INSTRUCTIONS FOR COMPLETING

LOCUM TENENS COVERAGE
OR
VISITING TEMPORARY CLINICAL PRIVILEGES

Enclosed please find the application form for processing of Locum Tenens or Visiting Temporary Clinical Privileges requests.

This application needs to be completed in full prior to consideration***. Applications will not be considered for processing until all areas are complete and all information is provided***. When complete, return:

By US mail to:
Stanford Hospital and Clinics
Attn:
Medical Staff Services
300 Pasteur Dr MC 5288
Stanford, CA 94305

By Fed Ex, UPS or hand delivered to:
Stanford Hospital and Clinics
Attn:
Medical Staff Services
1510 Page Mill Road, MC5288
Palo Alto, CA 94305

Phone: 650-723-7857 Fax: 650-725-0297

Along with your application, please include the following:

- Curriculum Vitae
- **CURRENT** Certificate of Insurance *as well* as completing the Professional Insurance form attached
- ECFMG Certificate if applicable

This is an abbreviated application. If additional space is needed to provide complete information, please attach additional pages as necessary.

Note:

- **All attempts will be made to process your application to accommodate you as well as your patient/department.**
- **Be complete and forward the application and all attachments promptly.**

STANFORD HOSPITAL AND CLINICS
Lucile Packard Children's Hospital

LOCUM TENENS OR VISITING TEMPORARY CLINICAL PRIVILEGES REQUEST FORM

☐ SHC ☐ LPCH

Applicant Demographic Information:

Name and Degree:		Specialty:	
Other names by which you have been known? Last: First: Middle:			Gender: ☐ Male ☐ Female
Social Security #:	Birth Date:	Foreign Languages Spoken: ☐ I am proficient in the English language	
Primary E-Mail Address:		Pager # :	
ECFMG # (if foreign medical graduate):	Valid Until (Date):	Date Issued:	
Practitioner Type: ☐ Physician ☐ Podiatrist ☐ Dentist ☐ Psychologist		Department:	

Visiting/Temporary Privileges Section ***Locum Tenens Section***

Temporary Privileges Requested for: (specify reason)	Locum Tenens Coverage for the following provider:
Admit/Treat One (1) Patient Name of Patient :	*Date From:
Procedure Requested:	*Date To:
Expected Procedure Date:	***Not to exceed 90 days (3 Months)**

Clinical Venue(s):

☐ Stanford University Hospital ☐ Stanford University Clinics ☐ Eye Laser Clinics ☐ LPCH

Office Address Information:

Office Address:	City:	State:	Zip:
Office Telephone Number:	Office Fax Number:		
Office Contact Person:			

Professional Licensure Information:

California Medical License #:	**Expiration Date:**
Out of State Medical License #: **State of License:**	**Expiration Date:**
DEA License #:	**Expiration Date:**
Fluoroscopy/X-Ray Operator, Supervisor Certificate #:	**Expiration Date:**
NPI #	

Professional Education / Post Graduate Training:

Medical Professional School:	Degree Received	Date
Mailing Address:		
City:	State/Zip	
FELLOWSHIP ***Did you successfully complete the program?*** ☐ ***Yes*** ☐ ***No***		
Institution:	***Date From:*** ***mm/dd/yy***	***Date To:*** ***mm/dd/yy***
City:	**State, Zip**	
RESIDENCIES ***Did you successfully complete the program?*** ☐ ***Yes*** ☐ ***No***		
Institution:	***Date From:*** ***mm/dd/yy***	***Date To:*** ***mm/dd/yy***
City:	**State, Zip**	
INTERNSHIP ***Did you successfully complete the program?*** ☐ ***Yes*** ☐ ***No***		
Institution:	***Date From:*** ***mm/dd/yy***	***Date To:*** ***mm/dd/yy***
City:	**State, Zip**	

Board Certifications

Include certifications by board(s) duly organized and recognized by:

- ***American Board of Medical Specialties or 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 post-graduate training that provides complete training in that specialty or subspecialty***

Name of Issuing Board	***Specialty***	***Date Certified***	***Date Recertified***	***Expiration Date***

Have you applied for board certification other than those indicated above? ***Yes*** ☐ ***No*** ☐ ***If yes, list board(s) and date(s).***

CURRENT AFFILIATIONS (Other than Stanford Hospital & Clinics or Lucile Packard Children's Hospital)			
Institution		Status (attending, active, provisional, courtesy, temporary, etc.):	
Mailing Address:	City:	State:	Zip:
Department: Email:	Phone: Fax:	Appointment Date: mm/yy ☐ Pending	
Institution		Status:	
Mailing Address:	City:	State:	Zip:
Department: Email:	Phone: Fax:	Appointment Date: mm/yy ☐ Pending	
Institution		Status:	
Mailing Address:	City:	State:	Zip:
Department: Email:	Phone: Fax:	Appointment Date: mm/yy ☐ Pending	
If you do not have hospital privileges, please explain:			

PEER REFERENCES (Someone who can assess competency in the past two years)

List three references, peers (**preferably within your specialty**) who are directly familiar with your current clinical work, either through direct clinical observation or through close working relations. Do not include relatives, current partners, or associates in practice. ***Please provide a total of three (3) references.***

(A) Head of Clinical Service at your current facility **OR** the person responsible for your training if you are presently in a Residency/Fellowship program			
Name of Reference:	Mailing Address:		
Title:	City:	State:	Zip:
Email:	Phone:	Fax:	
(B) List **two other peer references** below (preferably from facilities where you currently or most recently have practiced)			
Name of Reference:	Mailing Address:		
Title:	City:	State:	Zip:
Email:	Phone:	Fax:	
Name of Reference:	Mailing Address:		
Title:	City:	State:	Zip:
Email:	Phone:	Fax:	

ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." **IF YOUR ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES," PLEASE PROVIDE FULL DETAILS ON A SEPARATE SHEET.**

Professional Liability Insurance

☐ Yes	☐ No	Has any medical malpractice judgment been entered against you in any professional liability case(s)?
☐ Yes	☐ No	Has any settlement been made in any professional liability case in which you or your insurance carrier had to or agreed to make a monetary payment?
☐ Yes	☐ No	Are you aware of any malpractice claims currently pending/under investigation against you?
☐ Yes	☐ No	Has any policy been canceled, or has any professional liability insurer refused to renew your policy or placed limitations on the scope of your coverage?

The Medical Staff Bylaws states that, "Each Member of the Medical Staff shall report to the Medical Staff office the disposition (including settlement) and/or final judgment in professional liability cases in which they are involved within (30) days of disposition and/or final judgment."

Physical and Mental Health

☐ Yes	☐ No	Do you currently have, or have you ever had a problem associated with the use or misuse of drugs or controlled substances of any kind (whether obtained by prescription or otherwise), or alcohol? If yes, on a separate sheet please give a full explanation, including, without limitation, frequency and amount of use, the time period in which you engaged in such use, and the date last used.
☐ Yes	☐ No	Is there anything that might currently adversely affect your ability to exercise-or would require an accommodation for you to safely and competently exercise the clinical privileges requested? If yes, on a separate sheet please give a full explanation.

Disciplinary and/or Voluntary actions

*Voluntarily*** or involuntarily, have any of the following ever been, or are currently being, denied, revoked, suspended, relinquished, withdrawn, reduced, limited, placed on probation, or currently pending/under investigation?*

☐ Yes	☐ No	Medical/Psychology license in any state;
☐ Yes	☐ No	Other professional registration/license;
☐ Yes	☐ No	DEA Certificate of registration;
☐ Yes	☐ No	Academic appointment;
☐ Yes	☐ No	Membership on any hospital medical staff;
☐ Yes	☐ No	Clinical privileges, prerogatives/rights on any medical staff;
☐ Yes	☐ No	Board Certification;
☐ Yes	☐ No	Any other type of professional sanction;
☐ Yes	☐ No	Have you been subject to any disciplinary action in any health care organization or medical society, or is any such action pending;
☐ Yes	☐ No	Has any monitoring requirement been imposed;
☐ Yes	☐ No	Have you resigned or taken a leave of absence in order to avoid possible revocation, suspension, or reduction of privileges at any hospital or institution;
☐ Yes	☐ No	Have there been any, or are there any, misdemeanor or felony criminal convictions against you;
☐ Yes	☐ No	Have there been any, or are there any, misdemeanor or felony criminal charges pending against you;

*** *For the purposes of answering these questions, a "Voluntary" termination is considered a disciplinary action when the relinquishment is done to avoid an adverse action, preclude an investigation, or is done while the provider is under investigation related to professional conduct. You do not need to report resignations for reasons of relocation or change of activity.*

Compliance with Laws Related to Patient Care

☐ Yes	☐ No	Are there any pending or completed administrative agency, government, or court cases, decisions or judgments involving allegations that you 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	Are there any prior or pending government agency or third party payer 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?

Applicant Signature _____ **Date** _____

AUTHORIZATION, RELEASE, AND CONFIDENTIALITY STATEMENT

I FULLY UNDERSTAND THAT ANY SIGNIFICANT OMISSIONS, MIS-STATEMENTS OR MISREPRE-SENTATIONS IN THIS APPLICATION, OR DURING THE APPLICATION PROCESS, CONSTITUTE CAUSE FOR DENIAL OF THIS APPLICATION, OR FOR TERMINATION OR SUSPENSION OF MY MEMBERSHIP AND/OR CLINICAL PRIVILEGES AT STANFORD HOSPITAL AND CLINICS (SHC), AND/OR LUCILE PACKARD CHILDREN'S HOSPITAL (LPCH). I AFFIRM THAT THE INFORMATION SUBMITTED IN, OR APPENDED TO, THIS APPLICATION IS COMPLETE, CURRENT, AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND IS FURNISHED IN GOOD FAITH.

In making this application for appointment to SHC/LPCH, I acknowledge that I have received the pertinent Medical Staff Bylaws, Rules and Regulations and policies and procedures (herein "Bylaws"). Further, I agree to be bound by the terms thereof, and to uphold the Bylaws if I am granted membership, and/or clinical privileges. I further agree to be bound by the terms of the Bylaws without regard to whether or not I am granted membership and/or clinical privileges in all matters relating to the consideration of my application for appointment to SHC/LPCH. I further agree to comply with all applicable federal laws and laws of the State of California, as well as government regulations, in addition to specific department and/or service rules and regulations.

I signify my willingness to appear for interviews in regard to this application, and I authorize SHC/LPCH and its/their representatives to consult with representatives of other healthcare organizations with which I have been affiliated (*e.g.,* hospital medical staffs, medical groups, IPAs, HMOs, PPOs, other health delivery systems or entities), medical societies, professional associations, medical school faculties, 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, "other Healthcare Organizations"), and with others who may have information bearing on my competence, character, and ethical qualifications. I authorize and direct persons so consulted to provide such information to SHC/LPCH. I understand that letters of recommendation concerning me are to be written and maintained in confidence, and I waive any rights I might have to access to such letters unless otherwise required by law.

I agree to notify the Medical Staff Office of each Hospital (SHC and/or LPCH) to which I am applying in writing within five (5) days of receiving any written or oral notice of any adverse action by the Medical Board of California, whether taken or pending; any adverse action taken by any other Healthcare Organization which has resulted in the filing of an 805 Report with the Medical Board of California or a report with the National Practitioner Data Bank; any revocation of DEA certificate or pending action; any new restrictions and/or any pending actions on my membership and/or clinical privileges with any other Healthcare Organizations; a conviction of any felony or a misdemeanor of moral turpitude; any action or pending action against any certification under the Medicare or Medicaid programs; or any cancellation, non-renewal or material reduction in my professional liability insurance coverage.

I hereby further consent to the disclosure, inspection and copying of information in my Credentials file by and between SHC/LPCH and its/their representatives, and other Healthcare Organizations and its/their representatives, or other persons or entities who, in the opinion of the SHC/LPCH and its/their representatives, have a legitimate need for such information. I authorize and consent to the release by and between SHC/LPCH and other Healthcare Organizations and their representatives, all records and documents, including medical records, that may be material to an evaluation of my professional qualifications and competence for membership and/or clinical privileges herein requested, as well as my physical and mental health, and moral and ethical qualifications for membership and/or clinical privileges. I also consent to the sharing of credentialing, quality assessment and peer review between Stanford Hospital & Clinics and Lucile Packard Children's Hospital, to which I hereby apply, or where I already hold membership and/or clinical privileges. I understand that this may include sharing information received by any of them during this application process and during any corrective action procedures, including formal disciplinary hearings. I hereby release from liability Stanford Hospital & Clinics and Lucile Packard Children's Hospital, and other Healthcare Organizations, and their officers, directors, employees, liaisons, agents and representatives, including medical staff members, for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and other Healthcare Organizations who provide information to, or share information with, SHC/LPCH, in good faith and without malice, concerning my professional competence, ethics, character and other qualifications for membership and/or clinical privileges.

I understand and agree that I, as an applicant for membership and/or clinical privileges, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. By my signature below, I acknowledge and agree that I will promptly and fully report all information to the Medical Staff Office of each Hospital (SHC and/or LPCH) to which I am applying in the event any of the answers above change, or if any situation arises which affects my ability to treat patients, after I have signed and dated this form,

while my application is pending, and, if I am granted membership and/or clinical privileges, while I maintain membership and/or clinical privileges.

I am familiar with the principles and standards of the Joint Commission on Accreditation of Healthcare Organizations, and/or the National Committee for Quality Assurance, that apply to me. In accordance with them and the Bylaws of SHC/LPCH , I promise to provide patients with continuous care that meets the professional standards established by SHC/LPCH. I pledge to adhere to the ethical standards of my profession. In addition, I specifically pledge to refrain from fee splitting and from providing ghost surgical or medical services. I agree to respect and maintain the confidentiality of all discussions and records generated in connection with peer review and quality assurance activities conducted by the committees of SHC/LPCH involved in the evaluation and improvement of the quality of patient care. I agree to make no voluntary disclosure of such information except within committees on which I serve, in furtherance of committee business or otherwise as authorized by the Committee Chair or Chief of Staff. I understand that SHC/LPCH is/are entitled to undertake such action as is deemed appropriate to ensure that this confidentiality is maintained, including application to a court for relief. I further understand that violation by me of this agreement could subject me to corrective action, up to and including summary suspension and/or termination of Staff membership.

I agree that my password and/or electronic signature used to access SHC and/or LPCH computers shall be used only by me and that I will not disclose my password to any other individual (except to authorized security staff of the computer system). The use of a member's passwords is equivalent to the electronic signature of the member. The member shall not permit any physician, resident, or other person to use his/her passwords to access SHC or LPCH computers or computerized medical information. In addition, if I use a rubber stamp, I shall be the only person to carry and use that stamp. Any misuse may, in addition to any sanctions approved by the Stanford Hospital and Clinics Board of Directors and the Lucile Packard Children's Hospital Board of Directors regarding security measures, be a violation of State and federal law and may result in denial of payment under Medicare and Medi-Cal.

I hereby acknowledge that I am allowed access to my credentials/peer review file and that I may have copies of any documents which I submitted or which were addressed to me. In addition, I may have access to further information not submitted by me following written request by myself, and upon the approval of the Medical Board and either the Board of Directors or its designated representative. I have the right to correct erroneous information obtained throughout the credentialing process to ensure an accurate evaluation on my behalf.

Medicare Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by 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 laws.

Consent to Release Information to Contractors for Health Services and Contracted Health Plans

I hereby consent to SHC/LPCH providing access to insurers or other contractors for health services the information concerning me specified below:

1. The information contained in my application for membership and/or clinical privileges to SHC and/or LPCH;
2. The information in my credential file relating to my Medical Board of California verification;
3. The information in my credential file relating to my DEA Certification;
4. The information in my credential file of my California Professional License; and
5. The information in my credential file of my letters of recommendation submitted with my application for membership and/or and/or clinical privileges to SHC and/or LPCH.

By my signature below, I acknowledge that I have read and agree to be bound by all of the above information, including the Medicare Notice:

Print Name Here: _____

Signature: _____ **Date:**_____

(Stamped Signature is NOT Acceptable)

PROFESSIONAL LIABILITY QUESTIONNAIRE
AND AUTHORIZATION FOR RELEASE OF
INSURANCE COVERAGE AND CLAIMS HISTORY INFORMATION
(Requirements for all sites: $1 Million/3 Million)

Will you be covered by:
☐ Stanford Hospital and Clinics insurance risk pool

CURRENT PROFESSIONAL LIABILITY INSURANCE CARRIER ***(if not through Stanford Risk Management)***				
Insurance Carrier:		Policy #:		
Mailing Address:	City:	State:	ZIP:	Telephone:
Per claim amount: $	Aggregate amount: $	Expiration Date:		

Does your professional liability insurance extend to all procedures you have requested? ☐Yes ☐No Exclusions:
Does your insurance cover your practice at SHC and/or LPCH? ☐Yes ☐No

Please list all of your professional liability carriers for the past five years:			
Name of Carrier:	Mailing Address:	From: (mm/yy)	To: (mm/yy)
Policy #:	City, State Zip:	Phone:	Fax:
Name of Carrier:	Mailing Address:	From: (mm/yy)	To: (mm/yy)
Policy #:	City, State Zip:	Phone:	Fax:

Professional Liability Action Information

Please complete this form (or provide a one page statement) for each pending or settled professional liability action filed and served, or any payment made on behalf of you, the practitioner applicant. All questions must be answered completely. Please provide a separate sheet for each malpractice action. If additional sheets are required, photocopy this page prior to completing.

CLAIM STATUS

☐ **No Known Claims**
☐ **OPEN** If open, amount being sought:
☐ **CLOSED** If closed, indicate method of closing: ☐ Settlement ☐ Judgment Date:
Amount of settlement or judgment: $

Date of Alleged Incident:		Date Suit Filed:	
Patient Name:	Sex:	Age:	Location of Incident:
Your role in the Patient's care:			
Allegation:			
Liability Carrier when Incident Occurred:			
Additional Named Defendant(s):			

On a separate sheet, summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include (1) condition of patient and diagnosis at the time of incident; (2) dates and description of treatment rendered; and (3) condition of patient subsequent to treatment. Please print or type.

Occupational Health Services
Main Office: 650.723.5922
Redwood City Office: 650.721.7316

Per Title 22, OSHA, and the CDC recommendations for Health Care Personnel you will need to complete the following in order to be medically cleared by Occupational Health Services (OHS). We will not be able to complete your application process until this information is received and you have been cleared by OHS at Stanford Hospitals and Clinics/Lucile Packard Children's Hospital.

Please complete the following form, including supporting documentation, and return them with your application packet. You may complete any outstanding items at OHS on a walk-in basis or you may schedule an appointment by contacting Debbie Taormina at dtaormina@stanfordmed.org. The office is located in the basement at Stanford Hospital (take escalator by Gift Shop down to the basement floor and follow signs to OHS). Office hours are Monday and Wednesday: 7:00am to 3:30pm, Tuesday and Thursday: 7:00am to 6:00pm, and Friday: 7:00am to 2:30pm.

TITERS:

COMPLETED	NOT COMPLETED	
☐	☐	Hepatitis B Surface Antibody
☐	☐	Measles/Rubeola or proof of 2 MMR's or measles vaccinations (if born/vaccinated between 1963-1967 you will need proof of two doses from 1968 on)
☐	☐	Mumps or proof of 2 MMR's or mumps vaccinations
☐	☐	Rubella or proof of MMR or rubella vaccinations
☐	☐	Varicella or proof of 2 vaccines on or after your 1st birthday - **(History of disease is not sufficient proof of immunity)**

TB TESTING:

COMPLETED	NOT COMPLETED	N/A	
☐	☐		Questionnaire/symptom review
☐	☐	☐	QuantiFeron done within the last three months or Tuberculin Skin Testing (TST) done within the last three months along with prior documentation of another TST done within 365 days
☐	☐	☐	Chest X-Ray done within the last year if TST positive

VACCINES:

COMPLETED	NOT COMPLETED	N/A	
☐	☐	☐	Hepatitis B (unless you have provided a positive Hep. B Antibody titer)
☐	☐	☐	Influenza (annual)
☐	☐		TdaP or Declination

FIT TESTING:

COMPLETED	NOT COMPLETED	N/A	
☐	☐	☐	N95 Fit Test - Needed only if seeing inpatients

Name _____ Specialty _____

Phone _____ E-mail _____

Signature _____ Date _____

Cleared for Medical Staff membership and privileges: ☐ Yes ☐ No

_____ Occupational Health Services Representative

_____ Date

PreCheck
Investigate further.

800.999.9861
713.861.5959
info@PreCheck.com
www.PreCheck.com

Instructions for Completing PreCheck's Release Form

Filling out PreCheck's release form is easy and we offer you a variety of ways to do so. You may opt to fill out PreCheck's online release, via instructions below, **or** you can disregard the online release and just complete and sign the attached form and return that you your prospective employer.

Submitting an Online Release

Note: Supported browsers are Internet Explorer, Google Chrome, FireFox and Safari. Mobile users are not currently supported at this time. Adobe Flash Player 9.0+ is also required.

1. Go to **https://weborder.precheck.net/Release/release1.aspx** and enter the 4-digit code **7989.**

2. Fill out the entire form, entering as much information as possible.

3. Provide your signature on page 6 of the release form, by using your computer mouse to sign your name.

4. If you make a mistake while signing your name and would like to sign again before submitting, click on the  icon to erase and start over.

5. Once you are satisfied with your signature, mark the box below that confirms that you have read and understood the Terms of Service.

6. Finally, click 

to finish and submit the release.

Tips for optimum use of the online release:

- Use a supported browser, as listed above
- Install Adobe Flash Player, if needed: **http://get.adobe.com/flashplayer/**
- Complete each page/form in less than 30 minutes to avoid session timeout
- If you wish to view a copy of your release form, you will need Adobe Reader. You can obtain it here, if needed: **http://get.adobe.com/reader/**

☐ **Please check this box if you have completed the online release form. By doing so, you will not need to complete the attached paper version.**

PreCheck
Investigate further.

800.999.9861
713.861.5959
info@precheck.com
www.PreCheck.com

STANFORD HOSPITAL & CLINIC / LUCILE PACKARD CHILDREN'S HOSPITAL - #7989

APPLICANT'S FULL NAME: _____

Any Other Names Used _____

Social Security No. _____ Date of Birth[1] _____

Current Address _____

City _____ State _____ Zip _____

Driver's License State _____ No. _____

Address: _____

Have you ever been convicted of a crime? Yes ☐ No ☐

Offense _____ County _____ State _____ When _____

Please provide all locations where you have resided or practiced for the past ten (10) years, starting with your current residency.

	City	State	Dates From:	To:
1.	_____	_____	_____	
2.	_____	_____	_____	
3.	_____	_____	_____	
4.	_____	_____	_____	
5.	_____	_____	_____	
6.	_____	_____	_____	
7.	_____	_____	_____	
8.	_____	_____	_____	

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Stanford Hospitals and Clinics and/or Lucile Packard Children's Hospital ("the Company") may obtain information about you from a consumer reporting agency made in connection with your application for employment, contract or privileges. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews. These reports may contain information regarding your criminal history, social security verification, verification of your employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888)PreCheck [1-888-773-2432] or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment, contract, privileges or appointment to the extent permitted by law.

[1] The Age Discrimination in Employment Act of 1987 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is necessary for the proper processing of a consumer report.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout term of my employment, contract or privileges, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888) PreCheck [1-888-773-2432] another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

STATE LAW NOTICES

Minnesota or **Oklahoma** applicants or employees only: Please mark an X in the designated field if you would like to receive a free copy of a consumer report if one is obtained by the Company. The report will be mailed to the current address you indicated on this form. ☐

California applicants or employees only: Please mark the following field if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. The report will be mailed to the current address indicated above. ☐

California applicants or employees only: By marking an X in the designated field, you will receive and are acknowledging receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. ☐

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Client by directly contacting PreCheck Inc. Additionally, please mark this field to receive and acknowledge receipt of a copy of Article 23-A of New York Correction Law. ☐

Maine applicants or employees only: Under Chapter 210 Section 1314 of Maine Revised Statutes, you have the right, upon request, to be informed within 5 business days of such request of whether or not an investigative consumer report was requested. If such report was obtained, you may contact the Consumer Reporting Agency and request a copy.

Massachusetts applicants or employees only: If you ask, you have the right to a copy of any background check report concerning you that the Company has ordered. You may contact the Consumer Reporting Agency for a Copy.

Washington State applicants or employees only: You have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from the Company a complete and accurate disclosure of the nature and scope of the investigation we requested. You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

I have read and understand the above information and assert that all information provided by me is true and accurate.

Signature _____ **Date** _____

Appendix D

PHYSICIAN ACKNOWLEDGEMENT STATEMENT

Notice to Physicians:

Medicare payment to hospitals is based on each patient's Principal and Secondary Diagnosis 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 Laws.

_____

Physician Signature

_____ _____

Physician Name Date

Stanford Hospital and Clinics
Lucile Packard Children's Hospital

CONFIDENTIALITY, CONFLICT OF INTEREST AND CODE OF CONDUCT

Biennial Statement Of Compliance
For Medical Staff Members

Confidentiality

As a member of the Medical Staff at Stanford Hospital and Clinics (SHC) and/or Lucile Packard Children's Hospital (LPCH), I am involved in the evaluation and improvement of the quality of care rendered at SHC and/or (LPCH). I recognize that confidentiality is vital to the free and candid discussions necessary for effective Medical Staff peer review activities. Therefore, I agree to respect and maintain the confidentiality of all discussions, deliberations, records, and other information generated in connection with these activities, and to make no voluntary disclosures of such information except to persons authorized to receive it in the conduct of Medical Staff affairs.

Furthermore, my participation in peer review and quality improvement activities is in reliance on my belief that the confidentiality of these activities will be similarly preserved by every other member of the Medical Staff, every member of Medical Staff Committees, or any other individuals involved.

I understand that Stanford Hospital and Clinics and/or Lucile Packard Children's Hospital and the Medical Staff(s) are entitled to undertake such action as is deemed appropriate to ensure that this confidentiality is maintained, including application to a court for injunctive or other relief in the event of a threatened breach of this agreement.

This agreement and obligation of strictest confidence shall survive the term of my medical staff membership, any type of involvement with Medical Staff Committees, or any medical staff leadership responsibilities.

Conflict of Interest

I have reviewed the Conflict of Interest Policy for the Medical Staff of Stanford Hospital and Clinics and Lucile Packard Children's Hospital. To the best of my knowledge, I have complied with the Policy during the past twelve months, and I will use my best efforts to comply with the Policy on an on-going basis. If I identify a potential or real Conflict of Interest, I will comply with the Conflict of Interest Policy for the Medical Staff of Stanford Hospital and Clinics and Lucile Packard Children's Hospital.

Code Of Conduct

I have reviewed the Code of Conduct for the Medical Staff of Stanford Hospital and Clinics and Lucile Packard Children's Hospital located at SHC: http://stanfordhospital.org/overview/conduct.html or LPCH: http://www.lpch.org/utility/code-conduct.html.

****I have read, understand, and agree to abide by the above statements.****

Signature: _____

Print Name: _____

Date: _____

Medical Staff Code of Professional Behavior

Professional behavior, ethics and integrity are expected of each individual member of the Medical Staff at Stanford Hospital and Clinics (SHC) and Lucile Packard Children's Hospital (LPCH). This Code is a statement of the ideals and guidelines for professional and personal behavior of the Medical Staff in all dealings with patients, their families, other health professionals, employees, students, vendors, government agencies, society and among themselves, in order to promote the highest quality of patient care, trust, integrity and honesty.

Each Medical Staff member has a responsibility for the welfare, well-being, and betterment of the patient being served. In addition, the Medical Staff member has a responsibility to maintain his/her own professional and personal well-being, in addition to maintaining a reputation for truth and honesty.

Guidelines for Interpersonal Relationships

- Treat all medical staff, hospital staff, housestaff or students, and patients with courtesy and respect
- Do not treat patients while impaired by alcohol, drugs, or illness. The patient would be placed at risk
- Support and follow hospital policies and procedures; address dissatisfaction with policies through appropriate channels
- Use conflict management skills and direct verbal communication in managing disagreements with associates and staff
- Cooperate and communicate with other providers displaying regard for their dignity
- Be truthful at all times
- Wear attire that reflects your professional role and respects your patients
- Develop and institute a plan to manage your stress and promote your personal well being
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- You will not engage in the following behaviors:
  - Belittling or berating statements
  - Name Calling
  - Inappropriate Comments written in Medical Records
  - Blatant failure to respond to patient care needs or staff requests
  - Sexual harassment or making sexual innuendoes
  - Using abusive, threatening or disrespectful language including profanity or repetitive sarcasm or cynicism
  - Physical contact with another individual that is threatening or intimidating
  - Throwing instruments, chart or other things
  - Lack of cooperation without good cause
  - Refusal to return phone calls, pages or other messages concerning patient care
  - Inappropriate comments or behaviors at meetings
  - Making threats of violence, retribution, litigation, or financial harm
  - Making racial or ethnic slurs
  - Actions that are reasonably felt by others to represent intimidation
  - Using foul language, shouting, or rudeness
  - Condescending language, and degrading or demeaning comments regarding patients and their families; nurses, physicians, hospital personnel and/or the hospital.
  - Criticizing medical staff, hospital staff, housestaff, or students in front of others while in the workplace or in front of patients
  - Shaming others for negative outcomes
  - Physically or verbally slandering or threatening other physicians or health care professionals
  - Romantic and/or sexual relationships with your current or former patients. This extends to key third parties such as spouses, children or parents of patients
  - Revealing confidential patient or staff information to anyone not authorized to receive it
  -

Guidelines for Clinical Practice

- Respond promptly and professionally when called upon by fellow practitioners to provide appropriate consultation or clinical service
- Respond to patient and staff requests promptly and appropriately
- Respect patient confidentiality and privacy at all times; follow all regulations for release of information
- Treat patient families with respect and consideration while following all applicable laws regarding such relationships (release of information, advance directives, etc.)
- Seek and obtain appropriate consultation
- Arrange for appropriate coverage when not available

- Do one's best to provide the best effective and efficient care
- Prepare and maintain medical records within established time frames
- Disclose potential conflicts of interest and resolve the conflict in the best interest of the patient
- When terminating or transferring care of a patient to another physician, provide prompt, pertinent, and appropriate medical documentation to assure continuation of care
- For faculty, housestaff and medical students, refrain from accepting money, gifts, or personal benefits from commercial healthcare companies
- For non-faculty medical staff, refrain from accepting money, gifts, or personal benefits from commercial healthcare companies when on-site at the SoM, SHC or LPCH, or affiliated hospital

Guidelines for Relationship with Hospital and Community

- Abide by all rules, regulations, policies and bylaws of the SHC and LPCH
- Serve on Hospital and medical staff committees
- Assist in the identification of colleagues who may be professionally impaired or disruptive
- Maintain professional skills and knowledge and participate in continuing medical education
- Refrain from fraudulent scientific practices
- Accurately present data derived from research
- Follow and obey the law of the land and refrain from unlawful activity at all times
- Cooperate with legal professionals, including Hospital legal counsel, unless such cooperation is prohibited by law
- Participate in clinical outcome reviews, quality assurance procedures, and quality improvement programs
- Hold in the strictest confidence all information pertaining to peer review, quality assurance, and quality improvement
- Protect from loss or theft, and not share, log-ins and passwords to any hospital system that contains patient identifiable information or other confidential hospital information

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Complied from: The Disruptive Physician, Peter Moskowitz, M.D.
American Academy of Physical Medicine & Rehabilitation Code of Conduct
SHC/LPCH Policy on Code of Conduct and Principles of Compliance

STANFORD HOSPITAL & CLINICS
LUCILE PACKARD CHILDREN'S HOSPITAL

Medical Staff Code of Professional Behavior
Acknowledgement of Receipt

Each Medical Staff member has a responsibility for the welfare, well-being, and betterment of the patient being served. In addition, the Medical Staff member has a responsibility to maintain his/her own professional and personal well-being, in addition to maintaining a reputation for truth and honesty.

As a member of the Medical Staff at Stanford Hospital and Clinics and/or Lucile Packard children's Hospital, I have received and reviewed the *Medical Staff Code of Professional Behavior* for the Medical Staff of Stanford Hospital and Clinics and Lucile Packard Children's Hospital. To the best of my knowledge, I have complied with the Medical Staff Code of Professional Behavior, and I will use my best efforts to comply with the Code on an on-going basis.

I have read, understand, and agree to abide by this Policy

Signature:_____

Print Name:_____

Date:_____

Please sign, date and return this acknowledgement page along your application packet.

***** KEEP FOR REFERENCE *****

CALIFORNIA PATIENT ABUSE AND NEGLECT REPORTING REQUIREMENTS SUMMARY

For immediate questions contact Social Work (SHC 723-5091, LPCH 497-8303) or Risk Management 723-6824

For reporting phone numbers or forms, see "reporting" sections of: **http://domesticabuse.stanford.edu** **http://elderabuse.stanford.edu** **http://childabuse.stanford.edu** **These websites also contain important information on how to ask, what to look for, educational resources, upcoming events and conferences, and patient materials.**	**For general questions or to schedule free individual or group training/education:** **domesticabuse@med.stanford.edu** **elderabuse@med.stanford.edu** **childabuse@med.stanford.edu**

	ADULTS	ELDERS/DEPENDENT ADULTS	CHILDREN
Health Practitioner Mandated Reporters	**All medical health practitioners except in the fields of psychiatry or pediatrics**	**All health practitioners**	**All health practitioners**
What is reportable? **Knowledge or reasonable suspicion of:**	**- wound or physical injury from domestic violence or sexual assault** **- any injury from firearm or deadly weapon**	**- physical harm or pain, including inappropriate chemical/physical restraints or withholding meds** **- sexual abuse** **- neglect, including self neglect** **- abandonment, abduction, isolation** **- financial abuse**	**- non-accidental physical injury** **- sexual abuse** **- neglect** **- unlawful corporal punishment** **- willful cruelty or unjustifiable punishment** **- abuse or neglect in out of home care**
Where to report	**Police Dept. (PD) in city where incident occurred**	**- Outside of a nursing home – PD or Adult Protective Services (APS) in county of residence** **- Inside nursing home care – PD or Ombudsman in county of nursing home**	**PD in city where incident occurred, or Child Protective Services (CPS) in county of residence**
How to report	**Call ASAP and send report within 2 working days**	**Call ASAP and send report within 2 working days**	**Call ASAP and send report within 36 hours**
State reporting form	**CalEMA 2-920 plus optional forensic form CalEMA 2-502**	**SOC 341 plus optional forensic form CalEMA 2-602**	**SS 8572 plus optional forensic form CalEMA 2-900**

<u>Acute sexual assault</u>

- **DO NOT TOUCH GENITAL, ORAL, OR OTHER ASSAULTED AREAS**
- **contact police who can authorize a forensic examination through the county SART (Sexual Assault Response Team) program at Valley Medical Center**
- **competent patients over the age of 12 can refuse this examination**

SUSPICIOUS HISTORY, BEHAVIORS, PHYSICAL FINDINGS

History
- Delay in seeking care for an injury
- Injury inconsistent with history
- Injury inconsistent with patient developmental stage or physical abilities
- History vague or keeps changing
- A part-time caregiver was present at the time of the incident
- Patient has multiple visits for injuries, vague complaints, chronic pain syndromes, depression or anxiety symptoms
- Pregnancy – late or no prenatal care
- Sudden change in behavior
- Suicide attempt or gesture
- Patient or caregiver keeps changing physicians
- Patient reports items or money stolen, being made to sign documents
- Frequent cancelled appointments or no-shows

Condition
- Poor hygiene
- Clothing in disrepair or inappropriate for weather
- Torn, stained or bloody undergarments
- Patient appliances (glasses, hearing aid) broken or missing
- Poor growth parameters in children
- Dehydration or malnutrition
- Prior injury not properly cared for; lack of compliance with appointments, meds, or treatment regimens

Patient behavior
- Seems afraid to speak in front of partner/caregiver
- Embarrassed, evasive
- Highly anxious, inappropriate emotional responses
- Withdrawn, uncommunicative, staring, rocking, sucking, biting
- Listless, passive, flat or blunted affect, overly compliant
- Angry, disruptive, agitated
- Exaggerated startle response
- Withdraws quickly to physical contact
- Difficulty walking or sitting

Partner/caregiver behavior
- Overly attentive, doesn't want to leave patient alone
- Speaks for patient
- Anger or indifference towards patient
- Intimidating to staff
- Refuses consent for reasonable further evaluation or treatment

Soft tissue injuries (bruises, lacerations, burns, bites, scratches, punctures) to:
- Head and neck, orbit
- Lips/oral cavity/frenulum
- Forearms – defensive injuries
- Trunk, breasts, buttocks
- Restraint marks on wrists, axilla, ankles, corner of lips
- Genital/rectal area
- Any pressure ulcers or contractures

Bruises
- Multiple areas, different stages of healing
- Pattern reflecting article used (hand, fingermarks, belt, looped cord)
- "Battle sign" – bruising behind ear due to gravity and hidden scalp injury

Burns
- Shape of hot object (iron, curling iron)
- Cigarette – usually multiple, 8-10 mm dia. with indurated margin
- Caustic substance
- Friction (rope, or dragging)
- Immersion - straight demarcation line without splash marks
- Taser – paired round erythematous lesions 5 cm apart

Fractures
- Any fracture in a child under age 1
- Multiple old fractures in different stages of healing
- Dislocations or fractures of extremities or face

"Choking" (50% no immediate physical signs, but patient may have sx)
- Ligature or fingermarks on neck, scratches from patient trying to remove
- Petechiae above markings, subconjunctival hemorrhage
- Patient hoarseness, dysphagia, dyspnea, nausea, ringing in ears
- Unexpected stroke in relatively young patient

Occult injuries
- Head trauma – lethargy, irritability, vomiting, convulsions
- Blunt abdominal trauma – vomiting, pain, tenderness, hematuria, shock
- Ingestion of toxic substance (purposefully or through neglect)

Lab
- Evidence of over- or under-dosing medications
- Unexpected STDs or pregnancy
- Parameters of dehydration or malnutrition

HEALTH PRACTITIONER NOTIFICATION OF CALIFORNIA STATE ABUSE AND NEGLECT REPORTING REQUIREMENTS

Abuse and neglect can significantly impact the health and wellbeing of patients. In our county of Santa Clara alone, there are 20,000 reports of child abuse a year, and 5 reports of elder abuse a day.

California State law requires health practitioners to report knowledge or reasonable suspicion of specific harm to:

- Adults (age 18-64)
- Elders (age 65+)
- Dependent Adults (age 18-64 with physical or mental limitations that restrict their ability to carry out normal activities or to protect their rights)
- Children (under age 18)

I understand that:

Initial

_____ California state abuse and neglect reporting laws may differ from other states where I have trained or practiced.

_____ Stanford University Medical Center has Abuse Policies and Procedures regarding abuse reporting available on both SHC and LPCH intranet websites.

_____ I have received a copy of "California Patient Abuse and Neglect Reporting Requirements Summary".

_____ There is no criminal liability for reporting suspected abuse. However, there are criminal (jail, fines) and possibly civil penalties to me for failure to report.

_____ Should there be uncertainty as to whether or not to report, I can consult with Risk Management and Social Services. I will ensure that a report occurs for all cases in which reasonable suspicion or actual knowledge exists.

_____ The Reporting Requirements Summary sheet contains resource phone numbers and websites if I have questions or desire further education on this topic.

Date: _____

Signature: _____

Print name: _____

STANFORD
HOSPITAL & CLINICS
Stanford University Medical Center

300 Pasteur Drive, MC 5288
Stanford, CA 94305
Ph. 650.723.7857
Fx. 650.725.0297

INVOICE

Date:

Application Fee: **$300.00 (for each facility)** for the following physician

Physician: _____

Purpose: Fee for processing applications for Medical Staff Membership at

- **Stanford Hospital and Clinics**
- **Lucile Packard Children's Hospital**

Check payable to: Stanford Hospital and Clinics Medical Staff Office

Please remit to: *Stanford Hospital and Clinics*
Medical Staff Services
300 Pasteur Drive, MC 5288
Stanford, CA 94305

TO ENSURE PROPER CREDIT:
INCLUDE APPLICANT'S NAME ON FACE OF CHECK
MAIL DIRECTLY TO THE MEDICAL STAFF OFFICE

*****FOR DEPARTMENTS PAYING VIA JOURNAL TRANSFER, PLEASE REFER TO THE WEBSITE UNDER "APPLICATION FEES" SECTION *****

THE MEDICAL STAFF OFFICE REQUIRES CONFIRMATION FOR ALL NEW APPLICANT FEES. CONFIRMATION OF PAYMENT WILL ENSURE THE PROCESS OF A NEW APPOINTMENT APPLICATION.

If you may have any questions, please call (650) 723-7857.

Thank You,

Medical Staff Services
Stanford Hospital and Clinics