

**STANFORD HOSPITAL AND CLINICS
LUCILE PACKARD CHILDREN'S HOSPITAL**

**ALLIED HEALTH PRACTITIONER
JOB TRANSFER FORM**

PROVIDER INFORMATION:

Last Name (as it appears on your license):		First (as on license):		Middle (as on lic.):	Provider ID#
Home Address:				Social Security No:	
City:		State:		Zip:	
Home Phone: ()		Cell Phone: ()		Pager: ()	
Email Address:					
License No:	Expiration. Date:	DEA No:	Expiration Date:		

License/Certification Category: (You are **required** to submit a current copy of your license or certification with this form)

- | | |
|--|--|
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Nurse Practitioner |
| <input type="checkbox"/> Clinical Nurse Specialist | <input type="checkbox"/> Certified Nurse Midwife |
| <input type="checkbox"/> Certified Registered Nurse Anesthetist (CRNA) | |

Other: _____

Primary Employer: Stanford Hospital & Clinics LPCH Stanford School of Medicine

Other _____

Who will be your new Supervising Physician _____

ANTICIPATED START DATE FOR JOB TRANSFER: _____

PRACTICE JOB DESCRIPTION: A Job Description must be completed and approved by the Interdisciplinary Practice Committee of this application prior to start date.

Will work under existing approved Job Description for the following category:

New Job Description has been written and approved and a signed copy is attached.

1- In which of the following facilities are you interested in practicing: Stanford LPCH
Start Date at this facility: _____

2- Will you be treating patients in the hospital units? YES NO **SHC/LPCH Clinics?**
 YES NO

3 -Identify the location(s) where you plan to provide patient care within Stanford Hospital or LPCH (Clinic Name, Inpatient Unit, Office, etc.):

Practice Location: _____ Primary Clinical Dept/Service: _____

APPLICANT SIGNATURE

I certify that the information in this document and any attached documents is true and correct. I agree to notify this Hospital(s), in a timely manner of any change to the information included on this form. By my signature below, I acknowledge and agree that I will promptly and fully report all information to the Medical Staff Services Department of this facility in the event any information within this application changes or if any situation arises which affects my ability to treat patients. In addition, I agree and consent to a physical or mental health examination acceptable to the Interdisciplinary Practice Committee(s) and Medical Board(s) upon request by either as they deem necessary to determine compliance with Medical Staff requirements.

Applicant Signature

Date

ADMINISTRATIVE MANAGER (FOR EMPLOYEES ONLY)

Practice Protocols: Practice Protocols and/or Job Descriptions must be completed and approved in conjunction with the application process by the Interdisciplinary Practice Committee or Sponsoring Department as follows:

The applicant will be working under approved protocols/job description.

Protocol/JD Name: _____

Administrative Manager

Phone #

Mail ID/Date

Will this practitioner bill independently? Yes No

If yes individual's salary will be removed from Medicare and Medi-Cal Cost Report