Dear Practitioner:

Thank you for your interest in membership and privileges with Loma Linda University and its related facilities. We are pleased to enclose the following forms, which need to be fully completed in order for your application to be accepted:

- California Participating Physician (CPP) Application
- CPP Addendum’s A and B
- HIPAA Compliance Acknowledgement Agreement (purple)
- Medicare Penalty Acknowledgement Statement (blue)
- Privilege Request Form
- Required Items Check List

Please note that all forms must be filled out completely in blue or black ink only, and all required items must be received with the application forms. An incomplete application cannot be processed, and may be returned to you for completion. White out and/or correction tape is not permitted on any document.

Copies of the Bylaws, and Rules and Regulations are enclosed for your information. Please familiarize yourself with your requirements and prerogatives.

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

We look forward to receiving and processing your completed application. Please do not hesitate to contact Medical Staff Administration at 909/558-6052 if you have any questions regarding the enclosed forms or our processing procedures.

Sincerely,

Medical Staff Administration for
LLUMC, LLUBMC, LLUHC
Enclosures
SM

S:…Forms-NewApps/L-Applc Cover Ltr-3Fac.doc
REQUIREMENTS FOR INITIAL APPLICATION
(Practitioners must NOT begin patient care activities until notified of approval by Medical Staff Administration)

Processing is typically 90 days if the application is received complete.
The process may be longer if there is a long and varied history or several malpractice insurance carriers, etc.

- ORIGINAL APPLICATION - Fill in all blanks. If you need additional space, use an extra sheet of paper. ALL TIME MUST BE ACCOUNTED FOR WITH ANY GAPS FULLY EXPLAINED. **NOTE:** TEMPORARY PRIVILEGES – may be requested by the Service Chief after all required verifications have been received by Medical Staff Administration, and only awaiting the Committee/Board review process, or in extraordinary circumstances in accordance with the Bylaws.

- CURRICULUM VITAE - Current copy with chronological history of education, training, and activity.

- DELINEATION OF PRIVILEGES (N/A for UHC) - Check each privilege individually and sign the privilege form.

- INTERVIEW BY SERVICE CHIEF/DEPARTMENT CHAIR: It is the applicants responsibility to contact the Service Chief/Department Chair to make an appointment for an interview. At that time the Service Chief will review and sign the Delineation of Privilege request form (n/a for UHC).

- PICTURE ID – A copy of your Driver’s License or Passport must be made and signed by an LLUMC employee, the likeness on the copy must be identifiable.

- FEE - The initial application fee must be submitted with the application: LLUMC $800; LLUMC-AHP $400; BMC $250; UHC n/a. Please make check payable to “LLUMC Medical Staff Administration”.

- DIPLOMAS - Copy of diploma and/or certificates from all Medical/Dental School, Internship, Residency, Fellowship.

- ECFMG Certificate copy, or Proof from the graduating school or fifth pathway. Applies only to foreign medical graduates.

- WORK PERMIT/GREEN CARD Copy – If this is a photo ID, the photo must be made and signed by an LLUMC employee, if a photo, the likeness on the copy must be identifiable. Required for non-US Citizens.

- VERIFICATION OF CONTRACTUAL STATUS for Radiology, Pathology, Anesthesiology, Emergency Medicine.

- CALIFORNIA MEDICAL/DENTAL/AHP LICENSE(s) - Current copy.

- MALPRACTICE INSURANCE - Documentation of malpractice insurance. Minimum $1 million/$3 million required. A current face sheet which includes your name and the amount of coverage must be submitted.

- MEDICARE PENALTY STATEMENT - Provided by LLUMC. Must be signed and dated.

- HIPAA CONFIDENTIALITY ACKNOWLEDGEMENT - Provided by LLUMC. Must be signed and dated.

- CME/CE for 2 Past Years- Submit a list which includes the subject, # of credit hours, and dates.

- DEA - Current copy, if applicable. DEA Waiver form must be signed and dated by every applicant.

- RADIOGRAPHY/FLUOROSCOPY X-RAY SUPERVISOR AND OPERATOR CERTIFICATE – Indicate by checking and signing the appropriate space on the attached form. If radiography or fluoroscopy are used, copy of certificate is required.

- BOARD CERTIFICATION(S) - Copy of certification(s) and/or renewal(s).

- CPR/ACLS/PALS/etc - Required by various departments. Check with your individual Service.

- SEDATION PRIVILEGES- If you request Moderate or Deep Sedation, you must complete the appropriate test as indicated on first page of the privilege sheet. Tests and instructions are available on the LLUMC VIP Page under Employee Education, click on PURPLE, open the Procedure Related Sedation study guide and print the test, OR, on the LLUMC Web Site at: “www.llu.edu/llumc/medicalstaff/forms.html”. You must submit the correct/appropriate test with your application.

- COMPUTER LOG-ON FORMS – Sign and complete the highlighted portions ONLY. Return them BOTH with the application. Medical Staff Administration will complete the other areas of the form

If you have questions, please contact Medical Staff Administration (MSA) at 909/558-6052. MSA is located at 11314 Mountain View Ave., Cambridge Bldg., on the South/West corner of Mountain View Ave. & Barton Road.
California Participating Physician Application

This application is submitted to: **Loma Linda University Related Facilities**, herein, this Healthcare Organization

<table>
<thead>
<tr>
<th>APPLICATION FOR FACILITY/FACILITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please select the applicable Facility/Facilities this INITIAL application is applicable for from below and include the appropriate Department/Service and Section (if applicable) for that particular Facility.</td>
</tr>
<tr>
<td>□ Check here if you are an Allied Health Professional (AHP)</td>
</tr>
</tbody>
</table>
| □ Loma Linda University Medical Center (LLUMC)  
  Department/Service: ___________________________  
  Section: ___________________________ |
| □ Loma Linda University Behavioral Medicine Center (BMC)  
  Department/Service: ___________________________  
  Section: ___________________________ |
| □ Loma Linda University Health Care (UHC) – PSM from Department Required  
  Department/Service: ___________________________  
  Section: ___________________________ |

<table>
<thead>
<tr>
<th>I. INSTRUCTIONS</th>
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<tbody>
<tr>
<td>This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. Current copies of the following documents must be submitted with this application:</td>
</tr>
</tbody>
</table>
| - State Medical License(s)  
  - DEA Certificate  
  - Board Certification (if applicable)  
  - Face Sheet of Professional Liability Certificate  
  - Curriculum Vitae  
  - ECFMG (if applicable)  
  - Photo ID (Drivers License, ID Card, Passport)  
  - Visa (if applicable)  
  - X-Ray Certificate |

<table>
<thead>
<tr>
<th>II. IDENTIFYING INFORMATION</th>
</tr>
</thead>
</table>
| Last Name:  
  First:  
  Middle: |
| Is there any other name under which you have been known? Name(s): |
| Home Mailing Address:  
  City:  
  State:  
  ZIP:  
  E-mail Address:  
  Pager Number:  
  Birth Date:  
  Birthplace (city/state/country):  
  Citizenship (If not a US citizen, please include copy of Alien Registration Card):  
  Social Security #:  
  Gender:  
  Male  
  Female  
  Specialty:  
  Race/Ethnicity (voluntary):  
  Sub-Specialties: |
| NPI#  
  UPIN# |

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<thead>
<tr>
<th>III. PRACTICE INFORMATION</th>
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</table>
| Practice Name (if applicable):  
  Department Name (If hospital based): |
| Primary Office Street Address:  
  City:  
  State:  
  ZIP:  
  Telephone Number:  
  Fax Number:  
  Office Manager/Administrator:  
  Telephone Number:  
  Fax Number: |
| Name Affiliated with Tax ID Number:  
  Federal Tax ID Number: |
Print Applicants Name: _________________________________________________________

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<th>Office Manager/Administrator:</th>
<th>Telephone Number:</th>
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<tr>
<th>Name Affiliated with Tax ID Number:</th>
<th>Federal Tax ID Number:</th>
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<th>Name Affiliated with Tax ID Number:</th>
<th>Federal Tax ID Number:</th>
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| Other Medical Interests in Practice, Research, etc.: |

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

<table>
<thead>
<tr>
<th>College or University Name:</th>
<th>Degree Received:</th>
<th>Date of Graduation: (mm/yy)</th>
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<tbody>
<tr>
<td>Mailing Address:</td>
<td>City:</td>
<td>State:</td>
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### V. MEDICAL/PROFESSIONAL EDUCATION
(Attach additional sheets if necessary. Reference this Section Number and Title)

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<tr>
<th>Medical School:</th>
<th>Degree Received:</th>
<th>Date of Graduation: (mm/yy)</th>
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<td>Mailing Address:</td>
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<td>State &amp; Country:</td>
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<thead>
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<th>Medical School:</th>
<th>Degree Received:</th>
<th>Date of Graduation: (mm/yy)</th>
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</thead>
<tbody>
<tr>
<td>Mailing Address:</td>
<td>City:</td>
<td>State &amp; Country:</td>
</tr>
</tbody>
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### VI. INTERNSHIP/PGYI
(Attach additional sheets if necessary. Reference This Section Number and Title)

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<th>Institution:</th>
<th>Program Director:</th>
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<td>City:</td>
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<td>State &amp; Country:</td>
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<tr>
<th>Type of Internship:</th>
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<tr>
<th>Specialty:</th>
<th>From: (mm/yy)</th>
<th>To: (mm/yy)</th>
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</table>
### VII. RESIDENCIES/FELLOWSHIPS

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education since completion of medical school in chronological order, giving name, address, city and ZIP code, and dates (month and year). Include all programs you have attended, whether or not completed.

<table>
<thead>
<tr>
<th>Institution:</th>
<th>Program Director:</th>
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</thead>
<tbody>
<tr>
<td>Mailing Address:</td>
<td>City:</td>
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<tr>
<td>State:</td>
<td>ZIP:</td>
</tr>
<tr>
<td>Type of Training (e.g. Residency, etc.):</td>
<td>Specialty:</td>
</tr>
<tr>
<td>From</td>
<td>To</td>
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<tr>
<td>Did you successfully complete the program?</td>
<td>Yes</td>
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</table>

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<tr>
<th>Institution:</th>
<th>Program Director:</th>
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<td>Mailing Address:</td>
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<td>Type of Training (e.g. Residency, etc.):</td>
<td>Specialty:</td>
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<td>From: (mm/yy)</td>
<td>To: (mm/yy)</td>
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<tr>
<td>Did you successfully complete the program?</td>
<td>Yes</td>
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<th>Institution:</th>
<th>Program Director:</th>
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<td>Type of Training (eg. Residency, etc.):</td>
<td>Specialty</td>
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<td>From: (mm/yy)</td>
<td>To: (mm/yy)</td>
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<tr>
<td>Did you successfully complete the program?</td>
<td>Yes</td>
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### VIII. BOARD CERTIFICATION

Include certifications by board(s) which are duly organized and recognized by:
- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with equivalent requirements approved by the Medical Board of California
- a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty

<table>
<thead>
<tr>
<th>Name of Issuing Board-Specialty:</th>
<th>Date Certified/Recertified:</th>
<th>Expiration Date(if any):</th>
</tr>
</thead>
</table>

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

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

If not certified, describe your intent for certification, if any, and date of eligibility for Certification on separate sheet.
IX. OTHER CERTIFICATIONS (E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.)

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
<th>Expiration Date</th>
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X. MEDICAL LICENSURE/REGISTRATION (Remember to attach copies of documents)

<table>
<thead>
<tr>
<th>California State Medical License Number</th>
<th>Issue Date</th>
<th>Expiration Date</th>
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<tr>
<th>Drug Enforcement Administration (DEA) Registration Number</th>
<th>Expiration Date</th>
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<tr>
<th>Controlled Dangerous Substances Certificate (C.D.S.) (if applicable)</th>
<th>Expiration Date</th>
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<th>Medicare UPIN</th>
<th>National Physician Identifier (NPI)</th>
<th>Medi-Cal/Medicare Number</th>
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XI. ALL OTHER STATE MEDICAL LICENSES

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<tr>
<th>State</th>
<th>License Number</th>
<th>Expiration Date</th>
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XII. PROFESSIONAL LIABILITY List all past and present carriers. (Remember to attach copy of professional liability policy or certification face sheet for all carriers if possible.)

<table>
<thead>
<tr>
<th>Current Insurance Carrier</th>
<th>Policy #</th>
<th>Original Effective Date</th>
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<tr>
<th>Per claim amount</th>
<th>Aggregate amount</th>
<th>Expiration Date</th>
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Please list all of your professional liability carriers within the past seven years other than the one listed above:

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<thead>
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<th>Name of Carrier</th>
<th>Policy #</th>
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</table>
**XIII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS**

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

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

<table>
<thead>
<tr>
<th>Name and Mailing Address of <strong>Primary Admitting Hospital:</strong></th>
<th>City:</th>
<th>State:</th>
<th>ZIP:</th>
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</thead>
<tbody>
<tr>
<td>Department/Status (active, provisional, courtesy, temporary, etc.)</td>
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</tr>
<tr>
<td>Name and Mailing Address of <strong>Other Hospital/Institution:</strong></td>
<td>City:</td>
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<td>Department/Status:</td>
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<td>Appointment Date:</td>
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<tr>
<td>Name and Mailing Address of <strong>Other Hospital/Institution:</strong></td>
<td>City:</td>
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**B. PREVIOUS HOSPITAL AND OTHER INSTITUTION AFFILIATIONS**

<table>
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<th>City:</th>
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<td>City:</td>
<td>State:</td>
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<tr>
<td>From:</td>
<td>To:</td>
<td>Reason for leaving:</td>
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<tr>
<td>Name and Mailing Address of <strong>Other Hospital/Institution:</strong></td>
<td>City:</td>
<td>State:</td>
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<td>From:</td>
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<td>Reason for leaving:</td>
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<td>Name and Mailing Address of <strong>Other Hospital/Institution:</strong></td>
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<td>Reason for leaving:</td>
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<td>Name and Mailing Address of <strong>Other Hospital/Institution:</strong></td>
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**XIV. PEER REFERENCES**

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**XV. WORK HISTORY**

Chronologically list all work history activities since completion of medical school. This information must be complete. A curriculum vitae is sufficient provided it is current and contains the month and year. Please explain any gaps in professional work history on separate page.

<table>
<thead>
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From – To:

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<thead>
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<th>Name of Practice/Employer</th>
<th>Contact Name</th>
<th>Telephone Number</th>
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From – To:
**Loma Linda University & Related Facilities, Initial Application Form**

Print Applicants Name: _________________________________________________________

**XVI. ATTESTATION QUESTIONS**

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>A. Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?</td>
<td></td>
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</tr>
<tr>
<td>B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?</td>
<td></td>
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</tr>
<tr>
<td>C. Have your clinical privileges, membership, contractual participating or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?</td>
<td></td>
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<tr>
<td>D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?</td>
<td></td>
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<tr>
<td>E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?</td>
<td></td>
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<tr>
<td>G. Have you been denied certification/rectification by a specialty board, or has your eligibility, certification or rectification status changed (other than changing from eligible to certified)?</td>
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<tr>
<td>H. Have you ever been convicted of any crime (other than a minor traffic violation)?</td>
<td></td>
<td></td>
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<tr>
<td>I. Do you presently use any drugs illegally?</td>
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<tr>
<td>J. Have any judgments been entered against you, or settlements been agreed to by you within the last ten (10) years, in professional liability cases, or are there any filed and served professional liability/arbitration against you or are any pending?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?</td>
<td></td>
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</tr>
<tr>
<td>L. Are you able to perform all the services required by your agreement with, or the professional staff bylaws of, the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?</td>
<td></td>
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</table>

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

Print Name

Here

Physician

Signature

(Stamped Signature Is Not Acceptable)
I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between “this Healthcare Organization” and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents (collectively, “Healthcare Organizations”), for the purpose of evaluating this credentialing reapplication and any credentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. Without limiting the foregoing authorization in any way, I specifically recognize and agree that Loma Linda University Medical Center, Loma Linda University Health Care, and Loma Linda University Behavioral Medicine Center, all being affiliated within the same healthcare system, have a particular interest in sharing credentialing information, and will do so among and between any of these specific healthcare organizations where I am an applicant, staff member, or hold clinical privileges of any kind.” In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

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

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

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

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

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

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

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my reapplication or termination of my privileges, employment or physician participation agreement. A Photocopy of this document shall be as effective as the original, however, original signatures are required.
Individual healthcare organizations may request additional information or attach supplements to this form. They are not part of the California Participating Physician Application nor have they been endorsed by the above organizations. Any questions about supplements should be addressed to the healthcare organization from which it was provided.

SUPPLEMENT QUESTIONS FOR LOMA LINDA UNIVERSITY & RELATED FACILITIES

1. COMPLIANCE WITH LAWS RELATED TO PATIENT CARE

If you answer “YES” to any of the following questions, please give full details on an additional page.

A. Are there any pending or completed administrative agency, government, or court cases, decisions or judgments involving allegations that you:

1. Failed to comply with laws, statutes, regulations, or other legal requirements which may be applicable to the practice of your profession or to your rendition of services to patients?

   Yes □  No □

2. Violated any criminal law (excluding minor traffic violations)?

   Yes □  No □

B. Are there any prior or pending government agency or third party payor 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?

   Yes □  No □

II. COMPLIANCE WITH LAWS RELATED TO PHYSICAL AND MENTAL HEALTH STATUS

A. Do you have any physical or mental disability which impairs or could impair your ability to carry out your professional obligations in a manner that meets the standards of care in the community and the Bylaws, Rules and Regulations of this Healthcare Organization? (When answering this question, please consider all types of physical or mental disability, including past or present substance abuse.)

   Yes □  No □

B. Considering the essential functions of a practitioner in your area of practice, are you suffering from any communicable health condition that could pose any significant health and safety risk to your patients?

   Yes □  No □

C. In the past five (5) years, up to and including the present, have you had a history of chemical dependency or substance abuse that might adversely affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?

   Yes □  No □

D. If you answered A, B or C “YES”, could accommodations be made to allow you to practice at this Healthcare Organization?

   Yes □  No □

If you answer “YES” to any of the above questions, please describe on a separate page all physical and/or mental disabilities you have which impair or could impair your ability to carry out your professional obligations in a manner that meets the standards of care in the community and the Bylaws, Rules and Regulations, and Policies of this Healthcare Organization and the accommodations that could be made to enable you to practice at this Healthcare Organization.

III. MILITARY STATUS

1. Are you in a military Reserve Status?
   If “yes”, please explain: ____________________________________________________________

   Yes □  No □

2. Are you on Active Duty Status?
   If “Yes,” please explain: ____________________________________________________________

   Yes □  No □

Print Name Here ____________________________

Physician Signature ________________________

(Date) ________________________

(Stamped Signature Is Not Acceptable)
# California Participating Physician Application

**Addendum A**

**Health Plans and IPA’s/Medical Groups**

This Addendum is submitted to: **Loma Linda University Related Facilities**, herein, this Healthcare Organization.

## I. IDENTIFYING INFORMATION

<table>
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<tr>
<th>Last Name:</th>
<th>First:</th>
<th>Middle:</th>
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**Medical Group(s)/IPA(s) Affiliation:**

- Do you intend to serve as a primary care provider? [ ] Yes [ ] No
- Do you intend to serve as a specialist? [ ] Yes [ ] No (If yes, please list specialty(s))

Please check all that apply:

- [ ] Solo Practice
- [ ] Single Practice
- [ ] Group Practice
- [ ] Multi specialty

## II. BILLING INFORMATION

**Billing Company:**

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<thead>
<tr>
<th>Street Address:</th>
<th>City:</th>
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<tr>
<td>Street Address:</td>
<td>City:</td>
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**Contact:**

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<tr>
<th>Telephone Number:</th>
<th>Name Affiliated with Tax ID Number:</th>
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<tbody>
<tr>
<td>Telephone Number:</td>
<td>Name Affiliated with Tax ID Number:</td>
</tr>
</tbody>
</table>

**Federal Tax ID Number:**

## III. PRACTICE INFORMATION

- Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc)? [ ] Yes [ ] No
  
  If so, please list:

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<tr>
<th>Name:</th>
<th>Type of Provider:</th>
<th>License Number:</th>
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<td>Name:</td>
<td>Type of Provider:</td>
<td>License Number:</td>
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<td>Name:</td>
<td>Type of Provider:</td>
<td>License Number:</td>
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  If you are a Physician Assistant Supervisor, please include State License Number: ________________

- Do you personally employ any physicians (do not include physicians that are employed by the medical group)? [ ] Yes [ ] No
  
  If so, please list:

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<tr>
<th>Name:</th>
<th>California Medical License Number:</th>
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<tr>
<td>Name:</td>
<td>California Medical License Number:</td>
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<tr>
<td>Name:</td>
<td>California Medical License Number:</td>
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</table>

Please list any clinical services you perform that are not typically associate with your specialty: _______________________________

Please list any clinical services you *do not* perform that are typically associated with your specialty: _______________________________

---

The term “this Healthcare Organization” shall refer to the entity to which this Addendum is submitted as identified above.
Is your practice limited to certain ages? □ Yes □ No
If yes, specify limitations: ______

Are you Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council? □ Yes □ No

Do you participate in EDI (electronic data interchange)? □ Yes □ No
If so, which Network? __________________________

Do you use a practice management system/software? □ Yes □ No
If so, which one? __________________________

What type of anesthesia do you provide in your group/office?
□ Local □ Regional □ Conscious Sedation □ General □ None □ Other (please specify) __________________________

Has your office received any of the following accreditations, certifications or licensures?
□ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
□ California Department of Health Services Licensure
□ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
□ Medicare Certification
□ The Medical Quality Commission (TMQC)
□ Other __________________________

IV. OFFICE HOURS – Please indicate the hours your office is open:

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<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
<th>Holidays</th>
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V. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary)

Answering Service Company: Phone Number: ( ) Fax Number: ( )

Mailing Address
City: State: ZIP:

Covering Physician’s Name: Telephone Number: ( )

Covering Physician’s Name: Telephone Number: ( )

Covering Physician’s Name: Telephone Number: ( )

Covering Physician’s Name: Telephone Number: ( )

If you do not have hospital privileges, please provide written plan for continuity of care:

______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
VI. FOREIGNLANGUAGES SPOKEN

<table>
<thead>
<tr>
<th>Fluently by Physician:</th>
<th>Fluently by Staff:</th>
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VII. LABORATORY SERVICES

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

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<tr>
<th>Tax ID #:</th>
<th>Billing Name:</th>
<th>Type of Service Provided:</th>
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- Do you have a CLIA certificate? [ ] Yes [ ] No
- Do you have a CLIA waiver? [ ] Yes [ ] No

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<tr>
<th>Certificate Number:</th>
<th>Certificate Expiration Date:</th>
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VIII. PROFESSIONAL ORGANIZATIONS

Please list country, state or national medical societies, or other professional organizations or societies of which you are a member or applicant

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>Applicant</th>
<th>Member</th>
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I certify that the information in this document and any attached documents is true and correct.

Print Name Here

Physician Signature
(Stamped Signature Is Not Acceptable)
California Participating Physician Application
Addendum B
Professional Liability Action Explanation

This Addendum is submitted to: **Loma Linda University Related Facilities**, herein, this Healthcare Organization.

Please complete this form for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past ten (10) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

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<th>I. IDENTIFYING INFORMATION</th>
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<td>Last Name:</td>
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<td>Street Address:</td>
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<td>City:</td>
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<td>State:</td>
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<td>ZIP:</td>
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<th>II. CASE INFORMATION</th>
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<tbody>
<tr>
<td>City, County and State where Lawsuit filed:</td>
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<tr>
<td>Court case number, if known:</td>
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<tr>
<td>Date of alleged incident serving as basis for the lawsuit/arbitration:</td>
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<td>Date Suit Filed:</td>
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<td>Sex of patient:</td>
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<td>Age of patient:</td>
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<tr>
<th>Location of Incident:</th>
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<tr>
<td>Hospital</td>
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<tr>
<td>Other, (please specify)</td>
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<tr>
<th>Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consultant, etc.):</th>
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<tr>
<th>Allegation:</th>
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Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action?  
[ ] Yes  
[ ] No

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

___________________________________________________________________________________________________________________

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

Name ___________________________________________ Phone Number ( ) _______________________________

Name ___________________________________________ Phone Number ( ) _______________________________

\[1\] As used in the Information Release section of this Addendum, the term “this Healthcare Organization” shall refer to the entity to which this Addendum is submitted as identified above.
### III. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (CHECK ONE)

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

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

**SUMMARY**

__________________________________________________________________________________________________________

__________________________________________________________________________________________________________

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__________________________________________________________________________________________________________

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

Print Name Here

Physician Signature ____________________________ Date ____________________________

(Stamped Signature Is Not Acceptable)
RADIOGRAPHY/FLUOROSCOPY CERTIFICATION INFORMATION

I, _______________________________,

Print Name

☐ do supervise Radio/Fluoro Technicians or operate Radiography/Fluoroscopy equipment (attach current copy of certificate)

☐ do not supervise Radio/Fluoro Technicians or operate Radiography/Fluoroscopy equipment in procedures that use radiography/fluoroscopy.

_________________________________________  __________________________
Signature                                        Date

ATTACH COPY OF RADIOGRAPHY/FLUOROSCOPY CERTIFICATION HERE, IF APPLICABLE, AND RETURN THIS FORM TO MEDICAL STAFF ADMINISTRATION
LASER CERTIFICATION INFORMATION

I, ________________________________________________,

Print Name

☐ do perform procedures requiring the operation of laser equipment (attach current copy of certificate)

☐ do not perform procedures requiring the operation of laser equipment

___________________________________________  _______________
Signature        Date

ATTACH COPY OF LASER CERTIFICATION(S)/DOCUMENTATION HERE, IF APPLICABLE, AND RETURN THIS FORM TO MEDICAL STAFF ADMINISTRATION
PHYSICIAN/AHP ACKNOWLEDGEMENT of PENALTY STATEMENT

“Notice to Physicians/AHP: Medicare payment is based on each patient’s principal and secondary diagnoses and the major procedures performed on the patient, as attested to be 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 law.”

I have read the above PENALTY STATEMENT and agree to abide by it. I understand it will be kept on permanent file within Loma Linda University Related Facilities (LLURF) (Loma Linda University Medical Center (LLUMC), Loma Linda University Behavioral Medical Center (LLUBMC), and/or Loma Linda University Health Care (LLUHC)) and that it will be made available upon request to those acting on behalf of Medicare.

Date (not valid unless dated)

Signed (Stamped Signature is not acceptable)

Print Name

A Seventh-day Adventist Institution
Re: HIPAA Compliance Acknowledgement/Agreement

Dear Practitioner:

Regulations implementing the Health Insurance Portability and Accountability Act (“HIPAA”) become effective on April 14, 2003. Loma Linda University Medical Center (LLUMC), Loma Linda University Health Care (LLUHC), and Loma Linda University Behavioral Medicine Center (LLUBMC) herein referred to as Loma Linda University Related Facilities (“LLURF”), and each member of the respective Medical/AHP Staff are bound by these Regulations. LLURF is adopting policies and procedures that comply with HIPAA’s requirements, including that all patients be given a “notice of privacy practices.” We are asking each member of the Medical/AHP Staff to sign this letter to acknowledge their recognition that LLURF must meet its HIPAA obligations with respect to patients of the facility/facilities and to agree that each member of the Medical/AHP Staff will cooperate with and abide by any LLURF policies and procedures required by HIPAA.

Additionally, you are asked to acknowledge that you understand your responsibility for complying with HIPAA requirements in your office practice. This may be done either by yourself as an individual, as part of a group practice, or as part of any Organized Health Care Arrangement being established between LLURF and faculty members of the Loma Linda University School of Medicine. As a member of a respective Medical/AHP Staff, we ask that you acknowledge that you understand that these private practice obligations must be met and that the HIPAA policies and Procedures implemented at LLURF for inpatients will not apply to your office practices.

Finally, you understand that your obligations with respect to your inpatients at LLURF will end only upon termination of your Medical/AHP Staff membership at the following applicable facility/facilities:

Loma Linda University Medical Center (LLUMC)
Loma Linda University Health Care (LLUHC)
Loma Linda University Behavioral Medicine Center (LLUBMC)

We anticipate that the LLURF policies and procedures will be an efficient way for you and for LLURF to deliver health care to our mutual patients, help maintain high standards of patient care, and comply with HIPAA requirements. If you have questions regarding this letter, please call Tonya Okon, Privacy Manager at (909) 558-6453. Otherwise, please acknowledge your agreement as set forth in the body of this letter by signing below.

Print Name

Signature (Stamped Signature not acceptable)

Date

Please return this Acknowledgement/Agreement to Medical Staff Administration to the address above.

HIPAA/L-HIPAA Generic.doc
DEA WAIVER/ATTESTATION

I, ______________________________ agree that during any time that I do not have a current/valid DEA Certificate, I will not write prescriptions for drugs that require a DEA Certificate.

I attest that I will not write prescriptions for drugs that are not covered under the Schedules on my DEA certificate.

I do not have a current/valid DEA Certificate because ____________________________

________________________________________

Signature

You can quickly update/change your DEA address and/or Schedules online at http://www.deadiversion.usdoj.gov/drugreg/reg_apps/index.html

Forms-Misc/F-DEA Waiver Agreement.doc
9-13-06
LOMA LINDA UNIVERSITY HEALTH CARE

ALTERNATE ADMITTING AGREEMENT

Provider: ___________________________ Specialty(ies): ___________________________

Address: ____________________________________________________________

Phone: ___________________________

Admitting Provider: ___________________________ Specialty(ies): ___________________________

Phone: ___________________________

Admitting Hospital(s): Loma Linda University Medical Center

Comments/Special Arrangements: The above Admitting Provider shall provide hospital services for patients that need care at LLUMC

Admitter agrees to provide hospital services for members assigned to the above provider at the hospital indicated. For such services, bills will be submitted to and paid by the IPA.

*THIS AGREEMENT IS CURRENT AND VALID UNTIL THE PROVIDER TERMINATES FROM LLUHC OR OBTAINS HIS/HER OWN PRIVILEGES AT LLUMC.

Provider Signature ___________________________ Date ___________________________

Alternate Admitting Provider Signature ___________________________ Date ___________________________

Alternate Admitter PRINT NAME ___________________________

LLUHC Medical Director Signature ___________________________ Date Approved ___________________________
# Category Descriptions and Prerogatives

<table>
<thead>
<tr>
<th>Core Privileges</th>
<th>Provisional</th>
<th>Active</th>
<th>Courtesy</th>
<th>Consulting</th>
<th>Affiliate</th>
<th>Administrative</th>
<th>Honorary/Retired</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Admit – (Serve as Inpatient Attending Physician)</strong></td>
<td>Eligible</td>
<td>Eligible</td>
<td>Eligible (Limit 12 pts per yr)</td>
<td>Not Eligible</td>
<td>Eligible</td>
<td>Not Eligible</td>
<td>Not Eligible</td>
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<tr>
<td><strong>Ambulatory Care - (Serve as Outpatient Attending Physician)</strong></td>
<td>Eligible</td>
<td>Eligible</td>
<td>Eligible (Limit 12 pts per yr)</td>
<td>Eligible</td>
<td>Eligible</td>
<td>Not Eligible</td>
<td>Not Eligible</td>
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<tr>
<td><strong>Provide Consultation - (Includes Radiology Interpretation and Pathology Interpretation)</strong></td>
<td>Eligible</td>
<td>Eligible</td>
<td>Eligible (Limit 12 pts per yr)</td>
<td>Eligible</td>
<td>Eligible</td>
<td>Not Eligible</td>
<td>Not Eligible</td>
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<tr>
<th>Other Prerogatives</th>
<th>Provisional</th>
<th>Active</th>
<th>Courtesy</th>
<th>Consulting</th>
<th>Affiliate</th>
<th>Administrative</th>
<th>Honorary/Retired</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vote</strong></td>
<td>Not Eligible</td>
<td>Eligible</td>
<td>Not Eligible</td>
<td>Not Eligible</td>
<td>Not Eligible</td>
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<td>Not Eligible</td>
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<tr>
<td>Hold office (Includes Service Chief and MSEC Mbr at large)</td>
<td>Not Eligible</td>
<td>Eligible</td>
<td>Not Eligible</td>
<td>Not Eligible</td>
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<tr>
<td>Chair Committee</td>
<td>Not Eligible</td>
<td>Eligible</td>
<td>Not Eligible</td>
<td>Not Eligible</td>
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<tr>
<td>Committee Member</td>
<td>Eligible</td>
<td>Eligible</td>
<td>Eligible</td>
<td>Not Eligible</td>
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<tr>
<th>Responsibilities</th>
<th>Provisional</th>
<th>Active</th>
<th>Courtesy</th>
<th>Consulting</th>
<th>Affiliate</th>
<th>Administrative</th>
<th>Honorary/Retired</th>
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<tbody>
<tr>
<td>Carry Malpractice Insurance</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Not Required</td>
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</tr>
<tr>
<td>Attend Meetings</td>
<td>Required</td>
<td>Required</td>
<td>Not Required</td>
<td>Not Required</td>
<td>Required</td>
<td>Not Required</td>
<td>Not Required</td>
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<tr>
<td>Pay Fees</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Not Required</td>
</tr>
<tr>
<td>Apply for Reappointment</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Must Qualify w/Pt Activity</td>
<td>Required</td>
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</tbody>
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Confidentiality Warranty

I understand and agree that I am being issued a computer security code password. I hereby accept full responsibility of the use of this password and agree to adhere to, in accordance with, but not limited to, the requirements of LLUCM Policy A-34, “Computer Systems Security”. In addition, I understand and agree to adhere to, in accordance with, but not limited to, the requirement of LLUCM Policy A-43, “Use of Computer Internet Services.” Furthermore, I agree that I will not share this password with any other individual, nor will I use any other individual’s password. In addition, I understand and agree that I assume full responsibility for all transactions and information available through the use of this password. I also agree to immediately notify the IS Help Desk at ext. 48889 if I learn that any other person obtained information which may provide them the opportunity to use my password. Furthermore, in accordance with, but not limited to, the requirements of LLUCM Policies A-10, “Classification and Protection of Information” and I-25 “Personnel Records”, I understand and agree that I will have access to confidential information pertaining to patients, employees and business data which is the property of LLUCM. I also agree to be responsible for maintaining the confidentiality of such information. In addition to the above, for systems listed (denoted by an asterisk *) that allow for an electronic signature, I understand that the use of this password represents my electronic legal signature so that the use of this code is the same as my written signature. Finally, I understand and agree that any breach of confidentiality as stated herein and/or in accordance with LLUCM Policy or applicable law shall be grounds for disciplinary action, which may include immediate termination.

Employee/Staff Signature: __________________________ Date: __________/__________/__________
Cut on dotted line & Mail Application Packet to:

Attn: Medical Staff Administration
Loma Linda University Related Facilities
11314 Mountain View Avenue, Cambridge Bldg
Loma Linda, CA 92354