

<p>This policy applies to:</p> <p><input checked="" type="checkbox"/> <i>Stanford Hospital and Clinics</i></p> <p><input checked="" type="checkbox"/> <i>Lucile Packard Children's Hospital</i></p>	<p>Date Written or Last Revision: May 2011</p>
<p>Name of Policy: Credentiaing and Privileging Licensed Independent Practitioners</p>	<p style="text-align: center;">Page 1 of 13</p>
<p>Departments Affected: All Departments</p>	

I. PURPOSE

To establish mechanisms for gathering relevant data that will serve as the basis for decisions regarding credentialing and privileging of licensed independent practitioners who provide patient care services at Stanford Hospital and Clinics and/or Lucile Packard Children's Hospital ("Hospitals"). This policy applies to all medical staff members at SHC and LPCH as well as Advanced Practice Professionals (i.e., Advanced Practice Nurses and Physician Assistants) credentialed and privileged through the Medical Staff process. (reference AHP Policy)

II. POLICY STATEMENT

It is the policy of Stanford Hospital and Clinics ("SHC") and Lucile Packard Children's Hospital ("LPCH") to ensure that licensed independent practitioners meet the minimum credentials, privileging and performance standards. Credentialing is performed jointly for all physicians, podiatrists, psychologists and dentists prior to appointment to the SHC or LPCH Medical Staff. Credentialing and Privileges is performed jointly for all Advanced Practice Professionals prior to approval by the Governing Body. Credentials and Clinical Privileges are approved separately by each hospital to which the practitioner is applying. Members of the Medical Staff may be granted delineated clinical privileges as specified in the Medical Staff Bylaws for each facility.

The providers attest that all information submitted for the credentialing and privileging process is accurate, and agree to report immediately any change in status of the information maintained in the Credentials files. If any submitted items differ from documentation disclosed through the verification process, the Credentials Committee(s) or Interdisciplinary Practice Committee (IDPC) may consult with the provider to resolve discrepancies. All time sensitive documents for any applicant or re-applicant must be no more than 180 days from the date of the provider's attestation at the time of the Credentials Committee(s) or IDPC review. In the event that time sensitive documents are found to be out of compliance with regulatory guidelines, those documents will be re-verified prior to review by that committee.

All applications for appointment, reappointment, and requests for clinical privileges, will be evaluated based on current licensure, education, training or experience, current competence, and ability to perform the clinical privileges requested.

III. PROCEDURES

A. New Applicants

Individuals requesting to be credentialed and privileged will be provided a link to the Medical Staff Services webpage in an e-mail outlining the time frame and basic requirements for processing the request. Content of the website includes:

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<p>Name of Policy: Credentiaing and Privileging Licensed Independent Practitioners</p>	<p style="text-align: center;">Page 2 of 13</p>
<p>Departments Affected: All Departments</p>	

1. Application including licensure information on any active or inactive licenses, DEA registration, Work History and complete information for Peer References
2. Attestation Questionnaire: including applicant attesting to reasons for inability to perform the essential function of the position with or without accommodation, lack of present illegal drug use, history of loss of license and/or felony convictions, and history of loss of limitation of privileges or disciplinary activity. This statement provides attestation to the correctness and completeness of the application.
3. Authorization to Release Information Form which includes consent to release information to Contracted Health Plans if the applicant participates in the SHC or LPCH Health Plan Contract.
4. Insurance Liability Questionnaire
5. Claims Status Form to be completed for each Open or Closed Claim
6. Health Screening Requirements Form
7. Billing Form (for Finance Department)
8. Background Check Release Form
9. Continuing Education Reporting Form
10. Confidentiality and Conflict of Interest Statement of Compliance
11. Pharmacy Signature Sheet for each facility
12. Medicare Acknowledgement Statement
13. Code of Conduct and Professional Behavior
14. Important Contact Information Sheet
15. Privilege Forms
16. Training Modules; including, Sedation, HIPPA, QI, EPIC (for SHC) and PowerChart/LINKS(for LPCH)
17. Policies and Procedures
18. *Medical Staff Bylaws, Rules and Regulations*

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<p>Name of Policy: Credentiaing and Privileging Licensed Independent Practitioners</p>	<p style="text-align: center;">Page 3 of 13</p>
<p>Departments Affected: All Departments</p>	

19. *State of CA Abuse Form*

20. The hospital verifies that the practitioners requesting approval is the same practitioner identified in the credentialing documents by completing a Photo Identification Form or providing a government issued ID to the Photo ID/Security Department as described in their policy 'Badge – Identification Policy'.

21. 2x2 Photo required to be included on Privileging Module (MSOnet)

In order for a practitioner to be credentialed and privileged, he/she must submit a completed application form along with other documents requested in the application packet. The application must be completed in its entirety.

B. Reappointments

Reappointment to the Medical Staff and requesting of clinical privileges shall occur biennially.

Applications will be sent to providers five (5) months prior to their appointment expiration date and are expected to be completed and returned within 5 weeks of the post mark date.

The practitioner shall be required to submit an attestation for completion of continuing education activity for the previous two years, clinical privilege request form for each facility, complete information for Peer Reference and any other documentation/ information requested. All reappointment applications will also include an Attestation Questionnaire as outlined in Section III.A.2 of this policy.

If the provider fails to submit a completed application packet by the date stated on written notice he/she shall be deemed to have voluntarily resigned his/her Medical Staff membership. The procedural rights set forth in the Medical Staff Bylaws for each facility shall not apply to a voluntary resignation under this section.

C. Timeliness of Information

Any of the following information found to be beyond 180 days of the signed authorization , at the time the file is presented to the Credentials Committee(s) or IDPC will be re-verified prior to review by that committee:

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<p>Name of Policy: Credentialing and Privileging Licensed Independent Practitioners</p>	<p>Page 4 of 13</p>
<p>Departments Affected: All Departments</p>	

- All on line verifications
 - Medical License
 - DEA (Drug Enforcement Administration)
 - NPDB (National Practitioner Data Bank)
 - OIG (Office of Inspector General)
 - GSA (General Services Administration)
- Malpractice insurance coverage and claims history
- Answers to attestation questions
- Signature and date on authorization to release form
- Current hospital affiliations

D. Requests for Additional Privileges

Any provider may request additional privileges at any time. These requests are handled as follows:

1. The provider must complete the appropriate privileging form and supply supporting documentation regarding training or experience, as required.
2. The following must be verified
 - MBC (Medical Board of California)
 - NPDB
 - OIG
 - DEA, if applicable
3. The privilege request form and supportive documentation are sent to the appropriate Department Head/Service Chief/Division Head for review and recommendation to the Credentials Committee(s) or IDPC. If the Department Head/Service Chief/Division Head is disinclined to make a favorable recommendation for these privileges, the Department Head/Service Chief/Division Head shall send a letter to the Credentials Committee(s) or IDPC indicating his or her concerns.
4. The evaluation and approval for additional privileges is forwarded to the Credentials Committee(s) or IDPC, with final review and approval by the Medical Executive Committee (MEC) and Governing Board.

E. Changes of Status, Resignations, and Retirement

A status change may be initiated by the Department Head/Service Chief/Division Head or the Credentials Committee(s) to assure that the member meets the qualifications for medical staff membership under his or her membership category. In addition, the provider may request a change of status at any time. All requests must be in writing.

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<p>Name of Policy: Credentiaing and Privileging Licensed Independent Practitioners</p>	<p style="text-align: center;">Page 5 of 13</p>
<p>Departments Affected: All Departments</p>	

IV. PROVIDER RIGHTS TO AMEND APPLICATION AND TO RECEIVE UPDATES

- A. Providers have the right to correct erroneous information obtained throughout the credentialing process. If any submitted items differ substantially from documentation disclosed through the verification process, the provider will be asked via written request (email or certified letter) to resolve this discrepancy and will be expected to do so within 10 business days of the request. Any and all corrections should be submitted in writing to the SHC/LPCH Medical Staff Services Department for adequate review of current documentation. Any instance of the provision of information containing misrepresentations or omissions is forwarded to the Credentials Committee(s) for review and action. The provider will be notified of any actions following review by the Board of Directors.
Providers are allowed access to their own credentials files (with the exception of Peer Evaluations or verifications) as outlined in the policy for Confidentiality of Medical Staff/Allied Health Professional (AHP) Records.
- B. Providers have the right to contact Medical Staff Services at any time regarding the status of their application for appointment or reappointment. All such requests will be responded to by the appropriate coordinator within a reasonable period of time, not to exceed four work days.

V. PROCEDURE

- A. Processing and Verification
When the application for appointment or reappointment is returned, a review for completeness is performed by the Credentialing Office. If additional information is required, or if questions are left blank, the applicant is contacted and informed that processing will not begin until the application is entirely complete. The applicant is responsible for providing the information to satisfy the process. Failure to submit the requested information within 10 days shall be considered a withdrawal of the application.

All information gathered on the application will be verified by the primary source. Primary source may include verbal verifications which require a dated, signed note in the credentialing file stating who at the primary source verified the item, and the date and time of verification. In addition, queries will be made to the National Practitioner Data Bank (“NPDB”) and the Medical Board of California (“MBC”) regarding any adverse actions against the practitioner. If any verification received has adverse actions, the practitioner will be promptly contacted and will be expected to provide an explanation in writing for any of these issues. Sources used for verifications include:

- 1. California Professional License /Professional Licenses from Other States
Current California State professional licensure must be obtained by direct confirmation from the appropriate licensing board either on-line, or by phone. Boards used for verification:

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<p>Name of Policy: Credentialing and Privileging Licensed Independent Practitioners</p>	<p>Page 6 of 13</p>
<p>Departments Affected: All Departments</p>	

- State of California Medical and Professional Board– this verification confirms successful graduation from medical school and completion of at least one year of postgraduate residency training.
- Other State Medical and Professional Boards for active professional licenses

2. DEA Certification

An on-line NTIS query is required for primary source verification. All SHC/LPCH providers must have a valid DEA certificate, including all schedules (2, 2N, 3, 3N, 4 and 5), with a California address. Physicians under a 2113 Exemption are also exempted from this requirement. Pathologists and Psychologists are exempt from this requirement. For Advance Practice Professionals, DEA requirements are based on scope of service. Providers with an expired DEA, limited schedules or out of state address will have their privileges suspended until evidence of a valid DEA is provided to the Medical Staff Services Department.

A practitioner with an out-of-state address on their DEA may be credentialed pending the change of address or additional request for a DEA in the state of California.

The SHC/LPCH Pharmacy is notified on a monthly basis of all expired DEA certificates.

3. Fluoroscopy Certificate

Required for all radiologists and non-radiologists who will be using fluoroscopy equipment in the operating rooms or other procedure areas. Radiography Certificate is not accepted as a Fluoroscopy Certificate.

4. Verification of Hospital Affiliations and Work History

Written verification of five (5) years of clinical work history from hospitals or other health care organization affiliations is required. Verification of clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility should be confirmed in writing or verbally and includes the date of appointment, scope of privileges, restrictions, and recommendations.

Any gaps in work history of 90 days or more will require written clarification from the provider.

If verification of an affiliation is not obtained after two requests the provider is contacted regarding the delay, including a phone call to the facility, this should be noted in the file. If verification can't be obtained due to extraordinary circumstances this needs to be documented in file and noted for Department Head/Service Chief/Division Head and Credentials Committee. The file may then move through the evaluation process without this piece of documentation.

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<p>Name of Policy: Credentiaing and Privileging Licensed Independent Practitioners</p>	<p style="text-align: center;">Page 7 of 13</p>
<p>Departments Affected: All Departments</p>	

5. Verification of Graduation from Medical/Professional School and Completion of Residencies and Fellowships

Verification of medical/professional school graduation and completion of residency and fellowship training may be obtained from the institution(s) where the training was completed, and/or an agency that is deemed a primary source verification, (such as the American Medical Association (AMA) Physician Masterfile or American Osteopathic Association (AOA) Physician Database) or state licensing agency, if the state verifies. (Medical Board of California performs primary source verification of medical education and training).

Foreign Medical Graduates from schools of medicine other than those in the United States and Canada must present evidence of certification by the Education Commission for Foreign Medical Graduates (ECFMG) or successful completion of a fifth pathway, or, successful passing of the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS).

6. Board Certification

Board Certification is verified, through querying the ABMS on-line database (CertiFACTS), or by a letter directly from the certification board. Verification of Board Certification confirms successful completion of an approved residency program in the practitioner's specialty. Board certification is verified at time of initial appointment and also for each reappointment in order to verify current status and re-certifications.

7. Current, Adequate Malpractice Insurance

Professional Liability Insurance coverage and amounts of coverage must be confirmed directly with the carrier. If the provider is insured through SUMC, a copy of the blanket policy should be included in the provider's file. The provider must hold a minimum amount of coverage that covers requested privileges as determined from time to time by the Stanford Hospital and Clinics and Lucile Packard Children's Hospital Board of Directors.

8. Professional Liability Claims History

Verification of claims history for five years on new appointments and two years for reappointments must be obtained from the current and/or previous carriers. The NPDB query may be used as evidence of settlement and judgment history.

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<p>Name of Policy: Credentialing and Privileging Licensed Independent Practitioners</p>	<p style="text-align: center;">Page 8 of 13</p>
<p>Departments Affected: All Departments</p>	

Those providers who hold a full-time Faculty or Adjunct Clinical Faculty appointment with the Stanford University School of Medicine are covered under the Medical Professional Liability and General Liability plan while acting within the scope of their duties on behalf of SHC and LPCH. A copy of this coverage statement will be included in the provider's file as appropriate.

9. Background Checks

Stanford Hospital and Clinics and Lucile Packard Children's Hospital engage in background checks as a verification element within the credentialing process. Any and all background reports will be stored and protected in the Quality folder within the corresponding credential file. All adverse information found on background checks is evaluated by Department/Service/Division Chief as well as the Credentials Committee or IDPC.

10. Privileging Criteria

Each applicant is expected to meet the criteria related to the privileges they are requesting on the privilege form.

11. National Practitioner Data Bank

The NPDB must be queried for all new appointments, biennially for reappointments and at time of the request for additional privileges. Each query to the NPDB is facility specific therefore there will be one (1) NPDB query for Stanford Hospital and Clinics and one (1) query for Lucile Packard Children's Hospital if provider is on staff at both facilities. PDS is utilized for all privileged members. Adverse information will be addressed on an as needed basis.

12. Medicare/Medicaid Sanctions

Sanction verifications for Medicare and Medicaid will be processed by querying the National Practitioner Data Bank (NPDB) and by obtaining a Sanctions Exclusions Report (published by the Office of Inspector General (OIG)) via Internet site for each credentialed provider. In addition, ongoing monitoring of sanctions to Medicare and Medicaid will be done on a monthly basis by downloading the OIG Monthly Reports and verifying against current SHC/LPCH rosters within 30 days of their release.

13. Professional References

Three professional references are requested for new applicants and two are required for packets to be complete; One peer reference for reappointments is required. These references must be from individuals who have recently worked with the applicant, have directly observed his/her professional performance over a reasonable period of time, and who can and will provide

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<p>Name of Policy: Credentialing and Privileging Licensed Independent Practitioners</p>	<p style="text-align: center;">Page 9 of 13</p>
<p>Departments Affected: All Departments</p>	

reliable information regarding current clinical ability, health status, ethical character, and ability to work with others. If the applicant has recently completed a residency or fellowship within the past two years, a reference from the program director should be requested. Ratings of 2 or less and/or any adverse comments will be flagged for Service Chief and Credentials Committee review.

14. Continuing Medical Education

A statement documenting Continuing Medical Education must be included with the application for appointment or reappointment, or a statement signed indicating that the practitioner has met or exceeded continuing medical education requirements for licensure.

15. Reappointment Performance Improvement Data

In addition to verifying credentials, a provider's quality file is compiled for the evaluation process. Information from the following areas may be included for consideration. Information is gathered for each facility on an ongoing basis to which the practitioner is applying. All data is then assembled and reviewed at time of reappointment and based on the timeline outlined in the Professional Practice Policy.

1. Patient
2. Medical Knowledge
3. Professionalism
4. System Based Practice
5. Interpersonal
6. Practice based medicine

16. Training Modules

Providers are required to complete any training modules relative to privileges requested and patient care provided. The module descriptions are outlined below and the link to the modules are located on the Medical Staff Services Website: <http://medicalstaff.stanfordhospital.org/mss/credentialing/application/training.html>

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<p>Name of Policy: Credentialing and Privileging Licensed Independent Practitioners</p>	<p>Page 10 of 13</p>
<p>Departments Affected: All Departments</p>	

- a. QI and HIPPA:
These modules are required and are available via Healthstream. (There are two QA/QI Modules and six HIPAA Modules. New applicants are required to complete Part 1 and 2 of QA/QI and all six of the HIPAA modules. For physicians who have completed the modules during a training program in the previous 2 years, the requirement can be waived by the Service Chief. Reappointments are required to complete Part 2 of QA/QI module. Logins and passwords are assigned by the credentialing coordinator.
- b. EPIC (For SHC):
Providers who request privileges at SHC are required to take EPIC training.
- c. Power Charts Instructions(For LPCH):
Providers who request privileges at LPCH are required to take PowerChart (LINKS) training.
- d. Sedation:
This module is required for any non-exempt provider who will be performing procedures using sedation. This module is located on Healthstream.

17. Health Screening

All providers are required to comply with all health screening policies set forth by regulatory standards as well as medical staff policies and procedures.

18. Opt Out Report

The Opt Out Report of Northern California is checked within 10 days of publication for any practitioners who have opted out of Medicare. When a practitioner, who is currently on our Medical Staff, is found to be on the Opt Out report using the hospital address(s) he/she will no longer be on our Health Plan contracts.

19. Additional Information

Other information as deemed necessary may also be collected and considered. Clinical Services may impose additional documentation requests, such as monitoring requirements.

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<p>Name of Policy: Credentialing and Privileging Licensed Independent Practitioners</p>	<p style="text-align: center;">Page 11 of 13</p>
<p>Departments Affected: All Departments</p>	

20. Delegated Health Plans

Providers on our medical staff who would be considered eligible for our delegated agreements with health plans are those with a faculty appointment through the Stanford School of Medicine and any community provider who has a contract with Stanford Hospital and Clinics and/or Lucile Packard Children's Hospital. Providers not considered for participation on our delegated agreements would be community physicians with no teaching titles or contracts. The Managed Care department has access to the information Medical Staff Office database for the purpose of providing accurate credentialing information to health plans and for the publishing of provider directories.

21. All Medical Staff members are required to pay the appropriate amount of dues and application fees based on the medical staff categories outlined in the Medical Staff Bylaws. APP members do not pay dues, but may be required to pay an application fee based on employment status.

SHC/LPCH Category Assessment (refer to SHC or LPCH Bylaws)

During the processing of each reappointment, the coordinator will gather patient activity information for each facility and determine if the provider holds the appropriate status. The following guidelines will be used:

1. If a provider is currently on the Active Medical Staff
 - had less than 11 patient contacts per year at SHC and/or LPCH during the previous two years
 - has had minimal or no administrative activity
 - is on the Active staff at another hospital then the provider's status will be changed to Courtesy-Admitting (SHC), Consulting (LPCH), Refer and Follow (LPCH) or Courtesy (LPCH). PLEASE NOTE: Faculty providers must remain in an Active status at least one of the facilities unless specific exception is requested by the Department Head/Service Chief/Division Head.

2. If a provider is currently Active, Courtesy or Courtesy-Admitting, and has no patient contacts or administrative activity at SHC or LPCH during the previous two years, the provider may be voluntarily resigned from the Medical Staff(s) due to non-compliance with the Medical Staff Bylaws.

3. If a provider is currently Courtesy-Teaching and it is determined that the teaching appointment with the Stanford School of Medicine has expired the provider will be processed as a voluntarily resignation from the Medical Staff.

<p>This policy applies to:</p> <p><input checked="" type="checkbox"/> <i>Stanford Hospital and Clinics</i></p> <p><input checked="" type="checkbox"/> <i>Lucile Packard Children's Hospital</i></p>	<p>Date Written or Last Revision: May 2011</p>
<p>Name of Policy: Credentialing and Privileging Licensed Independent Practitioners</p>	<p style="text-align: center;">Page 12 of 13</p>
<p>Departments Affected: All Departments</p>	

4. If the provider is currently in the Affiliate status, no privileges are granted. The provider will be credentialed only as part of the requirement to participate in Health Plan contracts.

If any of the above conditions are met, the coordinator will send a letter, email or fax to the provider outlining the change being recommended. The provider may inform Medical Staff Services if he/she feels the information is inaccurate. Recommendations will be forwarded to the Department Head/Service Chief/Division Head along with any additional information submitted by the provider for review and approval.

VI. RELATED DOCUMENTS

Stanford Hospital and Clinics Medical Staff Bylaws, Rules and Regulations

Lucile Packard Children's Hospital Medical Staff Bylaws, Rules and Regulations
Credentials Policies and Procedures

Policy – AHP: Authorization for Individuals to Provide Services as Allied Health Professionals

VII. DOCUMENT INFORMATION

- A. Legal Authority/References
 1. TJC Standards
 2. NCQA Standards
 3. Title 22 Regulations
- B. Author/Original Date
This Policy was authored by the Director, Medical Staff Services in April, 2000.
- C. Gatekeeper of Original Document
The Director, Medical Staff Services (or designee), who will be responsible for initiating its review and revision. The Policy will reside in the Credentials Policy and Procedure Online Manual.
- D. Distribution and Training Requirements
The distribution and training requirements for this Policy will be handled through the Credentials Department.
- E. Review and Renewal Requirements
This Policy will be reviewed and/or revised every three years or as required by change of law or practice.
- F. Review and Revision History

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<p>Name of Policy: Credentialing and Privileging Licensed Independent Practitioners</p>	<p style="text-align: center;">Page 13 of 13</p>
<p>Departments Affected: All Departments</p>	

Revision – September, 2000 3/02, 12/02, 7/03, 6/05, 9/06, 6/08, 12/08, 1/09, 3/10, 11/10, 5/11

- G. Local Approvals
 Credentials Committee (2) – Sept, 2000, March, 2002, 7/03, 6/05, 9/06, 2/08, 6/08, 5/11
 Medical Executive Committee (2) – April, 2002; August, 2003, 7/05, 10/06, 7/08, 3/09, 5/11

- H. Board Approvals
 April, 2002; August, 2003, 7/05, 10/06, 7/08, 3/09, 5/11

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Direct inquiries to:
 Director, Medical Staff Services, (650) 497-8920
 SHC and LPCH