600 N. Highland Springs Ave
Banning, CA 92220
Tel. (951) 769-2155

Dear Doctor:

Thank you for your interest in applying for membership to the Medical Staff at San Gorgonio Memorial Hospital. Enclosed please find an Application, Liability Addendum and Privilege Delineation Request form. Please complete and sign all documents as indicated. The following check list is for your convenience to ensure your application is complete before submitting it for processing:

1. Enclose a picture identification card, preferably a state driver's license. **Mandatory**

2. A complete summary of your education, including dates of attendance at schools and institutions. **Account for all periods of time since graduating from medical school.**

3. A current copy of your California License to practice, current DEA certificate, current X-ray/Fluoroscopy license (if applicable), ACLS (if performing Moderate Sedation or applying for Emergency Medicine privileges) and ECFMG certificate (if applicable).

4. Evidence of current continuing medical education. (Please include **copies of certificates of completion** and/or CMA verification records).

5. A current copy of your professional liability insurance certificate, along with a detailed description of all legal actions of alleged medical malpractice pending or settled against you in the sixty (60) month period preceding the date of application.

6. A completed delineation of privileges list.

7. Copy of the Board Certificate issued to you. If not Board Certified, you must provide evidence that you satisfactorily completed an approved residency program in your specialty.

8. **Filing fee of $500.00 ($575.00 if expedited).** Check should be made payable to the San Gorgonio Memorial Hospital Medical Staff.

9. Please do not leave any blanks on any of the documents forwarded. If it is not applicable, please indicate by putting N/A.

The Medical Staff categories are divided into Active, Courtesy, Consulting, Associate, Honorary or Retired, Telemedicine, and Provisional categories. All members of the Active Staff and Provisional Staff members, who are pending active appointment, are required to take Emergency Room calls.

ACTIVE STAFF - Must regularly admit or are otherwise involved in the care of at least twenty (20) patients per year in this hospital, except that this requirement shall not apply to physicians, dentists and podiatrists who serve the hospital in a medico-administrative capacity;

COURTESY MEDICAL STAFF - Must have satisfactorily completed proctoring requirements (proctoring may be obtained from primary hospital) and has been a member in good standing (Provisional status) for at least one year; have not had more than twenty (20) patient contacts, defined as admissions and consultations, at the Hospital within the past twelve (12) months.

CONSULTING STAFF - Must have satisfactorily completed proctoring requirements (proctoring may be obtained from primary hospital) and has been a member in good standing (Provisional status) for at least one year; is a member of the active medical staff of another hospital licensed by California, or any other state, although exceptions to this requirement may be made by the Medical Executive Committee for good cause; and is willing and able to come to the hospital on schedule or promptly respond when called to render clinical services within their area of competence.

ASSOCIATE STAFF - Must provide staff coverage for patients requiring emergency medical services.

TELEMEDICINE AFFILIATE - The Telemedicine Staff shall consist of Practitioners who are not otherwise members of the Medical Staff but who participate in telemedicine interactions involving Hospital patients.

PROVISIONAL STATUS - All initial appointments to any category (except Honorary, Retired or Telemedicine) of the Medical Staff shall remain provisional for a minimum period of six months.

The responsibilities and prerogatives of each Medical Staff category are outlined below:

		Active Staff	Courtesy Staff	Consulting Staff	Associate Staff	Honorary/ Retired Staff	Telemedicine Affil.	Provisional Staff
PREROGATIYES	May Admit Patients	YES[1]	YES[1]	NO[2]	NO	NO	NO	YES
	Clinical Privileges	YES	YES	YES	YES	NO	YES[3]	YES
	Vote	YES	NO	NO	YES	NO	NO	NO
	Hold Office	YES	NO	NO	YES	NO	NO	NO
	Serve as Committee Chair	YES	NO	NO	YES	NO	NO	NO
	Serve on Committee	YES	YES	YES	YES	YES	YES	YES

RESPONSIBILITIES	Medical Staff Functions	YES	YES	YES	YES	NO	YES	YES
	Attend Meetings	YES	YES	YES	YES	NO	YES	YES
	Pay Dues	YES	YES	NO	YES	NO	YES	YES
	Pay Application Fees	YES	YES	YES	YES	NO	YES	YES
	ER Call	YES	NO	NO	NO	NO	NO	YES[4]
OTHER RQMTS	Must first complete Provisional	YES	YES	YES	YES	NO	NO	N/A
	Malpractice Insurance	YES	YES	YES	YES	NO	YES	YES

We would like to schedule a date and time for you to receive Physician Orientation as soon as possible. To do so, please contact me at (951) 769-2155 or by e-mail: Afrazier@sgmh.org.

Should you have any questions regarding the credentialing process, please feel free to contact me at (951) 769-2155.

Sincerely,

Amelia Frazier

Amelia Frazier, MHA, CPMSM
Director, Medical Staff Services

California Participating Physician Application

This application is submitted to: **SAN GORGONIO MEMORIAL HOSPITAL,** herein, this Healthcare Organization[1]

I. INSTRUCTIONS:

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. **Current copies of the following documents must be submitted with this application:**

- State Medical License(s)
- DEA Certificate
- Board Certification (if applicable)
- Face Sheet of Professional Liability Policy or Certification
- Curriculum Vitae
- ECFMG (if applicable)

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known? Name (s):		
Home Mailing Address:	City:	
	State:	ZIP:
Home Telephone Number: ( ) Home Fax Number: ( )	E-Mail Address: Pager Number: ( )	
Birth Date: Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include copy of Alien Registration Card).	
Social Security #:	Gender[2]: ☐ Male ☐ Female	
Specialty: Subspecialties:	Race/Ethnicity[2] (voluntary):	
Other Languages:		
Staff Status Desired: ☐ Active ☐ Consulting ☐ Courtesy ☐ Associate ☐ Telemedicine		

III. PRACTICE INFORMATION

Practice Name (if applicable):	Department Name (If Hospital Based):	
Primary Office Street Address:	City:	
	State:	ZIP:
Telephone Number: ( )	Fax Number: ( )	
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	

[1] As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

[2] This information will be used for consumer information purposes only.

Secondary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Tertiary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
NPI Number:		
Other Medical Interests in Practice, Research, etc.:		

IV. PREMEDICAL EDUCATION (Attach additional sheets if necessary. Reference This Section Number and Title)

College or University Name:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State:	ZIP:

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

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

POSTGRADUATE TRAINING AND EXPERIENCE

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

Institution:	Program Director:	
Mailing Address:	City:	
	State & Country:	ZIP:
Type of Internship :		

Specialty:	From: (mm/yy)	To: (mm/yy

Physician Name:

VII. RESIDENCIES/FELLOWSHIPS (Attach additional sheets if necessary. Reference This Section Number and Title)

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education in chronological order, giving name, address, city and ZIP code, and dates. Include **all** programs you attended, whether or not completed.

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

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

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)

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

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)

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

VIII. BOARD CERTIFICATION

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

- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with equivalent requirements approved by the Medical Board of California
- a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty

Name of Issuing Board:	Specialty:	Date Certified/Recertified:	Expiration Date (if any):

Have you applied for board certification other than those indicated above? ☐ Yes ☐ No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for certification on separate sheet.

IX. OTHER CERTIFICATIONS (E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.)
(Attach additional sheets if necessary. Reference This Section Number and Title)

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

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

California State Medical License Number:	Issue Date:	Expiration Date:
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Date Issued: Valid Through:
Medicare UPIN/National Physician Identifier (NPI):		MediCal/Medicaid Number:

XI. ALL OTHER STATE MEDICAL LICENSES. List All Medical Licenses Now or Previously Held.
(Attach additional sheets if necessary. Reference This Section Number and Title)

State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:

XII. PROFESSIONAL LIABILITY (Remember to attach copy of professional liability policy or certification face sheet)

Current Insurance Carrier:	Policy Number:	Original effective date:	
Mailing Address:		City:	
		State:	ZIP:
Per Claim Amount $	Aggregate Amount: $	Expiration Date:	

Please explain any surcharges to your professional liability coverage on a separate sheet. Reference This Section Number and Title.

Please list all of your professional liability carriers within the past seven years, other than the one listed above:

Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:

Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:

XIII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in reverse chronological order (with the current affiliation{s} first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B) during the past ten years. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

A. CURRENT AFFILIATIONS (Attach additional sheets if necessary. Reference This Section Number and Title)

Name and Mailing Address of Primary Admitting Hospital:	City:	
	State:	ZIP:
Department/Status (active, provisional, courtesy, etc.):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status:	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status:	Appointment Date:	

If you do not have hospital privileges, please explain on Addendum A.

B. PREVIOUS AFFILIATIONS During Last Ten Years. (Attach additional sheets if necessary. Reference This Section Number and Title)

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

XIV. PEER REFERENCES

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

Name of Reference:	Specialty:	Telephone Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number: ( )	
Mailing Address:		City:	
		State:	ZIP:

XV. WORK HISTORY (Attach additional sheets if necessary. Reference This Section Number and Title)

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

Current Practice:	Contact Name:	Telephone Number: ( )	
		Fax Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		

Name of Practice /Employer:	Contact Name:	Telephone Number: ( )	
		Fax Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		

Name of Practice /Employer:	Contact Name:	Telephone Number: ( )	
		Fax Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		

I, ________________________, M.D/D.O, have made an agreement with ____________________________,

M.D. /D.O., to provide back-up patient care coverage at San Gorgonio Memorial Hospital.

____

Signature   Date

XVI. ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If your answer to questions A through L is "yes," please provide full details on separate sheet.

A. Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?

Yes ☐ No ☐

B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?

Yes ☐ No ☐

C. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?

Yes ☐ No ☐

D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?

Yes ☐ No ☐

E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?

Yes ☐ No ☐

F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed , or is any such action pending?

Yes ☐ No ☐

G. Have you been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)? Yes ☐ No ☐

H. Have you ever been convicted of any crime (other than a minor traffic violation)? Yes ☐ No ☐

I. Do you presently use any drugs illegally? Yes ☐ No ☐

J. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending?

Yes ☐ No ☐

K. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?

Yes ☐ No ☐

L. Are there any limitations that would enable you to perform all services required by your agreement with, or the professional staff bylaws of, the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance, that may pose a direct threat to the safety of patients? If yes, please explain?

Yes ☐ No ☐

I hereby affirm that the information submitted in this Section XVI, Attestation Questions, and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material, omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name Here:

Physician Signature____Date ____________________
(Stamped Signature Is Not Acceptable)

INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations {IPAs}, health plans, health maintenance organizations {HMOs}, preferred provider organizations {PPOs}, other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state[3] laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et seq, if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement. A photocopy of this document shall be as effective as the original, however, original signatures and current dates are required on pages 8 and 9.

Print Name Here____

Physician Signature____ Date___________________
(Stamped Signature Is Not Acceptable)

[3] The intent of this release is to apply at a minimum, protections comparable to those available in California to any action, regardless of where such action is brought.

Addenda Submitting (Please check the following): ☐ Addendum A - Health Plan and IPA/Medical Group ☐ Addendum B - Professional Liability Action Explanation	*This Application and Addenda A and B were created and are endorsed by:* • American Medical Group Association - (703/838-0033 x325) • California Association of Health Plans - (916/552-2910) • California Healthcare Association - (916/552-7574) • California Medical Association - (415/882-3368)

Individual healthcare organizations may request additional information or attach supplements to this form. They are not part of the California Participation Physician Reapplication nor have they been endorsed by the above organizations. Any questions about supplements should be addressed to the health care organization from which it was provided.

Notice to Practitioners:

This hospital has agreed to provide a community service and to accept Medi-Cal and Medicare patients. The administration and enforcement of this agreement is the responsibility of the California Health Facilities Financing Authority and this facility.

____

Signature Date

PHYSICIAN ACKNOWLEDGEMENT STATEMENT

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

Notice to Physicians: Medicare/Champus/Medicaid payment to the hospitals is based in part on each patient's principal and secondary diagnoses and 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. Federal Register regulation 42 CFR 412.46.

I FULLY UNDERSTAND THAT ANY SIGNIFICANT MISSTATEMENTS IN OR OMISSIONS FROM THIS APPOINTMENT/REAPPOINTMENT APPLICATION WILL CONSTITUTE CAUSE FOR DENIAL OF MY APPLICATION FOR APPOINTMENT/REAPPOINTMENT AND TERMINATION OF MEMBERSHIP, PRIVILEGES, EMPLOYMENT OR PARTICIPATION. I HEREBY AFFIRM THAT THE INFORMATION I HAVE FURNISHED IN THIS FORM IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

____
Print Name

____
Applicants Signature

____
Date

California Participating Physician Application

Addendum B

Professional Liability Action Explanation

This Addendum is submitted to **San Gorgonio Memorial Hospital** herein, this Healthcare Organization[1].

Please complete this form for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past three (3) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

I. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Street Address:	City:	
	State:	ZIP:

II. CASE INFORMATION

City, County and State where lawsuit filed: _____	Court case number, if known:		
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suit Filed:	Sex of patient:	Age of patient: _____

Location of Incident:
☐ Hospital ☐ My office ☐ Other doctor's office ☐ Surgery Center
☐ Other, (please specify)

Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consultant, etc.):

Allegation:

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ☐Yes ☐No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number of insurance company, or other liability protection company or organization.

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name _____ Phone Number ( )

Name _____ Phone Number ( )

1 As used in the Information Release section of this Addendum, the term "this Healthcare Organization" shall refer to the entity to which this Addendum is submitted as identified above.

III. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (CHECK ONE)

☐ Lawsuit/arbitration still ongoing, unresolved.
☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: $
☐ Judgment rendered and I was found not liable.
☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: $
☐ Lawsuit/arbitration settled, no judgment rendered, no payment made on my behalf.

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 and diagnosis at time of incident, 2) dates and description of treatment rendered, and 3) condition of patient subsequent to treatment. **Please print.**

SUMMARY

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Physician Application. In order for participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization information abut my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorneys listed on Page 1 to discuss any information regarding this case with “this Healthcare Organization.”

Print Name Here: ____

Physician Signature ____Date:______
(Stamped Signature Is Not Acceptable)

MEDICAL STAFF/ALLIED HEALTH PROFESSIONAL STAFF

CONFIDENTIALITY STATEMENT & CONFLICT OF INTEREST AGREEMENT

Confidentiality Statement:

As a member of a Medical Staff/Allied Health Professional Staff, Service, or Committee involved in the evaluation and improvement of the quality of patient care rendered in the Hospital, I recognize that confidentiality is vital to the free and candid discussions for a successful quality assurance program, peer review process, and other related matters of the San Gorgonio Memorial Hospital. 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 disclosure of such information except to persons authorized to receive it in the conduct of Medical Staff/Allied Health Professional Staff affairs.

Furthermore, my participation in quality assessment and/or peer review 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/Allied Health Professional Staff. I understand the Hospital and the Medical Staff 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.

Conflict of Interest Agreement:

It is the policy of San Gorgonio Memorial Hospital and its Medical Executive Committee that all members of the Medical Executive Committee shall agree to and execute this "Conflict of Interest Agreement" at the time they begin service on the Committee. Failure to do so or failure to abide by the terms of the Agreement shall constitute grounds for removal from the Committee.

In addition, as a matter of procedure, I acknowledge that the Chair of the Committee has the authority to inquire, prior to the discussion of any matter, whether any member has any conflict of interest. The existence of a potential conflict of interest or bias on the part of any Committee member may also be called to the attention of the Chair by any Committee member with knowledge of the matter.

________________________________ ______________________
Signature Date

____
Print Name

CONFIDENTIALITY AGREEMENT

It is the responsibility of San Gorgonio Memorial Hospital (SGMH) employees(associates), medical staff and other health care professional; agency, temporary and registry personnel; students and volunteers to preserve and protect confidential patient, associate and business information.

The federal Health Insurance Portability Accountability Act (the "Privacy Rule") and the Confidentiality of Medical Information Act (California Civil Code § 56 et seq.) govern the release of patient identifiable information by hospitals and other health care providers. The State Information Practices Act (California Civil Code sections 1798 et seq.) governs the acquisition and use of data that pertains to individuals. All of these laws establish protections to preserve the confidentiality of various medical and personal information and specify that such information may not be disclosed except as authorized by law or the patient or individual.

Confidential Patient Care Information includes: Any individually identifiable information in possession or derived from a provider of health care regarding a patient's medical history, mental, or physical condition or treatment, as well as the patients and/or their family members records, test results, conversations, research records and financial information. (Note: this information is defined in the Privacy Rule as "protected health information.") Examples include, but are not limited to:

- license number
- social security number
- name
- address
- account number
- photos
- Telephone number.

Confidential Employee and Business Information includes, but is not limited to, the following:

- Employee home telephone number and address;
- Spouse or other relative names;
- Social Security number or income tax withholding records;
- Information related to evaluation of performance;
- Other such information obtained from SGMH records which if disclosed, would constitute an unwarranted invasion of privacy; or
- Disclosure of Confidential business information that would cause harm to SGMH.

Peer review and risk management activities and information are protected under California Evidence Code section 1157 and the attorney-client privilege.

1. I will treat all information received in the course of my employment with SGMH as confidential and privileged information. Under no circumstances may I discuss or disclose any patient or business related data, unless it is being shared on a need to know basis for specific business reasons. Discussions of patient presence, conditions, treatment, or other medical record data must be held in private clinical areas so as not to be inadvertently overheard.

2. My user ID is recorded when I access electronic records and that I am the only one authorized to use my user ID. Use of my user ID is my responsibility whether by me or anyone else. I will only access the minimum necessary information to satisfy my job role or the need of the request.

3. I will not log on to any of the SGMH computer systems that currently exist or may exist in the future using a password other than my own. I will safeguard my computer password and will not post it in a public place, such as the computer monitor or a place where it will be easily lost, such as on my nametag. I will not allow anyone, including other employees, to use my password to log on to the computer and I will log off of the computer as soon as I have finished using it.

4. I understand that all information, regardless of the media on which it is stored (paper, computer, videos, recorders, etc.), the system which processes it (computers, voice mail, telephone systems, faxes, etc.) or the methods by which it is moved (electronic mail, face to face conversation, faxes, etc.) is the property of SGMH and shall not be used inappropriately or for personal gain.

6. I understand that SGMH reserves the right to inspect or monitor any company owned, leased, or controlled computer, computer device, network, computer facility, storage device, voice mail or telephone system at any time for any reason and that SGMH may divulge any information found during such inspections or monitoring to any party it deems appropriate.

7. I understand that I should not consider electronic communications to be either private or secure, nor have an expectation of privacy in anything I create, store, send, or receive on the computer and network.

8. I understand that SGMH has an active on-going program to review records and transactions for inappropriate access and I understand that inappropriate access or disclosure of information can result in penalties up to and including termination of employment and/or legal action.
9. Upon cessation of my employment/affiliation with SGMH, I agree to continue to maintain the confidentiality of any information I learned.

I understand that violation of this agreement could result in corrective/disciplinary action, which might include, but is not limited to, termination of employment and/or loss of my privileges within SGMH, as well as potential civil or criminal penalties.

____ ______________________
Signature Print Name

____
Date Department / Position

____
Company Name

SAN GORGONIO MEMORIAL HOSPITAL
FACT SHEET FOR PHYSICIANS OR OTHER AUTHORIZED LICENSED INDEPENDENT PRACTITIONERS
ON RESTRAINT & SECLUSION

Dear Physician or LIP:

You are authorized by your scope of practice, and privileges granted by the medical staff, to order the use of restraint or seclusion. Key policy requirements are reiterated as follows:

Policy Statement & Patient Rights
All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a convenience, or retaliation by staff.
Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

The hospital will work to actively decrease the use of restraint or seclusion. When restraint or seclusion is necessary, such activity will be undertaken in a manner that protects the patient's health and safety and preserves his or her dignity, rights, and well being. The use of restraint/seclusion is a last resort, after alternative interventions have either been considered or attempted.

Prohibitions to Use of Restraint or Seclusion
The use of restraint or seclusion for the following reasons is strictly prohibited:

- Use that is based solely on a patient's prior history and/or behavior.
- Use as a convenience to staff.
- Use as a method of coercion or as punishment.

Requirements for Patient Assessment & Ordering of Restraint or Seclusion
The use of restraint or seclusion must be in accordance with the order of a physician or other LIP who is responsible for the care of the patient. The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.

Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).

Each order for restraint or seclusion must contain at least the following information:

- The name of the patient being restrained or placed into seclusion
- The date and time of the order
- The name of the LIP ordering the restraint or seclusion
- The type of restraint or seclusion to be applied
- The time limit (duration) of the restraint or seclusion

If there is to be any variation from this policy for monitoring of the patient and/or release from restraint before the order expires, then the rationale for such variation must be contained in the order.

The initial order for **non-violent / non-self-destructive behavior restraint** (formerly called safety restraint) must be time limited and renewal orders for restraint shall be obtained at least every 3 days. Renewal orders shall be based on an examination of the patient by an LIP.

Each order for restraint or seclusion used for the management of **violent or self-destructive behavior** (formerly called behavioral restraint) that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be ordered / renewed in accordance with the following limits for up to a total of 24 hours:

- Four (4) hours for adults age 18 and older;
- Two (2) hours for children and adolescents ages 9 to 17;
- One (1) hour for patients under age 9.

After 24 hours, before writing a new order a physician or other LIP who is responsible for the care of the patient must see and assess the patient.
When restraint or seclusion is used for the management of **violent or self-destructive behavior** that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen **face-to-face within one (1) hour** after the initiation of the intervention by a Physician or other LIP; or PA who has been trained in accordance with the requirements of this policy. The purpose of the face-to-face evaluation is to assess; the patient's immediate situation; the patient's reaction to the intervention; the patient's medical and behavioral condition; and the need to continue or terminate the restraint or seclusion.

____ ______________
Signature of Physician or Other LIP Date

SAN GORGONIO MEMORIAL HOSPITAL
HEALTH SCREENING ASSESSMENT
MEDICAL STAFF AND ALLIED HEALTH PROFESSIONAL

San Gorgonio Memorial Hospital supports a strong infection control program. All new and current medical staff must comply with the State of California Department of Health (title 22) regulations, which is that the Medical Staff are required to have annual TB screening. Screening includes an annual Symptom Review and Quantiferon testing. Skin testing from outside facilities is accepted. All medical staff should provide proof of immunity to Hepatitis B, Measles, Mumps, Rubella, and Varicella.

ATTESTATION FOR TB SKIN TESTING

Yes ☐ No ☐ I attest that I have had a TB skin test yearly and within the last twelve months and the results have been negative.

Yes ☐ No ☐ I attest that I have had a TB skin test that was positive, followed by a negative CxR within the last twelve months, and I have no symptoms of active disease.

Yes ☐ No ☐ I attest that I currently have TB symptoms that are under treatment, I have attached applicable documentation.

Note: **The Employee Health Department will provide TB skin testing for Medical Staff and Allied Health Professionals free of charge. Call for clinic times and/or questions.**

***Immune Status:** I am considered immune to the following diseases either through immunization, having had the disease, or having a record of an immune blood titer.

Rubella	☐Yes	☐No	☐Not Sure
Rubeola	☐Yes	☐No	☐ Not Sure
Mumps	☐Yes	☐No	☐ Not Sure
Varicella	☐Yes	☐No	☐ Not Sure
Hepatitis B	☐Yes	☐No	☐ Not Sure

*If you are not sure of any of the above questions and would like to discuss your immunity status, immunizations, or TB status, please call the Medical Staff Office at (951) 769-2155.

IF YOU RECENTLY HAVE HAD A PHYSICAL THAT INCLUDED A TB SKIN TEST PERFORMED BY YOUR PHYSICIAN, PLEASE ATTACH A COPY TO THIS DOCUMENT.

Health Statement: To the best of my knowledge, I am free of any infectious diseases and am safe to be around immuno-compromised patients.

______________________________ ______________________________
Print Name Signature

____
Date

Date:

Physician Name: ____

Dear San Gorgonio Hospital Practitioner:

Senate Bill 158 requires that all physicians receive training on preventing hospital acquired infections. In order to comply we are distributing the enclosed educational modules for your reference.

Beginning January 2010, all staff and contract physicians and all other licensed independent contractors, including but not limited to, nurse practitioners and physician assistants, shall be trained in methods to prevent the transmission of Hospital Acquired Infections, including but not limited to Methicillin Resistant Staphylococcus Aureus **(MRSA)** and Clostridium difficile infections.

Please read the enclosed education module, sign the attestation below to confirm that you have received and read the material and return to Medical Staff Services by mail or fax (951) -769- 4812.

Thank you for your assistance

Mark J. Beck, M.D.
Chair- Infection Control

I received and read the enclosed material on the prevention of Hospital Acquired Infections.

_________________________________ ___________________

Physician Signature Date

EDUCATION MODULE FOR PHYSICIANS ON PREVENTION OF HOSPITAL AQUIRED INFECTIONS

Hand Hygiene:

Compliance with hand hygiene policy is the single most important means of preventing the spread of infection, as well as, the spread and colonization of patients with multiple drug resistant organisms.

Hand washing with soap and water or hand disinfection with an antiseptic based hand rub should be performed before and after every patient contact. It is not necessary to actually touch a patient to contaminate hands, items such as bed rails, may become heavily contaminated with bacteria, such as **MRSA.**

Gloves do not prevent contamination of the hands (just reduction of contamination); hands should be washed or disinfected immediately after removing gloves.

Antiseptic hand rubs are very effective at killing most microorganisms on clean hands. Dirt, proteinaceous materials, skin oils can reduce the efface of antiseptic hand rubs, so soap and water hand washing is needed of hands are soiled or between every 4 to 5 hand rub use.

Antiseptic hand rubs will not harm *Clostridium difficile* spores. Only soap and water hand washing should be utilized when patients may have this organism.

In every hand hygiene study published, physicians have had the lowest compliance with hand hygiene policies, this despite the fact they are among the most likely healthcare workers to spread infections and drug resistant organisms. This is unfortunate, both because of the obvious risk to do harm, and because physicians act as a major role model for other healthcare workers. Often the reason other healthcare workers fail to comply with hand hygiene is given as “the doctor didn’t wash his hands, why should I”?

Personal Protective Equipment (PPE)

Bloodborne Pathogens Standard requires all personal protective equipment shall be removed prior to leaving the work area. This means no PPE’s (gown, gloves, mask, or booties) in hallways, nursing stations, break rooms, cafeteria. Violation could be the basis of an OSHA fine. Surgical mask dangling from the neck is not a pretty sight and serves no useful purpose.

Standard Precaution

The concept of Universal precautions was introduced in 1987 in response to the **AIDS** epidemic. Universal precautions now called Standard precautions, does not mean **NO** precautions. Standard precautions protects against bloodborne pathogens from blood and body fluids.

Gloves are worn if patients have unbroken skin, skin infections, burns or rashes, if mucous membranes are to be touched and during any invasive procedure.

Gowns are worn if there is any chance of contact of clothing with blood, body fluids, or respiratory secretions.

Masks (including surgical masks, **NIOSH 95** and **PAPRs)** and eye protection is worn if there is a chance of aerosolization of respiratory secretions during procedures such as suctioning, intubation or bronchoscopy.

And of course - strict compliance with Hand Hygiene policy is mandatory.

Transmission Based (Barrier) Precautions

Contact precautions require gloves when entering a patient's room and gown when having direct contact with the patient and the environment. These requirements plus those of standard precautions (e.g. mask during aerosol producing procedures) will prevent the spread of **MRSA**, VRE, MDR *Acinetobacter* and other drug resistant organisms. Also, **RVS** is managed with contact precautions (per **CDC** guidelines).

Contact Plus (Spore) Precautions are for C. difficile as bleach is used for room cleaning and hand washing with soap and water. (Note all bathrooms at **SGMH** are cleaned with bleach 1:10 solution).

Droplet Precautions

Droplet precautions require a surgical mask, gloves and gown.

Influenza, N. *meningitides* meningitis, group a strep in the respiratory tract, pertussis and pneumococcus are all managed with droplet precautions.

Airborne Precautions

Require an N95 mask and placement in a negative pressure room or a room with a hepafiltration unit. Tuberculosis, measles and chickenpox are the three diseases managed with airborne precautions.

Protective Precaution (formerly Reverse or Neutropenic Precaution)

The CDC does not recognize the need for reverse or neutropenic isolation. However, Protective (Neutropenic) Precautions are still valued by physicians under certain circumstances and must write a physician order for this precaution. Patients with Absolute Neutrophil counts of less than 500cells/mm3 constitute a dangerous neutropenia and are at risk of infection from two primary sources, the patient's own normal flora and from airborne fungal spores.

Negative pressure rooms are not appropriate for these patients as this type of room draws air (possibly containing fungal spores) from the outside into the room. Positive pressure rooms can be use where available (not available at **SGMH**).

No fresh fruits or vegetables, as these can contain minute fungal colonies which will release fungal spores into the air. No flowers or plants as these almost always will be a source of fungal spores and the water in vases is another source of infection. No visitors who are ill or under 12 years of age.

Microbiology

For the purposes of hospital epidemiology, we can divide the microbial world into three types: non-pathogens, pathogens and opportunists (opportunist pathogens)

Non-pathogens- nothing more to say

Pathogens are organisms that cause disease pathology whenever they are present. They are the organisms to which Koch's postulates apply. The major problem organisms in the healthcare setting are:

Tuberculosis

Influenza

Scabies

Norovirus

Hospital outbreaks of these are rare and indicate a breakdown in infection control practices. They are best prevented by early recognition, followed by appropriate precautions and treatment.

Opportunists are the real challenge in hospital infection control. These organisms are normally part of the human body's normal flora and/or the natural environment. Under normal circumstances they do not cause disease, but if the opportunity presents itself, they are very capable of causing severe, even fatal infections. The problem organisms in the healthcare setting are:

MRSA

VRE

ESBL Klebseilla

Acinetobacter

Pseudomonas

They cause infections secondary to invasive devices (Foley Catheter, Endotracheal tubes, and central venous catheters), aspiration or surgery. They are not eradicated by antibiotic treatment of infections, as they service on skin and mucosal surfaces (their normal flora habituates). They are best managed through hand hygiene, oral care aseptic technique, environmental cleaning, surveillance and the use of appropriate precautions.

Methicillin Resistant – Staphylococcus auereus

MRSA is the most common microbe involved in healthcare associated infections. **MRSA** may colonize patients becoming a part of their normal flora. They will live on the mucosal surface of the nose and throat, lower GI tract, and/or female genital tract. They can colonize skin, in warm wet areas of the body, around the nose and mouth, around the anus and groin and under the arms. Introduction of **MRSA** to otherwise sterile areas of the body can occur through aspiration, surgical procedures, or the use on invasive medical devices, such as Foley catheters, endotracheal tubes and central venous catheters, thereby causing infection. Treatment of such infection does not rid the patient of the organisms on mucus membrane or skin, so even after a decolonization of **MRSA** is not recommended as it is costly, time consuming and usually temporary.

The California Health and Safety Code mandates that hospitals perform active surveillance for **MRSA** on admission and starting in 2011 upon discharge, as well. While the law does not recommend what type of infection control actions are to be taken for those with positive cultures, it does refer infection control options to either the State's Healthcare Associated Infection Advisory Committee or to the CDC guidelines. CDC guidelines state that contact precautions are to be used for all patients with infections, colonization or have been previously positive with **MRSA** or other drug resistant organisms.

The Code also states: "If a patient tests positive for MRSA, the *attending physician* shall inform the patient or the patient's representative immediately or as soon as practically possible".

The Code has provisions mandating patient education and public reporting of **MRSA** blood stream infections. In some instances **MRSA** infections are reportable to the public health authorities under Title 17 regulations.

Clostridium difficile

Clostridium difficile is primarily a hospital acquired organism. How it affects patients is dependent upon when, during the hospital stay, patients become exposed to the organism. If the patient acquires the organisms before antibiotic therapy is started, then the patient is likely to become an asymptomatic super shedder flooding the environment with long lived, practically

indestructible endospores. If patients become exposed after antibiotic therapy the patient may become ill with pseudomembranous colitis and flood the environment with long-lived practically indestructible endospores.

In a recent study the most heavily contaminated area of hospitals with *Clostridium difficile* endospores was the physician charting areas, a reflection of the generally poor compliance of physicians with hand washing.

Prevention of C. *difficile* transmission requires very high compliance with hand washing. Soap and water hand washing only is used for *c. difficile* as the endospores are not killed by alchohol hand rubs. Contact Plus isolation is utilized, along with the use of bleach as a disinfecting agent to control the spread of C. *difficile*. Bleach is the only disinfecting agent with FDA approval for use with C. difficile.

Influenza

The most effective infection control strategy for controlling influenza in the healthcare setting is high compliance with annual vaccination of healthcare workers. In California, vaccination is mandatory for all healthcare workers, including physicians. There is a provision for refusal to be vaccinated in the form of a written declination that must include the reasons for refusal. The hospital is then expected, through education, to annually increase their vaccination rates until they approach 100%.

The complement to vaccination programs, high compliance with hand hygiene, respiratory etiquette, and the use of droplet isolation are used to stop the transmission of influenza. Hand hygiene plays a most important role in the prevention of influenza. Influenza virus can live for hours to days on inanimate objects and contact transmission is an important part of epidemic spread of this disease.

Novel influenza viruses, such as **H1N1** swine influenza, are transmitted in the same manner as seasonal virus, by large respiratory droplets. The aerosol transmissible disease law in California mandates the use of N95 particle respirators when caring for a patient that is or is suspected of being infected with a virus described as novel by the **CDC**, including influenza.

Pseudomonas and Acinetobacter

Environmental organisms such as *Pseudomonas* and *Acinetobacter* are both inherently resistant to a number of antibiotics and able to survive indefinitely in the environment. Both these organisms can also colonize patients becoming part of the normal flora. *Pseudomonas* requires water for survival and will only live for a few days on dry hard surfaces, but can survive forever anywhere there is moisture. *Acinetobacter*, on the other hand, can survive on dry hard surfaces for months without any moisture. *Acinetobacter* and *Pseudomonas* can acquire antibiotic resistance, enhancing their already inherent resistance to become pan-resistant. In addition, *Acinetobacter* with its ability to survive for prolonged period in the hospital environment can create such a severe problem that medical units, especially ICU units must be closed and fumigated. In one notable case an ICU was torn down and rebuilt after an outbreak lasting years failed to be controlled, even with fumigation. Strict compliance to hand hygiene combined with contact isolation can control these organisms.

Laws mandating infection control policies/procedures

Beginning in 2007, California legislated a number of laws governing infection control practices; the driving force behind these laws has been the increasing rates of nosocomial infections and the increasing spread of multi-drug resistant organisms.

SB 739 now part of the California Health and Safety code mandates, compliance with hand hygiene guidelines by all healthcare workers including physicians, central line insertion practices requiring full surgical asepsis, mandatory influenza vaccines for all healthcare workers including physicians, public reporting of infection rates and running of an infection control program.

SB1058 now part of the California Health and Safety Code mandates an active surveillance culture practice in hospitals to identify patients who are colonized with **MRSA**, a requirement that the patient’s attending physician notify patients with positive surveillance cultures of their results, education for patients, public reporting of C. *difficile* infections, surgical site infections, **MRSA** and **VRE** infections, and much more.

SB0158 now part of California Health and Safety Code mandates hand hygiene compliance by all healthcare workers including physicians, infection control training for all clinicians, employees and house cleaning staff, specific training o f clinicians on **MRSA** and C. *difficile* prevention, and much more.

Aerosol transmissible diseases legislation is now part of Title 8; it mandates hand hygiene compliance by all healthcare workers including physicians, respiratory etiquette, vaccination programs, a biosafety program and much more.

This trend towards mandating infection control practices, through legislation, is expected to continue in the future.

Further information may be found in the Infection Control manual on each unit or the Hospital shared drive. In particular the SHEA infection control prevention practices of:

- STRATEGIES TO PREVENT VENTILATOR-ASSOCIATED PNEUMONIA IN ACUTE CARE HOSPITALS
- STRATEGIES TO PREVENT SURGICAL SITE INFECTIONS IN THE ACUTE CARE HOSPITALS
- STRATEGIES TO PREVENT CATHETER-ASSOCIATED URINARY TRACT INFECTIONS IN ACUTE CARE HOSPITALS
- STRATEGIES TO PREVENT CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS IN ACUTE CARE HOSPITALS
- STRATEGIES TO PREVENT CLOSTRIDIUM DIFFICILE INFECTIONS IN ACUTE CARE HOSPITALS
- STRATEGIES TO PREVENT TRANSMISSION OF METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS IN ACUTE CARE HOSPITALS

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

San Gorgonio Memorial Hospital ("the Company") may obtain information about you from a third party consumer reporting agency for employment purposes. 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 with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. Credit history will only be requested where such information is substantially related to the duties and responsibilities of the position for which you are applying.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you, and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report is an employment history or verification.

A consumer report will be conducted by peopleG2, 135 South State College Blvd, Suite 200, Brea, CA 92821, 800-630-2880, www.peopleG2.com. The scope of this disclosure is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports throughout the course of your employment to the extent permitted by law.

Signature ___________________________________ Date ______________

ACKNOWLEDGMENT AND AUTHORIZATION FOR BACKGROUND CHECK

I acknowledge receipt of the separate document entitled 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 Employer at any time after receipt of this authorization and throughout my employment, 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 peopleG2, 135 South State College Blvd, Suite 200, Brea, CA 92821, 800-630-2880, www.peopleG2.com and/or Employer itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants only: Upon request, you will be informed whether or not a consumer report was requested by the Company, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly. By signing below, you acknowledge receipt of Article 23-A of the New York Correction Law

Washington State applicants only: 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.

Minnesota and Oklahoma applicants only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. [___]

California applicants only: Under California Civil Code section 1786.22, you are entitled to find out what is in the CRA's file on you with proper identification, as follows:

- In person, by visual inspection of your file during normal business hours and on reasonable notice. You also may request a copy of the information in person. The CRA may not charge you more than the actual copying costs for providing you with a copy of your file.
- A summary of all information contained in the CRA file on you that is required to be provided by the California Civil Code will be provided to you via telephone, if you have made a written request, with proper identification, for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to you.
- By requesting a copy be sent to a specified addressee by certified mail. CRAs complying with requests for certified mailings shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the CRAs.

"Proper Identification" includes documents such as a valid driver's license, social security account number, military identification card, and credit cards. Only if you cannot identify yourself with such information may the CRA require additional information concerning your employment and personal or family history in order to verify your identity. The CRA will provide trained personnel to explain any information furnished to you and will provide a written explanation of any coded information contained in files maintained on you. This written explanation will be provided whenever a file is provided to you for visual inspection. You may be accompanied by one other person of your choosing, who must furnish reasonable identification. An CRA may require you to furnish a written statement granting permission to the CRA to discuss your file in such person's presence.

Please check this box 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. [___]

Signature ____________________________________ Date _______________

BACKGROUND INFORMATION

Last ______________________________ First __________________________ Middle ________________

Other Names/Alias ____

Social Security # * _____________________________ Date of Birth* ______________________________________

Drivers License # __________________________ State of Driver's License ___________________________

Present Address ____

City/State/Zip ____

Phone Number ____

Email Address(s) ____

*This information will be used for background screening purposes only and will not be used as hiring criteria.

PLEASE RETURN TO THE MEDICAL STAFF OFFICE BY MAIL OR FAX (951) 769-4812

Name:

Examination:

1. Which of the following is required prior to sedation?
   a. documentation of informed consent
   b. history and physical appropriate to the planned sedation
   c. ASA evaluation
   d. NPO status
   e. All of the above
   f. A and B

2. During a minor sedation procedure the patient is breathing slowly, arousable by painful stimuli only. At which level of sedation is the patient?
   a. anxiolysis
   b. moderate sedation
   c. deep sedation
   d. anesthesia

3. The most common adverse effect of sedation is:
   a. Hypotension
   b. Allergic reaction
   c. Respiratory depression
   d. Seizure

4. Minimum safe monitoring for deep sedation during the procedure includes:
   a. BP, HR, RR, 02 saturation and LOC utilizing the Ramsey scale every 5 minutes
   b. BP, HR, RR, 02 saturation and LOC utilizing the Ramsey scale every 15 minutes
   c. BP, HR, RR, 02 saturation every 5 minutes and LOC utilizing the Ramsey scale every 15 minutes
   d. BP, HR, 02 saturation and LOC utilizing the Ramsey scale every 5 minutes

5. Barbituates, Benzodiapines, and opiates are known to cause the following complications:
   a. Respiratory depression
   b. Airway obstruction
   c. Hypotension
   d. All of the above

6. Ketamine can lead to all except:
   a. nightmares, psychomotor changes
   b. increased intracranial pressure
   c. bradycardia
   d. hypertension and ischemia in the cardiac patient
   e. catatonic facies, but tolerant of pain

7. Before giving intravenous sedation/analgesia, the following must be documented:
   a. past medical history, sedation history
   b. last po intake
   c. medication history, allergy history
   d. ASA class
   e. All of the above

8. Which agent would be used to reverse a benzodiazepine?
   a. romazicon
   b. narcan
   c. benadryl
   d. sublimaze

9. Which agent would be used to reverse a narcotic (antagonist) agent?
   a. benadryl
   b. narcan
   c. romazicon
   d. midazolam

10. T F Narcan typically reverses respiratory depression, leaving the analgesic component of the narcotic intact.

11. Deep sedation/analgesia is a drug induced state which is characterized by: (more than one answer)
   a. patient is easily aroused
   b. patient may respond following painful stimuli
   c. ventilatory function may be impaired
   d. cardiovascular function is usually not matintained
   e. a patient airway and spontaneous ventilation are unimpaired

12. Methods to rescue a patient who has been compromised by medications leading to deep sedation/analgesia include:
   a. jaw/thrust/chin lift
   b. oral or nasal airway
   c. deep stimulation
   d. IV fluid administration
   e. Ambu bag ventilation
   f. All of the above

13. Appropriate discharge criteria from sedation include:
   a. vital signs, mental status return to baseline
   b. verbal report given to receiving department (if not outpatient)
   c. written discharge instructions given to patient when discharge home
   d. all of the above

14. Which of the following statements about opioids and apnea is true?
   a. responsive patients can become apneic, especially with rapid intravenous administration of opioids
   b. apnea is an unlikely, uncommon adverse reaction
   c. apnea doesn't usually lead to cardiac arrest
   d. apnea doesn't occur, since the main effect of opioids is analgesia

15. Which of the following statements about using naloxone (Narcan) to reverse opioid effects is true?
  a. it should be given in a continuous IV drip without boluses
  b. it can induce narcotic withdrawal
  c. it is absent of side effects
  d. it does not antagonize the respiratory effects of opioids

16. Which of the following statements are true?
  a. naloxone can be used to reverse narcotic overdose
  b. flumazenil can be used to reverse narcotic overdose
  c. flumazenil can be used to reverse ketamine overdose
  d. naloxone can be used to reverse barbiturate overdose

17. Factors associated with an increase incidence of emergence delirium in association with ketamine include:
  a. age greater than 16 years of age
  b. female sex
  c. doses of ketamine greater than 2 mg/kg IV
  d. history of personality problems or frequent dreaming
  e. all of the above

18. Infants and small children are particularly susceptible to complications during sedation. The unique anatomy of which body system contributes to this susceptibility:
  a. neurological
  b. gastrointestinal
  c. respiratory
  d. renal

19. The Aldretes scoring system is:
  a. an objective measure used to determine a patient's suitability for discharge
  b. the same as an ASA Physical Status Classification
  c. a neurological assessment of LOC
  d. a physician test of how well a patient will tolerate narcotics

20. T F During sedation the jaw may relax and the base of the tongue may fall back in contact with the posterior pharynx and result in obstruction. Often a simple realignment of the airway may correct this problem.

21. Risk factors that are most consistently associated with a difficult airway include:
  a. obesity
  b. decreased head and neck movement
  c. receding mandible
  d. reduced jaw movement
  e. protruding teeth
  f. all of the above

22. Considerations for the administration of naloxone (Narcan) include all of the following except:
  a. appropriate as a reversal agent for midazolam (Versed)
  b. onset of action is 1-2 minutes
  c. duration of action is shorter than most opioid agonists
  d. high doses may cause pulmonary edema, arrhythmias, hypertension, or tachycardia

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Name: | **Score:**

23. The most common serious adverse event associated with intravenous ketamine administration in an otherwise healthy child is:
    a. hypoventilation
    b. increased salivation potentially causing laryngospasm
    c. hypotension
    d. bradycardia

24. Patients receiving reversal agents need to undergo longer periods of monitoring because of which of the following:
    a. due to the adverse effects associated with these drugs
    b. the analgesic properties of the sedation agents are removed
    c. the half-life of the sedation agents are longer than those of the reversal agents
    d. due to the potential of respiratory depression and dysrhythmias

25. During the administration of diprivan (Propofol) all of the following are true except:
    a. patients receiving propofol should receive care consistent with that required for deep sedation
    b. the physician may delegate the administration of propofol to the RN
    c. Administration of propofol will be done by a physician who is not simultaneously involved in the procedure
    d. The physician should be physically present throughout the sedation and remain immediately available until the patient is medically discharged.

Physician Signature:________________________Date:__________

Physician Printed Name:________________________

Reviewed by:________________________Date:__________
Director, Anesthesiology

SAN GORGONIO MEMORIAL HOSPITAL
PRIVILEGE DELINEATION LIST
SURGICAL SERVICES – SECTION OF ANESTHESIA

SEDATION FOR THE NON-ANESTHESIOLOGIST

NAME OF APPLICANT:_________________________________ DATE:_______________

All non-anesthesiologists wishing to administer moderate and/or deep sedation must apply and be granted privileges. It is the responsibility of the physician to submit evidence of competency during the reappointment period as requested.

QUALIFICATIONS:

1. M.D. or D.O. with current medical staff privileges at the hospital;
2. Current certification or active participation in the examination process leading to certification by an ABMS or a recognized American Osteopathic Board;

REQUIREMENTS:

1. Review the moderate/deep sedation patient care policy and procedures.
2. Completion of the sedation/analgesia competency test with satisfactory score of >90%, or ED residency program, or ED board eligibility.
3. Current ACLS certification or equivalent from specialty board.

   Note: Emergency Department physicians must also have current PALS certification or equivalent from specialty board

ADVANCED PROCEDURAL PRIVILEGES ***Require additional documentation of specific training, experience and/or current competence.***	**# REQUIRED FOR INITIAL APPOINTMENT**	**# TO BE PROCTORED**	**# PER 2 YRS. TO MAINTAIN**	**YES**	**NO**	**GRANTED**
Moderate Sedation and Analgesia	2	1	5			
Deep Sedation (may only be performed by ED physicians and intensivists)	5	1	5			

SAN GORGONIO MEMORIAL HOSPITAL
NON-ANESTHESIOLOGIST ANESTHESIA PRIVILEGE LIST

Acknowledgement of Practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at San Gorgonio Memorial Hospital, and;

I understand that:

(a) In exercising any clinical privileges granted, I am constrained by medical staff bylaws, hospital and medical staff policies and rules.
(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Print Name:_________________________ Signed:______________ Date:_________________

I have reviewed the requested clinical privileges and supporting documentation for the above named applicant and recommend action on the privileges as noted above.

☐ Recommended with the following modification(s) and reason(s):

_______________________________ _______________________
Director of Anesthesiology Date

_______________________________ _______________________
Chair Credentials Committee Date

_______________________________ _______________________
Chair of Medical/Executive Committee Date