Lakewood Regional Medical Center

Lakewood Regional Medical Center Application For Appointment To Medical Staff

ATTACH SMALL PHOTO HERE **(MANDATORY)**

Lakewood Regional Medical Center
Tenet California Health System
3700 E. South St.
Lakewood, CA 90712
(562)602-6811
(562)634-6303 fax

ID#_____

For MSO use:

Date Received/Returned incomplete

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.

LAST NAME | FIRST NAME | INITIAL | ☐MD ☐DO ☐DPM TITLE

OFFICE ADDRESS | CITY | STATE | ZIP | TELEPHONE | FAX

HOME ADDRESS | CITY | STATE | ZIP | TELEPHONE | PAGER

BIRTHDATE | BIRTHPLACE | CITIZENSHIP | ☐M ☐S ☐D ☐W MARITAL STATUS | NAME OF SPOUSE

SPECIALTY | SOCIAL SECURITY #/TAX ID# | NPI # | E-Mail Address

PRACTICING WITH WHOM AND NATURE OF AFFILIATION/ NAME OF GROUP/ORGANIZATION/CORPORATION

IF YOU ARE OUT OF THE IMMEDIATE AREA DO YOU PLAN TO RELOCATE TO THIS AREA? ☐YES ☐NO _____ IF YES, WHEN?

PRE-MEDICAL EDUCATION

COLLEGE OR UNIVERSITY | DEGREE | DATES

MEDICAL EDUCATION

MEDICAL SCHOOL | ADDRESS | DATE OF GRADUATION

POST GRADUATE TRAINING:

INTERNSHIP

TYPE OF INTERNSHIP | SPECIALTY | DATES

HOSPITAL | ADDRESS | FAX #

RESIDENCIES FELLOWSHIPS

TYPE OF RESIDENCY | SPECIALTY | DATES

HOSPITAL | ADDRESS | FAX #

TYPE OF RESIDENCY/FELLOWSHIP | SPECIALTY | DATES

HOSPITAL | ADDRESS | FAX #

TYPE OF RESIDENCY/FELLOWSHIP/OTHER | SPECIALTY | DATES

HOSPITAL | ADDRESS | FAX #

Lakewood Regional Medical Center

Lakewood Regional Medical Center Application For Appointment To Medical Staff

Lakewood Regional Medical Center < Medical Staff Membership Application

POST GRADUATE PRACTICE

(Account for all time since graduation from medical school, including office, clinic and military experience.)

Location	Address	Dates

HOSPITAL AFFILIATIONS

Use separate sheet if necessary

Have you had any previous affiliations with Lakewood Regional Medical Center? o Yes o No

List all past and present hospital affiliations, including temporary privileges, locum tenens arrangements and pending applications:

Name and Address of Hospital	Type of Affiliation/Status	Dates

LICENSURE

Please attach copies of all current licensure and/or certification

(**List all past and present licenses.**)

State	Date Issued	License Number	Expiration Date

ECFMG NUMBER (if applicable) _____ *Please attach copy of certificate.*

CURRENT DEA NUMBER _____ EXPIRATION DATE _____

FLUOROSCOPY CERTIFICATE _____ EXPIRATION DATE _____

CERTIFICATION

Please attach copy of certificate

Are you certified by an ABMS Specialty Board? ☐ Yes ☐ No

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 Certified? ☐ Yes ☐ No

Use separate sheet if necessary

If you did not re-certify with an ABMS Specialty Board, please explain why: _____

Lakewood Regional Medical Center < Medical Staff Membership Application

PROFESSIONAL REFERENCES

Please list three physicians who are in your discipline, have known you professionally for at least one year, and have current, direct knowledge of your training and/or experience, and current competence to perform the privileges you are requesting:

Name Address Phone & Fax Number

Name Address Phone & Fax Number

Name Address Phone & Fax Number

PROFESSIONAL LIABILITY COVERAGE

Please continue on separate sheet of paper if necessary.

Please list all previous Insurance Companies you have been covered by in the last 10 years.

Insurance Carrier Coverage Amount Policy Number Expiration

Insurance Carrier Coverage Amount Policy Number Expiration

Have any liability insurance carriers canceled, refused coverage or rated up because of unusual Risk? ☐ Yes ☐ No Name of Carrier _____

STATEMENT OF APPLICANT

In making application for appointment to the Medical Staff of this hospital, I have read and agree to abide by its bylaws, rules and regulations, and by hospital policy as now written and as may be amended. By applying for appointment to the Medical Staff, I hereby signify my willingness to appear for interviews or inquiries in regard to my application. I authorize the hospital, its medical staff and their representatives to consult with administrators and members of medical staffs and other hospitals or institutions who may have information bearing on my professional competence, character and ethical qualifications. I release from liability all individuals and entities who provide information in good faith and without malice concerning my qualifications for staff appointment and clinical privileges.

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 completion of this application is my sole 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: _____ 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, placed on

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.) ☐ Yes ☐ No

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 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

Have you ever been denied certification/recertification by a specialty

Board, or has your eligibility, certification or recertification status changed (Other than changing from eligible to certified?) ☐ Yes ☐ No

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 you presently using any illegal drugs or illegally obtained DEA Class 1-5 drugs?

☐ 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). ☐ Yes ☐ No

PROFESSIONAL LIABILITY FORM

PRINT NAME_____

If you answered "Yes" to: "Have any judgments or settlements been made against you in professional liability cases?", or "Yes" to: "Are there any professional liability cases pending against you?" please complete the following for **each** case and/or claim:

If you choose to not complete this form, you must submit written details regarding your affirmative answers with all the 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:_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Applicant Date

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

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.

5. I agree that the hearing and appeal procedures set forth in the Medical Staff Bylaws shall be my sole and exclusive remedy with respect to any professional review actions taken at the Hospital.

DATE: _____ _____
Signature of Practitioner

_____
Printed or Typed Name of Practitioner

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. Fortunately, the minimum necessary principle does not apply in direct treatment situations. 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

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

(4) Other appropriate action.

_____ _____

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.

1. 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)

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_____Specialty_____

Tel No _____

Address_____

City_____

Signature_____Specialty_____

Date_____

Name_____
(Please Print)

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 outpatient testing. Under the new rules, the laboratory that performs the test is required to have documentation of the ***medical necessity*** 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, **you must provide a diagnosis or symptom** 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 ***screening*** 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