **STATEMENT**

"Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses an the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature on 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	
PRINTED NAME	
DATE	



### MEDICAL STAFF CODE OF CONDUCT

The Medical Staff of Lakewood Regional Medical Center requires that all individuals working in the Hospital treat others with respect, courtesy, dignity and conduct themselves in a professional and cooperative manner.

I acknowledge that conduct which does not conform with this Code of Conduct may be detrimental to patient safety and the delivery of patient care and disruptive to Hospital and Medical Staff operations. I understand that my failure to comply with this Code of Conduct may result in such disciplinary action as deemed appropriate by the Executive Committee pursuant to the Medical Staff's Bylaws, Rules and Regulations and policies, which may include, but not be limited to, suspension, or termination of Medical Staff membership and/or clinical privileges.

Date	Signature
	Typed or Printed Name

F:\Medical Staff Policies\Medical Staff Code of Conduct 2000.frm.doc



(4) Other appropriate action.

#### Lakewood Regional Medical Center Application For Appointment To Medical Staff

#### MEDICAL STAFF PEER REVIEW CONFIDENTIALITY

As a member of the medical staff who will be permitted to attend Medical Staff Peer review meetings for the purpose of evaluating and improving the quality of patient care rendered at Lakewood Regional Medical Center, ("the Hospital") I recognize that I will have access to confidential information regarding credentialing, quality improvement and peer review activities.

I understand the importance of maintaining the confidentiality of all such information, and any and all discussions and deliberations. I agree to make no disclosures of such peer review information outside of appropriate Medical Staff meetings, except in the following circumstances: (1) when the disclosures are limited to another member on the Medical Staff or employee of the Hospital for the purpose of furthering the quality of care and in accordance with the procedures set forth in the Medical Staff Bylaws, or (2) when the disclosures have been authorized, in writing, by the hospital's Chief Executive Officer or the Chief of Staff.

I understand that my breach of this Confidentiality Agreement may compromise the interests of the Hospital, and other Medical Staff members. I recognize that any breach of confidentiality may result in loss of legal protections to myself and the Medical Staff and its members.

In the event I breach this Confidentiality Agreement, I understand that I may be subject to:

- (1) dismissal from my committee assignment and/or Medical Staff office;
- (2) loss of immunities from liability and other legal protections and loss of indemnification for any litigation costs and expenses;
- (3) Medical Staff disciplinary action as deemed appropriate by the Executive Committee which may include, but not be limited to suspension or termination of my Medical Staff membership and/or privileges; and/or

( )		
Date	Signature	
	Printed Name	



### MEDICAL STAFF/APPLICANT REPRESENTATION

(Home Health Agency)

The undersigned Physician (the "Physician") hereby represents that neither Physician, nor any immediate family member of the Physician, has any ownership interest, compensation arrangement or other financial relationship with any home health agency or supplier to home health agency that violates federal or state anti-kickback or self-referrals laws.

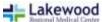
- An ownership interest includes any direct or indirect equity, debt or other ownership or investment interest in the home health agency, supplier or in an entity that holds an ownership or investment interest in the home health agency or supplier.
- 2. A compensation arrangement includes any arrangement involving any remuneration. The term "remuneration" includes any payment or other remuneration, directly or indirectly, overtly or covertly, in cash or in kind.
- 3. The term "other financial relationship" includes any control or operation of the home health agency or supplier by Physician or any immediate family member of Physician.
- 4. For purposes of this representation, immediate family member means husband or wife, natural or adoptive parent, child or sibling; step-parent, step-child, step-brother or step-sister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and a spouse of a grandparent or grandchild.

An example of a relationship that would violate such laws would be whereupon discharge from a hospital, Physician orders home health services for patients and refers those patients to an agency in which the Physician and/or an immediate family member had an ownership interest.

(Another example of a relationship that would violate such laws would be whereupon discharge from a hospital, Physician orders home health services for patients and consistently refers such patients to a specified DME company, which is owned by the Physician. Similarly, the referral of such patients would be prohibited in the previous example if Physician's sister-in-law, and not Physician, owned the DME company.)

Physician Signature	Date	
Physician Name (Please Print)		

9/97 cred\homehlth.frm



## **PHYSICIAN CROSS COVERAGE**

Recognizing that I am responsible for providing continuous medical care for all my patients, I confirm that the following physician(s) have agreed to provide such coverage in my absence.

Name	Specialty
Tel No	
Address	
City	
Name	
Tel No	
Address	
City	
Signature	Specialty
Date	
Name(Please Print)	
(i lease Filit)	



## **MEMORANDUM**

## LAKEWOOD REGIONAL MEDICAL CENTER Laboratory Services

TO:	Physicians and Practitioners	
FROM:	Director Laboratory Services	
RE:	MEDICAL NECESSITY	
	In 1997, Medicare enacted a new documentation rule for labs that bill the government for <u>outpatient</u> testing. Under the new rules, the laboratory that performs the test is required to have documentation of the <i>medical necessity</i> of any tests that are billed to a Federal program. Medical necessity can be in the form of an appropriate diagnosis code or other information that explains the need for the test.	
	If you send Medicare or MediCal patients to the hospital lab for testing, <b>you must provide a diagnosis or symptom</b> on your prescription or lab request form. If this information is not provided on the request form, we will telephone your office prior to testing to obtain this information.	
	Furthermore, Medicare and MediCal do not reimburse for <i>screening</i> tests. If you order a test such as PSA or CEA for screening purposes, you must indicate so on the requisition or prescription. The patient should be advised that the test is for screening purposes and that since Medicare and MediCal do not pay for these tests, he/she will be asked to sign an Advanced Beneficiary Notice. By signing the ABN, he/she will assume financial responsibility for the test if Medicare or MediCal does not pay for it. If the patient refuses to sign the ABN, the test will not be performed.	
	We are required to send notices to the staff physicians to acknowledge the medical necessity requirements when ordering laboratory tests. Please sign the bottom portion of this memorandum for inclusion in your credential file. Thank you for your cooperation.	
	I acknowledge that I have read the above Medical Necessity documentation requirements and I specifically agree to abide by all such policies as are in force during the time I am appointed or reappointed to the medical staff of the hospital.	
	Signature Date	
	Please Print Name	