UCSF and LPPH&C Medical Staff

CHECKLIST FOR VISITING PRIVILEGES

(privileges to attend a specific patient(s) or for a specified period of time)

NOTE: A MINIMUM OF 14 BUSINESS DAYS ADVANCE NOTICE IS REQUIRED TO PROCESS YOUR REQUEST FOR VISITING PRIVILEGES. PATIENT CARE ACTIVITIES MAY NOT COMMENCE UNTIL YOU HAVE BEEN NOTIFIED THAT YOUR PRIVILEGES ARE APPROVED.

1) **The following documents MUST BE attached and submitted, as required for your practice at this institution:**

- ☐ Fully completed, signed, and dated Visiting Privileges Application Form
- ☐ Fully completed, signed, and dated Delineation of Clinical Privileges
- ☐ Professional License(s) (California and any out-of-state)
- ☐ Other Certificates/Permits applicable to your request for privileges
- ☐ DEA Certificate if you will prescribe controlled substances
- ☐ Fluoroscopy/X-ray Operator, Supervisor Certificate if you will use or supervise the use of this equipment
- ☐ Current Certificate of Professional Liability Company with, name, phone and fax number of the organization who will confirm your insurance coverage. Minimum coverage is $1-$3 million.
- ☐ Curriculum Vitae, including work history (account for *all* periods of time from medical school forward)
- ☐ Photo
- ☐ Indicate PPD Skin test within the last 12 months

2) **Forward your completed application packet and all attachments to the Chair/Chief of the Department to which you are applying for privileges.**

3) **Contact the department to ensure your application has been signed and forwarded to the Medical Staff Office.**

VISITING PRIVILEGES REQUEST FORM

Request Visiting Privileges at: ☐ **UCSF Medical Center** ☐ **Langley Porter Psychiatric Hospitals and Clinics (LPPH&C)**
Date: _____

- Department: _____ Specialty: _____ Subspecialty: _____
- Have you previously applied for privileges or been on staff at UCSF Med Ctr? _____ or LPPH&C? _____
- Describe your proposed patient care at the campus at which you are seeking visiting privileges; include # of patients, type of procedure(s), and/or illness/condition to be treated:

_____

_____

_____

- Date(s) of your proposed patient care activity: From _____ Through _____

VITAL:			
Last Name:		First Name:	Middle Initial:
Degree:	UCSF Academic Title (If Applicable):	Email:	Pager:

HOME INFORMATION:		
Street Address:		City:
State:	Zip:	Telephone #: ( )

PERSONAL:			
Date of Birth:	Place of Birth (City, State, Country):	Gender:	Social Security #:

PROFESSIONAL OFFICE ADDRESS:		
Street Address:		City:
State:	Zip:	Phone #: ( ) Fax #: ( )

BOARD CERTIFICATION :			
Board/Subspecialty Board:	Certified Date:	Expir. Date:	Recert. Date:

HOSPITALS:		
Primary Hospital Name:	City:	Phone and Fax #:

PEER REFERENCE: (Name of Service Chief at Primary Hospital)	
Chief's Name:	Phone and Fax #:

CREDENTIALS:	
Name of Medical School:	Year of Graduation:

MEDICAL LICENSE/DEA CERTIFICATE:		
CA License # and Expir. Date:		DEA # and Expir. Date:
Out of State Lic #:	Name of State:	Expir. Date:

PROFESSIONAL LIABILITY:		
Company Name:	Phone #:	Fax #:
Policy #:	Expiration Date:	Amounts: $ /$

XII. 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 judgement.

Physical and Mental Health

☐ Yes ☐ No	Do you currently have, or have you had, a problem associated with the use or misuse of drugs or controlled substances of any kind (whether obtained by prescription or otherwise), or alcohol? If yes, on a separate sheet please give a full explanation, including, without limitation, frequency and amount of use, the time period in which you engaged in such use, and the date last used.
☐ Yes ☐ No	Do you have any reason you cannot safely perform all the essential mental and physical functions related to the specific clinical privileges you are requesting or required by your agreement with the medical staff or professional staff bylaws of the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance, and without posing a significant health and safety risk to others? If yes, on a separate sheet, please describe the essential function(s) and state the reason why you may not be able to safely perform it.

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

**** 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 licensee is under investigation related to professional conduct. You do not need to report resignations for reasons of relocation or change of activity.*

Compliance with Laws Related to Patient Care

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

Signature Date:

AUTHORIZATION, RELEASE, AND CONFIDENTIALITY STATEMENT

I FULLY UNDERSTAND THAT ANY SIGNIFICANT OMISSIONS, MIS-STATEMENTS OR MISREPRE-SENTATIONS IN THIS APPLICATION, OR DURING THE APPLICATION PROCESS, CONSTITUTE CAUSE FOR DENIAL OF THIS APPLICATION, OR FOR TERMINATION OR SUSPENSION OF MY CLINICAL PRIVILEGES AT THIS HEALTHCARE ORGANIZATION. I AFFIRM THAT THE INFORMATION SUBMITTED IN OR APPENDED TO THIS APPLICATION IS COMPLETE, TRUE AND CURRENT TO THE BEST OF MY KNOWLEDGE AND BELIEF AND IS FURNISHED IN GOOD FAITH.

In making this application for Visiting privileges to this Healthcare Organization, I acknowledge that I have received the pertinent 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 Visiting privileges. I further agree to be bound by the terms of the Bylaws without regard to whether or not I am granted Visiting privileges in all matters relating to the consideration of my application for Visiting Privileges to this Healthcare Organization. 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 this Healthcare Organization and its/their representatives to consult with representatives of other healthcare organizations with which I have been (*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 this Healthcare Organization. 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.

I agree to notify the Medical Staff Office of each Healthcare Organization 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 this Healthcare Organization and its/their representatives and other Healthcare Organizations and its/their representatives, or other persons or entities who, in the opinion of the this Healthcare Organization and its/their representatives, have a legitimate need for such information. I authorize and consent to the release by and between this Healthcare Organization and other Healthcare Organizations and their representatives, of all records and documents, including medical records, that may be material to an evaluation of my professional qualifications and competence for Visiting privileges herein requested, as well as my physical and mental health, and moral and ethical qualifications for Visiting privileges. I also consent to the sharing of credentialing, quality assessment and peer review information among all UCSF Medical Center organizations, including LPPH&C and UCSF Medical Group, to which I hereby apply and 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 UCSF Medical Center, this Healthcare Organization 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 this Healthcare Organization, in good faith and without malice, concerning my professional competence, ethics, character and other qualifications for Visiting privileges.

I understand and agree that I, as an applicant for Visiting 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 Healthcare Organization 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 Visiting privileges, while I maintainVisiting 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 this Healthcare Organization, I promise to provide patients with continuous care that meets the professional standards established by this Healthcare Organization. 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 this Healthcare Organization involved in the evaluation and improvement of the quality of patient care. I agree to make no voluntary disclosure of such information except to persons authorized to receive it. I understand that this Healthcare Organization 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 termination or suspension.

I understand compliance with the following Infection Control Standards & Safety Precautions is required and will be considered as a component for privileges at the UCSF and LPPH&C Medical Staff.

- **OSHA Bloodborne Pathogen Standard (including use of safety engineered medical devices)**
- **OSHA Respiratory Protection Standard as described above**
- **Infection Control and Safety policies and procedures, and**
- **Environment of Care policies and procedures**

Medicare/TRICARE Notice to Physicians: Medicare/TRICARE 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.

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:

Provider Name: _____

Signature:_____ **Date:** _____

(Stamped Signature is not acceptable)

University of California San Francisco
Confidentiality of Patient, Employee and University Business Information

Statement of Policy:

It is the legal and ethical responsibility of all UCSF faculty and staff employees, house staff, students and volunteers to use personal and confidential patient, employee and University business information (referred to here collectively as "confidential information") in accordance with the law and University policy, and to preserve and protect the privacy rights of the subject of the information as they perform their University duties.

Laws controlling the privacy of, access to and maintenance of confidential information include, but are not limited to, the federal Health Insurance Portability and Accountability Act (HIPAA), the California Information Practices Act (IPA), the California Confidentiality of Medical Information Act (COMIA), and the Lanterman-Petris-Short Act (LPS). These and other laws apply whether the information is held in electronic or any other form, and whether the information is used or disclosed orally or in writing.

University policies that control the way confidential information may be used include, but are not limited to the following: UCSF Medical Center Policy 05.02.01, LPPI Policy, UC Personnel Policies PPSM 80, APM 160, applicable union agreement provisions, UC Business and Finance Bulletin RMP 8, and as summarized below.

Confidential information includes information that identifies or describes an individual and the disclosure of which would constitute an unwarranted invasion of personal privacy. Examples of confidential employee and University business information include home address and telephone number; medical information; birthdate; citizenship; social security number; spouse/partner/relative's names; income tax withholding data and performance evaluations and proprietary/trade secret information.

The term "medical information" includes the following: medical and psychiatric records, including paper printouts, photos, videotapes, diagnostic and therapeutic reports, x-rays, scans, laboratory and pathology samples; patient business records, such as bills for service or insurance information whether stored externally or on campus; electronically stored or transmitted patient information; visual observation of patients receiving medical care or accessing services; verbal information provide by or about a patient; peer review/risk management information and activities; or other information the disclosure of which would constitute an unwarranted invasion of privacy.

Acknowledgement of Responsibility

I understand and acknowledge that:

It is my legal and ethical responsibility to preserve and protect the privacy, confidentiality and security of all medical records, proprietary and other confidential information relating to UCSF, its patients, activities and affiliates, in accordance with the law and University policy.

I agree to access, use or disclose confidential information only in the performance of my University duties, where required by or permitted by law, and only to persons who have the right to receive that information. When using or disclosing confidential information, I will use or disclose only the minimum information necessary.

I agree to discuss confidential information only in my workplace and for University-related purposes. I will not knowingly discuss any confidential information within the hearing of other persons who do not have the right to receive the information. I agree to protect the confidentiality of any medical, proprietary or other confidential information which is incidentally disclosed to me in the course of my relationship with UCSF.

I understand that psychiatric records, drug abuse records, and any and all references to HIV testing, such as clinical tests, laboratory or otherwise, used to identify HIV, a component of HIV, or antibodies or antigens to HIV, are specially protected by law.

I understand that my access to all University electronic information systems is subject to audit in accordance with University policy.

I agree not to share my Login or User ID and/or password with anyone and that any access to UCSF electronic information systems made using my Login or User ID and password is my responsibility. If I believe someone else has used my Login or User ID and/or password, I will immediately report the use to Information Technology Services and request a new password.

I understand that violation of any of the University's policies and procedures related to confidential information or of any state or federal laws or regulations governing a patient's right to privacy may subject me to legal and/or disciplinary action up to and including immediate termination from my employment/professional relationship with UCSF.

I understand that I may be personally liable for harm resulting from my breach of this Agreement and that I may also be held criminally liable under the HIPAA privacy regulations for an intentional and/or malicious release of protected health information.

Print Name Signature Date

University of California San Francisco
Prevention, Detection, and Response to Sexual Violence and Sexual Harassment

Please respond either "yes" or "no" to each question. In case of any doubt, please respond affirmatively. If your response is "yes," please provide a detailed explanation of your response, including any explanatory or exculpatory information. An affirmative response to any of the following questions will not automatically result in your disqualification but will trigger individual review and assessment process during which you will receive notice and additional opportunity to respond in the event of a preliminary decision to deny your application. For the purposes of the following questions, **sexual misconduct** refers collectively to the commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer; or any other inappropriate contact or communication of a sexual nature.

1. *Since the age of 18, has any allegations of sexual misconduct been substantiated against you through a formal investigation by any educational institution, employer, regulatory or law enforcement agency, or other organization or entity, or through any other administrative or judicial proceeding?*

	No		Yes, please provide explanation below

2. *Are you now or, since the age of 18, have you been subject to any administrative or disciplinary action (e.g., no-contact order, investigatory leave, reprimand, probation, suspension), dismissal, or voluntary or involuntary separation from a post-secondary educational institution (college, university), medical staff, medical group, or employer related to allegations of sexual misconduct?*

	No		Yes, please provide explanation below

3. *Has any health professional licensing authority subjected you to any administrative or disciplinary action (as described above) related to allegations or sexual misconduct?*

	No		Yes, please provide explanation below

4. *Have you ever been arrested for, convicted of, or pled guilty or nolo contendere to any criminal sexual misconduct offense or been named as a defendant, or found liable or otherwise responsible, in any civil action that alleged sexual misconduct?*

	No		Yes, please provide explanation below

5. *Have you ever been required to be accompanied by a chaperone when examining, diagnosing, or treating patients as a result of an allegation of sexual misconduct made against you (answer "no" if chaperones were consistently present as a matter of institutional policy and not in response to a specific allegation against you)?*

	No		Yes, please provide explanation below