

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

**ADVANCED PRACTICE PROFESSIONAL APPLICATION**

**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:		Date of Birth:	
Home Phone: ( ) ( )	Cell Phone: ( ) ( )		Pager: ( ) ( )		
Email Address:				Driver's License #: State:	
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 \_\_\_\_\_

**ANTICIPATED START DATE and/or DATE OF HIRE**

--

**PRACTICE PROTOCOLS:** Practice Protocols must be completed and approved by the Interdisciplinary Practice Committee of this application prior to start date.

Will work under existing approved protocols for the following category: \_\_\_\_\_

New protocols specific to my duties are in the process of being written.

New protocols have been written and approved and a signed copy is attached PRACTICE INFORMATION:

**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

**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, after I have signed and dated this form, while my application is pending, and, if I am appointed to Advanced Practice Professional Staff while I maintain Advanced Practice Professional Staff membership.*

*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 : \_\_\_\_\_

The applicant is working with the Interdisciplinary Practice Committee or sponsoring department on developing new Practice Protocols for this position

\_\_\_\_\_  
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*

<b>1) CLINICAL PRACTICE INFORMATION</b> <i>(Please indicate ONE address as preferred mailing address)</i>			
<b>Primary Location</b> <i>(where you provide the majority of your patient care):</i>			<input type="checkbox"/> <b>Outpatient Clinic</b> <input type="checkbox"/> <b>Inpatient Unit</b>
Name:			<input type="checkbox"/> <i>Preferred mailing address</i>
Street:			Phone: (     )
City:	State:	Zip:	Fax: (     )
<b>Secondary Office Street Address:</b> <i>(if applicable)</i>			<input type="checkbox"/> <b>Outpatient Clinic</b> <input type="checkbox"/> <b>Inpatient Unit</b>
Name:			<input type="checkbox"/> <i>Preferred mailing address</i>
Street:			Phone: (     )
City:	State:	Zip:	Fax: (     )

<b>2) PROFESSIONAL EDUCATION</b>		
<b>Professional School:</b>		Degree Received:
Mailing Address City, State Zip:	Phone: Fax:	Date Received: (mm/dd/yy):
Country:	Email:	
<b>Professional School:</b>		Degree Received:
Mailing Address City, State Zip:	Phone: Fax:	Date Received: (mm/dd/yy):
Country:	Email:	

<b>3) PREVIOUS EMPLOYMENT</b> <i>(If NOT an employee of Stanford Hospitals and Clinics or Lucile Packard Children's Hospital)</i>
<b>In section A below, list all previous employment to cover the past ten (10) years.</b> If more space is needed, attach additional sheet(s).

<b>A. PREVIOUS EMPLOYMENT (attach additional pages as necessary)</b>				
<b>Hospital or Clinic Name:</b>			Supervisor:	
Department:	Job Title:		Supervisor's Email:	
Address:			Phone: (     )	Fax: (     )
			From (mm/yy):	To (mm/yy):
City:	State:	Zip:	Reason for Leaving:	
<b>Hospital or Clinic Name:</b>			Supervisor:	
Department:	Job Title:		Supervisor's Email:	
Address:			Phone: (     )	Fax: (     )
			From (mm/yy):	To (mm/yy):
City:	State:	Zip:	Reason for Leaving:	
<b>Hospital or Clinic Name:</b>			Supervisor:	
Department:	Job Title:		Supervisor's Email:	
Address:			Phone: (     )	Fax: (     )
			From (mm/yy):	To (mm/yy):
City:	State:	Zip:	Reason for Leaving:	

**4) PEER REFERENCE** (Someone who can assess competency in the past two years)

In the area below, list as references, 2 peer and 1 supervising physician (**preferably within your specialty**) who are directly familiar with your current clinical work, either through direct clinical observation or through close working relations. Do not include relatives, or associates in practice.

(A) Name of person who can serve as a peer reference who is not an MD.

<b>Name of Reference and Degree:</b>	E-mail Address:
Mailing Address:	Phone:
City/State/Zip:	Fax:

(B) Name of person who can serve as a peer reference who is not an MD.

<b>Name of Reference and Degree:</b>	E-mail Address:
Mailing Address:	Phone:
City/State/Zip:	Fax:

(C) Supervising Physician with whom you have **worked before**, or another peer reference.

<b>Name of Reference and Degree:</b>	E-mail Address:
Mailing Address:	Phone:
City/State/Zip:	Fax:

**5) SUPERVISING PHYSICIAN at Stanford Hospital or Lucile Packard Children's Hospital**

In the area below, list the name, specialty and mailing address of the Medical Staff Member who will serve as your Supervising Physician. *All Advanced Practice Professionals must have a Supervising Physician.*

(A) Name of supervising physician (*must be a member of the Medical Staff at the facility to which you are applying*)

<b>Name of Physician:</b>	Specialty
Mailing Address:	Phone:
City/State/Zip	Pager #:
E-mail Address:	Fax #:

**6) LICENSE INFORMATION AND ID NUMBERS**

*If you have a additional license, certification, credentials, or other relevant professional information (e.g. furnishing number) appropriate to your protocols, please list here and provide documentation:*

_____	_____
_____	_____
_____	_____

**Please check here if you do not write prescriptions for controlled substances**

## 7) ATTESTATION QUESTIONS

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

### Professional Liability Insurance

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

*Please note that members of this Healthcare Organization shall report to this Healthcare Organization the disposition (including settlement) and/or final judgement in professional liability cases in which they are involved, within thirty (30) days of disposition and/or final judgment.*

### Physical and Mental Health

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

### Disciplinary and/or Voluntary actions

*Voluntarily \*\*\* or involuntarily, have any of the following ever been, or are currently being, denied, revoked, suspended, relinquished, withdrawn, reduced, limited, placed on probation, not renewed, or currently pending/under investigation?*

- Yes  No Professional license or certification in any state;
- Yes  No Other professional registration/license
- Yes  No DEA Certificate of registration
- Yes  No Employment on the staff of any institution;
- Yes  No Any other type of professional sanction;
- Yes  No Have you been subject to any disciplinary action in any health care organization, or is any such action pending;
- Yes  No Has any additional supervisory requirement been imposed;
- Yes  No Have you resigned or taken a leave of absence in order to avoid possible revocation, suspension, or reduction of duties at any hospital or institution;
- Yes  No Have there been any, or are there any, misdemeanor or felony criminal convictions against you;
- Yes  No Have there been any, or are there any, misdemeanor or felony criminal charges pending against you;

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

### Compliance with Laws Related to Patient Care

- Yes  No Are there any pending or completed administrative agency, government, or court cases, decisions or judgments involving allegations that you failed to comply with laws, statutes, regulations, or other legal requirements that may be applicable to the practice of your profession or to your rendition of service to patients;
- Yes  No Are there any prior or pending government agency or third party payer proceedings or litigation challenging or sanctioning your patient treatment, charging, collection, or utilization practices, including, but not limited to, Medicare and Medicaid fraud and abuse proceedings or convictions?

**Applicants Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

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

Stanford Hospital and Clinics insurance risk pool

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

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

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

### Professional Liability Action Information

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

#### CLAIM STATUS

<input type="checkbox"/> <b>No Known Claims</b>
<input type="checkbox"/> <b>OPEN</b> If open, amount being sought:
<input type="checkbox"/> <b>CLOSED</b> If closed, indicate method of closing: <input type="checkbox"/> Settlement <input type="checkbox"/> Judgment Date:
Amount of settlement or judgment: \$

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

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

## WORK HISTORY INFORMATION

### ADDENDUM

**Chronologically list all work history activities since receiving your professional degree. This information must be complete.** Please explain any gaps of more than three months in professional work history on a separate page.

**Please Print**

Practice or Association:	Contact Name:	Phone:	
	E-mail:	Fax:	
Complete mailing address:		From: (mm/yy)	To: (mm/yy)

Practice or Association:	Contact Name:	Phone:	
	E-mail:	Fax:	
Complete mailing address:		From: (mm/yy)	To: (mm/yy)

Practice or Association:	Contact Name:	Phone:	
	E-mail:	Fax:	
Complete mailing address:		From: (mm/yy)	To: (mm/yy)

Practice or Association:	Contact Name:	Phone:	
	E-mail:	Fax:	
Complete mailing address:		From: (mm/yy)	To: (mm/yy)

Practice or Association:	Contact Name:	Phone:	
	E-mail:	Fax:	
Complete mailing address:		From: (mm/yy)	To: (mm/yy)

*Occupational Health Services*

Main Office: 650.723.5922

Redwood City Office: 650.721.7316

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

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

**TITERS:**

COMPLETED NOT COMPLETED

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

**TB TESTING:**

COMPLETED NOT COMPLETED N/A

Questionnaire/symptom review  
QuantiFeron done within the last three months or Tuberculin Skin Testing (TST) done within the last three months along with prior documentation of another TST done within 365 days  
Chest X-Ray done within the last year if TST positive

**VACCINES:**

COMPLETED NOT COMPLETED N/A

titer)

Hepatitis B (unless you have provided a positive Hep. B Antibody  
Influenza (annual)  
Tdap or Declination

**FIT TESTING:**

COMPLETED NOT COMPLETED N/A

N95 Fit Test - Needed only if seeing inpatients

Name \_\_\_\_\_ Specialty \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Cleared for Medical Staff membership and privileges:  Yes  No

\_\_\_\_\_ Occupational Health Services Representative

\_\_\_\_\_ Date

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

In connection with my application, and for the duration of my membership, with **STANFORD HOSPITAL AND CLINICS/LUCILE PACKARD CHILDREN'S HOSPITAL ("Hospitals")**, I understand that investigative background inquiries may be made on me from time to time, including but not limited to previous employer verifications, education verifications, criminal convictions or history, motor vehicle reports, Social Security trace reports, and other reports. These reports may include reasons for termination of past employment from previous employers. Further, I understand **the Hospitals and their Advanced Practice Professionals and Medical Staffs**, and/or their authorized agent may be requesting information from various Federal, State, and other agencies which maintain records concerning my past activities relating to my driving, criminal, civil, and other experiences, and may include information involving me in the files of malpractice insurance companies.

I hereby authorize and release, without reservation, USA-FACT (Consumer Reporting Agency) and **the Hospitals and their Advanced Practice Professionals and Medical Staffs**, their directors, officers, agents, representatives, employees and/or assigns from any and all claims, actions, suits, agreements, or liabilities arising from the release of said information to **the Hospitals and their Advanced Practice Professionals and Medical Staffs**, or any authorized agent thereof. Your background information will be submitted by:

**USA-FACT, Inc. • 6200 Box Springs Blvd, Riverside, CA 92507 • 909-656-7800**

I am entitled to receive a free copy of my consumer report before any adverse decision of possible employment is made because of information obtained within my report. I am also entitled to receive a free copy of my consumer report if I so choose. I hereby:

- request** a copy of my background report directly from USA-FACT, Inc.
- waive** my right to receive a copy of my background report.

*I have read and understand the above notice.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Print Name: \_\_\_\_\_  
PRINT ENTIRE NAME LEGIBLY

Mailing Address: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

Telephone number (including area code): \_\_\_\_\_

Driver's License Number: \_\_\_\_\_ State: \_\_\_\_\_

**AUTHORIZATION, RELEASE, AND CONFIDENTIALITY STATEMENT**

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

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

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

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

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

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

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

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

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

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

**Medicare Notice to Physicians:** Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

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

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

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

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

**Print Name Here:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Stamped Signature is NOT Acceptable)

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

**Medical Staff Code of Professional Behavior**

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

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

*Guidelines for Interpersonal Relationships*

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

*Guidelines for Clinical Practice*

- Respond promptly and professionally when called upon by fellow practitioners to provide appropriate consultation or clinical service
- Respond to patient and staff requests promptly and appropriately
- Respect patient confidentiality and privacy at all times; follow all regulations for release of information
- Treat patient families with respect and consideration while following all applicable laws regarding such relationships (release of information, advance directives, etc.)

- Seek and obtain appropriate consultation
- Arrange for appropriate coverage when not available
- Do one's best to provide the best effective and efficient care
- Prepare and maintain medical records within established time frames
- Disclose potential conflicts of interest and resolve the conflict in the best interest of the patient
- When terminating or transferring care of a patient to another physician, provide prompt, pertinent, and appropriate medical documentation to assure continuation of care
- For faculty, housestaff and medical students, refrain from accepting money, gifts, or personal benefits from commercial healthcare companies
- For non-faculty medical staff, refrain from accepting money, gifts, or personal benefits from commercial healthcare companies when on-site at the SoM, SHC or LPCH, or affiliated hospital

Guidelines for Relationship with Hospital and Community

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

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

STANFORD HOSPITAL & CLINICS  
LUCILE PACKARD CHILDREN'S HOSPITAL

**Medical Staff Code of Professional Behavior**  
**Acknowledgement of Receipt**

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

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

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

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

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

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

**CONFIDENTIALITY, CONFLICT OF INTEREST AND CODE OF CONDUCT**

*Biennial Statement Of Compliance*  
*For Advanced Practice Professional Staff Members*

**Confidentiality**

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

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

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

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

**Conflict of Interest**

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

**Code Of Conduct**

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

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

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

## CONTINUING EDUCATION REPORTING FORM

<b>Name</b>	If there are any questions concerning Credit Hours or Categories, please refer to the State of California booklet, "Continuing Medical Education Unit Requirements for Non-Physicians as Licensed by the California State Board of Medical Quality Assurance."
<b>CA Professional License Number</b>	
<b>Birth date (Mo/Day/Year)</b>	
<b>Report Period</b>	

Title of Course/Program (Specify if approved full-time residency or clinical fellowship)	Organizer's Name and Address	Dates of Attendance or Activity From/To	Credit Hours
Total Number of Credit Hours Claimed:			

Retain certificates of participation for your files.

I certify under penalty of perjury to the truth and accuracy of all statements, answers, and representations made in the foregoing application.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

## CALIFORNIA PATIENT ABUSE AND NEGLECT REPORTING REQUIREMENTS SUMMARY

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

<p>For reporting phone numbers or forms, see “reporting” sections of:  <a href="http://domesticabuse.stanford.edu">http://domesticabuse.stanford.edu</a>  <a href="http://elderabuse.stanford.edu">http://elderabuse.stanford.edu</a>  <a href="http://childabuse.stanford.edu">http://childabuse.stanford.edu</a></p> <p>These websites also contain important information on how to ask, what to look for, educational resources, upcoming events and conferences, and patient materials.</p>	<p>For general questions or to schedule free individual or group training/education:  <a href="mailto:domesticabuse@med.stanford.edu">domesticabuse@med.stanford.edu</a>  <a href="mailto:elderabuse@med.stanford.edu">elderabuse@med.stanford.edu</a>  <a href="mailto:childabuse@med.stanford.edu">childabuse@med.stanford.edu</a></p>
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	ADULTS	ELDERS/DEPENDENT ADULTS	CHILDREN
<b>Health Practitioner Mandated Reporters</b>	All medical health practitioners except in the fields of psychiatry or pediatrics	All health practitioners	All health practitioners
<b>What is reportable? Knowledge or reasonable suspicion of:</b>	<ul style="list-style-type: none"> <li>- wound or physical injury from domestic violence or sexual assault</li> <li>- any injury from firearm or deadly weapon</li> </ul>	<ul style="list-style-type: none"> <li>- physical harm or pain, including inappropriate chemical/physical restraints or withholding meds</li> <li>- sexual abuse</li> <li>- neglect, including self neglect</li> <li>- abandonment, abduction, isolation</li> <li>- financial abuse</li> </ul>	<ul style="list-style-type: none"> <li>- non-accidental physical injury</li> <li>- sexual abuse</li> <li>- neglect</li> <li>- unlawful corporal punishment</li> <li>- willful cruelty or unjustifiable punishment</li> <li>- abuse or neglect in out of home care</li> </ul>
<b>Where to report</b>	Police Dept. (PD) in city where incident occurred	<ul style="list-style-type: none"> <li>- Outside of a nursing home – PD or Adult Protective Services (APS) in county of residence</li> <li>- Inside nursing home care – PD or Ombudsman in county of nursing home</li> </ul>	PD in city where incident occurred, or Child Protective Services (CPS) in county of residence
<b>How to report</b>	Call ASAP and send report within 2 working days	Call ASAP and send report within 2 working days	Call ASAP and send report within 36 hours
<b>State reporting form</b>	CalEMA 2-920 plus optional forensic form CalEMA 2-502	SOC 341 plus optional forensic form CalEMA 2-602	SS 8572 plus optional forensic form CalEMA 2-900

**Acute sexual assault**

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

## SUSPICIOUS HISTORY, BEHAVIORS, PHYSICAL FINDINGS

### History

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

### Condition

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

### Patient behavior

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

### Partner/caregiver behavior

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

### Soft tissue injuries (bruises, lacerations, burns, bites, scratches, punctures) to:

Head and neck, orbit  
Lips/oral cavity/frenulum  
Forearms – defensive injuries  
Trunk, breasts, buttocks  
Restraint marks on wrists, axilla, ankles, corner of lips  
Genital/rectal area  
Any pressure ulcers or contractures

### Bruises

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

### Burns

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

### Fractures

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

### “Choking” (50% no immediate physical signs, but patient may have sx)

Ligature or fingermarks on neck, scratches from patient trying to remove  
Petechiae above markings, subconjunctival hemorrhage  
Patient hoarseness, dysphagia, dyspnea, nausea, ringing in ears  
Unexpected stroke in relatively young patient

### Occult injuries

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

### Lab

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

# HEALTH PRACTITIONER NOTIFICATION OF CALIFORNIA STATE ABUSE AND NEGLECT REPORTING REQUIREMENTS

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

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

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

I understand that:

Initial

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

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

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

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

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

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

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Print name: \_\_\_\_\_

## IMPORTANT CONTACT INFORMATION FOR NEW PROVIDERS

### Photo ID Department located in the Security Office on Ground Level at Stanford Hospital and Clinics ID Badge

650-498-6290

[photoid@stanfordmed.org](mailto:photoid@stanfordmed.org)

### Parking Access (Community Physicians and Staff Physicians / Unit Access / OR Access)

650-498-6290

[photoid@stanfordmed.org](mailto:photoid@stanfordmed.org)

### Information Technology Department

Your clinical department approves all computer access requests. This cannot be done by Medical Staff Services.

#### LPCH Help Desk 650-498-7500

Cerner

LINKS

Network Access

Remote Access

#### Stanford Help Desk 650-723-3333

MedRec

Network Access

Remote Access

EPIC

- Access Issues – 650-723-3333
- Functional Issues – 650-724-EPIC(3742)

### Dictation Inquiries

Once a provider has been approved to commence work by the Medical Staff Office contact Transcription directly and request to be added to the dictation system. Transcription will ask you for the following information:

- Provider Name
- Physician ID Number
- Office Mailing Address
- Rm Number and Mail Code
- Facility and Department

#### LPCH Transcription Department

Contact Person: Simona

**650-736-2983**

#### Stanford Transcription Department

Contact Person: Belle

**650-721-7591**

### Billing Questions

Provider Enrollment Coordinator

Patient Financial Services

(650) 498-7103

(650) 498-5840 FAX

### SUnet ID Website Link

<http://lane.stanford.edu/howto/index.html?id= 127>

### MSS Website Links (Please Bookmark the following sites):

SHC: <https://medicalstaff.stanfordhospital.org/>

LPCH: <https://intranet.lpch.org/mss/index.html>

### Applicant Benefits

Applicant must contact division directly

**Do not complete if you are an SHC/LPCH employee**



# **TRAINING**

## **PowerChart for New Providers**

Training for LINKS, the electronic health record at Lucile Packard Children's Hospital (LPCH), is required for all incoming providers at LPCH. This training curriculum offers essential details for interacting with the LINKS system and must be completed before practicing medicine at Lucile Packard Children's Hospital.

The training is divided into two parts: the web based training tool and the online assessment. You must complete both parts.

**Part 1:**

1. Complete a self-paced (1-2 hour) web-based tutorial (WBT) on <http://learnlinks.LPCH.org>. This site can be accessed from anywhere with Internet Explorer using a PC without a password.
2. Take the following WBTs for **Providers**:
  - **CTP LINKS Provider Training**
3. After completing the WBT, you will be directed to take assessment in HealthStream at <http://healthstream.com/hlc/stanford>.

**Part 2:**

You will need a userID and password for HealthStream, our Learning Management System. For medical staff, this will be your 6-digit physician ID/Dictation # (add a zero to the front), preceded by 'md-' (i.e., if your number is 12345, your userID and password will be 'md-012345'.

1. Login to HealthStream
  - <http://www.healthstream.com/hlc/stanford>
2. Complete the online assessments for:
  - **LINKS CTP Provider Training08**

**Getting Access to LINKS:**

Upon receiving approval from the Credentialing Office for privileges to work at LPCH, you may call the LPCH Helpdesk at 650.498.7500 and select option for physician assistance. Let the agent know that you are now on the LPCH Medical Staff and provide them your physician ID/Dictation number. You may request LINKS access (Cerner Applications) and Remote Access logins at the same time.