>>> HIGHLIGHT AND REPLACE THIS TEXT WITH THE NAME OF YOUR FACILITY <<<
>>> HIGHLIGHT AND REPLACE THIS TEXT WITH THE ADDRESS OF YOUR FACILITY <<<

Re: Allied Practitioner Application & Credentialing Questionnaire

Clear Form

Dear Allied Practioner:

To be considered for clinical privileges at this surgery center, complete the attached Allied Practitioner Application & Credentialing Questionnaire in its entirety and return to your surgery center contact with the following supporting forms and documents:

FORMS TO COMPLETE:

1. **Allied Practitioner Application & Credentialing Questionnaire.** Complete in its entirety, sign and date.
2. **Malpractice Insurance form**. Provide all claims information for malpractice action taken against you. Include settlement amounts and/or explanations of any dismissed or pending claims with pertinent dates.
3. **Request for Clinical Privileges form**. If applicable, select and then complete a privileges request form appropriate to your Allied Profession.
4. **Orientation Checklist.**
5. **Annual In-Service Module.**
6. **Non-Disclosure / Confidentiality Agreement.**
7. **Conflict of Interest Disclosure.**
8. **Corporate Compliance Plant Review.**
9. **Authorization for Background Check.**
10. **Acknowledgment of Duty to Report Patient Abuse.**
11. **Health Attestation.**
12. **Influenza Vaccination Statement.** Complete if you choose not to be, or have already been, vaccinated against the current season's flu strain.
13. **HEP B Immunization Statement.** Complete and sign if you choose not to be, or have already been, vaccinated against HEP B.
14. **HIV Test Informed Consent / Refusal Statement.** Complete and sign as appropriate to your circumstances.

DOCUMENTS TO PROVIDE:

1. **Curriculum Vitae.** Explain any gaps in clinical work history greater than 6 months.
2. **Professional clinical licenses or certificates.** Provide copies of clinical licenses or certification as are relevant to the procedures you are requesting.
3. **DEA Registration Certificate.** Provide evidence of current registration, if applicable.
4. **Board Certification Credentials.**
5. **ACLS/BLS Life Safety Certification.**
6. **Government-issued photo ID.**
7. **Malpractice Liability Insurance Certificate.** Current Allied Practitioner requirements are $1 million per occurrence and $3 million aggregate.
8. **Delineation of approved privileges.** Provide an approved delineated list of privileges held at another healthcare organization. Procedures listed must be on par with the procedures you are requesting to perform at this surgery center.
9. **Evidence of PPD skin test/chest X-ray.** Results of skin test must be negative and current to within 1 year; for positive skin test results we require a chest X-ray current to within 2 years evidencing “no active TB”.
10. **Self-Disclosure of Adverse Events.** Explain and/or provide document in reference to Allied Practitioner attestation statement, professional liability claims history and actions, and criminal misconduct, if applicable.

Please be sure you read and understand all elements of the application and other enclosed attachments. Please do not leave sections of any forms blank. If as section of a form does not apply to you, enter "N/A". All documents you provide must be current and valid. An application that includes expired credentials will be summarily returned for re-application.

Thank you for your interest in joining our team. We look forward to receiving and reviewing your completed application.

Sincerely,

Credentialing Department

Allied Practitioner Application & Credentialing Questionnaire

INSTRUCTIONS: 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.

1. IDENTIFYING INFORMATION

Full Legal Name:_____ Contact Phone:_____

Full Address:_____

Social Security no.:_____ Date of Birth.:_____ Email Address:_____

2. CREDENTIALS

Allied Profession.:_____ License/Certificate no.:_____ Issued by:_____ Expires:_____

DEA Registration Cert. no.:_____ Expires:_____ Life Support:___ACLS___BLS Expires:_____

Medicare no.:_____ Medicaid/Cal no.:_____ UPIN:_____ NPI:_____

Physician for whom you will work under, free of license restrictions that prohibit PA supervision (PAs only):_____

3. SPECIALTIES and BOARD CERTIFICATION

Primary Specialty:_____ Issuing Board:_____ Date Certified:_____ Expires:_____

Secondary Specialty:_____ Issuing Board:_____ Date Certified:_____ Expires:_____

Tertiary Specialty:_____ Issuing Board:_____ Date Certified:_____ Expires:_____

4. EDUCATION

Undergraduate Institution:_____ City & State:_____ Degree:_____ Year Graduated:_____

Graduate Institution:_____ City & State:_____ Degree:_____ Year Graduated:_____

Trade/Vocational School:_____ City & State:_____ Degree:_____ Year Graduated:_____

5. CLINICAL EMPLOYMENT HISTORY

Facility Name:_____ from:_____to:_____ Reason for Leaving:_____

Address:_____ Office Phone no.:_____

Office Manager/Credentialing Officer:_____ Office Fax no.:_____

Facility Name:_____ from:_____to:_____ Reason for Leaving:_____

Address:_____ Office Phone no.:_____

Office Manager/Credentialing Officer:_____ Office Fax no.:_____

Facility Name:_____ from:_____to:_____ Reason for Leaving:_____

Address:_____ Office Phone no.:_____

Office Manager/Credentialing Officer:_____ Office Fax no.:_____

6. PEER REFERENCES

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges. **NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.**

Name of 1st Reference:_____ Phone No.:_____

Mailing Address:_____ Email Address.:_____

Name of 2nd Reference:_____ Phone No.:_____

Mailing Address:_____ Email Address.:_____

Name of 3rd Reference:_____ Phone No.:_____

Mailing Address:_____ Email Address.:_____

7. ATTESTATION QUESTIONS

Professional liability

a) Has any insurer ever denied, cancelled, refused to renew, or imposed restrictions upon your professional liability insurance? ☐ YES ☐ NO

b) Has there been any claim activity, filed or settled, with respect to your professional practice during the past 5 years? If "Yes", provide the following information on a separate sheet of paper: (1) how the matter was resolved; (2) the amount that was paid by you or on your behalf and date of settlement; (3) your role in the matter; (4) the patient outcome; and (5) detailed narrative regarding each incident of malpractice (or complete page 4 of application). ☐ YES ☐ NO

Privileges

a) Have your clinical privileges ever been voluntarily surrendered, expired, or withdrawn during a quality of care investigation? ☐ YES ☐ NO

b) Have your clinical privileges ever been voluntarily or involuntarily denied, restricted, reduced, or terminated? ☐ YES ☐ NO

c) Have you ever been the subject of disciplinary action, such as, but not limited to, punitive or disciplinary observation, preceptorship, or sponsorship in any type of healthcare facility? ☐ YES ☐ NO

Governmental

a) Has any regulatory or licensing agency ever suspended or revoked your license (whether or not such revocation or suspension was stayed), placed you on probation, issued a public or private reprimand with respect to your practice, or otherwise concluded that you engaged in professional misconduct? ☐ YES ☐ NO

b) Are you currently being investigated by or are you on probation with any governmental agency? ☐ YES ☐ NO

c) Has any sanction ever been imposed upon you by Medicare ☐ or recommended by the Medicare PRO ☐? ☐ YES ☐ NO

d) Have you ever been expelled or suspended from receiving payment under Medicare, ☐ Medi-Cal, ☐ or TRICARE/CHAMPUS ☐? ☐ YES ☐ NO

e) Have you ever been convicted of a felony or misdemeanor (including those deferred, set aside, dismissed, expunged, or issued a stay of execution? ☐ YES ☐ NO

Other

a) Have you ever been expelled from or disciplined by a medical organization for professional competency reasons? ☐ YES ☐ NO

b) Has your contract with an insurer, healthcare service plan, or any similar entity ever been terminated? ☐ YES ☐ NO

c) Do you have any health problems that might affect your practice of medicine? ☐ YES ☐ NO

d) Do you currently use illegal drugs? ☐ YES ☐ NO

e) Are there any reasons you would not be able to perform all the services required by your agreement with and the bylaws of this Surgery Center, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients? ☐ YES ☐ NO

I hereby affirm that the information submitted in this Section 7, 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 application or termination of my privileges granted hereafter, and may be reportable to medical boards or other licensing entities as required by law.

Date	Allied Practitioner Signature (sign here)	Print Name	License or Certificate No.

8. REQUEST for PRIVILEGES

List the names and contacts of healthcare organizations where you have been previously granted clinical privileges. In support of the information you supply herein, also attach a copy of each respective organization's letter to you evidencing privileges granted along with corresponding delineated lists of approved procedures.

Attach with this application a Request for Privileges form appropriate to your profession.

NOTE: The procedures listed in the delineation of privileges you provide must be, at minimum, on par with the procedures you are requesting to perform at this facility.

	Facility Name	Status of privileges granted (i.e. Active, Provisional, Courtesy, etc.)	Facility contact name and number
1.			
2.			
3.			

9. CONSENT to RELEASE of INFORMATION

I consent to the communication of information and documents between Surgery Center or its agents and other business entities, medical staffs, training programs, medical societies, professional associations, professional liability insurance companies, and licensing authorities in jurisdictions in which I have trained, resided, or practiced, for the evaluation of professional training, experience, character, conduct, and judgment. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records.

In the event that credentialing information obtained from other sources varies substantially from that which I have provided, I will be given the opportunity to review and explain the discrepancies.

I acknowledge that there shall be no monetary liability on the part of and no cause of action for damages that rise against any representative of Surgery Center or its agents for their acts performed in connection with evaluating practitioner applications, credentials, and qualifications. I acknowledge that there shall be no monetary liability on the part of and that no cause of action for damages shall rise against any or all individuals and organizations providing information to Surgery Center or its agents concerning professional competence, ethics, character, and other qualifications for participation. I have the right to review the information submitted in support of the credentialing/re-credentialing application, in accordance with Surgery Center guidelines.

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 immediately update the application and any documentation submitted and/or included with this application should there be any change in the information provided that may affect the application or its outcome.

I hereby affirm that the information submitted in this application is true and correct to the best of my knowledge and is furnished in good faith. I understand that willful and substantial omissions or misrepresentations may result in denial of my application or termination of my privileges granted hereafter, and may be reportable to medical boards or other licensing entities as required by law.

Date	Allied Practitioner Signature (sign here)	Print Name	License or Certificate No.

Request for Anesthesia Privileges

Applicant Name: _____

I hereby request privileges in the specialty of Anesthesia as shown on this form. I understand that privileges granted are subject to a bi-annual review coinciding with reapplication for medical staff membership. I also understand that application for additional or new procedures can be made at any time with proper documentation.

Documentation of training and experience is attached for those procedures marked by an asterisk (*). The following privileges are requested and are consistent with my abilities, training and experience.

PRIVILEGES	APPROVAL (check)		COMMENTS
General Anesthesia for			
❑ Pediatric	❑ YES	❑ NO	
❑ Adult	❑ YES	❑ NO	
❑ Local stand-by	❑ YES	❑ NO	
❑ Intravenous regional block	❑ YES	❑ NO	
❑ Regional Anesthesia	❑ YES	❑ NO	
❑ Lumbar epidural block	❑ YES	❑ NO	
❑ Axillary block	❑ YES	❑ NO	
❑ Caudal block	❑ YES	❑ NO	
❑ Interscalene block	❑ YES	❑ NO	
❑ Blocks of nerves of upper and lower extremities	❑ YES	❑ NO	
❑ Stellate ganglion block	❑ YES	❑ NO	
❑ Epidural Block	❑ YES	❑ NO	
❑ Spinal Block	❑ YES	❑ NO	
❑ Bier Block	❑ YES	❑ NO	
❑ Axillary nerve block	❑ YES	❑ NO	
❑ Trigger Point block	❑ YES	❑ NO	
❑ Occipital nerve block	❑ YES	❑ NO	
❑ BCLS	❑ YES	❑ NO	
❑ ACLS	❑ YES	❑ NO	
❑ IV Sedation	❑ YES	❑ NO	
❑ Monitored Anesthesia Care	❑ YES	❑ NO	
❑ IntraDiscal ElectroThermal Therapy (IDET)	❑ YES	❑ NO	

❑ Radiography Use of Modality & interpretation of images (therapeutic and diagnostic)	❑ YES	❑ NO	
❑ Ultrasound Use of Modality & interpretation of images (therapeutic and diagnostic)	❑ YES	❑ NO	
❑ Fluoroscopy Use of Modality with State License & interpretation of images (therapeutic & diagnostic)	❑ YES	❑ NO	
❑ Local anesthesia	❑ YES	❑ NO	
❑ Conscious Sedation	❑ YES	❑ NO	
❑ Supervision of Conscious Sedation Trained Registered Nurse	❑ YES	❑ NO	
❑ History & Physical	❑ YES	❑ NO	
OTHERS NOT LISTED			
❑	❑ YES	❑ NO	
❑	❑ YES	❑ NO	
❑	❑ YES	❑ NO	
❑	❑ YES	❑ NO	
❑	❑ YES	❑ NO	

Applicant Print Name

Signature of Applicant

Date

Signature of QI Committee Chairperson

Date

Signature of Governing Body Chairperson

Date

Adverse Events Disclosures

Allied Practitioner Name:_____

INSTRUCTIONS: If applicable, please take a moment to explain in your own words the circumstances surrounding that have given rise to any malpractice claim or other disciplinary action made against you or your license. Your response will be kept strictly confidential and will be reviewed only by this Healthcare Facility's credentialing department and a committee of your peers. Photocopy and complete this form including all relevant clinical information for each claim filed or settled in the past five years. If more space is needed on each report, continue information on your letterhead. If you have no Adverse Events to declare, write in "N/A" in line no. 1. Please write legibly.

1. Patient's initials or case I.D: _____ **2.** Date of Incident:_____

3. Your professional role at the time incident occurred:_____

4. Specific allegation:_____

5. Status:

_____ Lawsuit/arbitration/claim currently pending

_____ Withdrawn/dropped/date:_____

_____ Lawsuit/arbitration/judgment

_____ Dismissed/date:_____

_____ Settlement/date:_____

- Total amount paid:_____
- Amount paid on your behalf:_____

_____ Lawsuit is related to a Medical Board accusation/action Date:_____

_____ Lawsuit is related to a cancellation of liability insurance Date:_____

6. Condition and diagnosis of patient at time of incident:

7. Dates and clinical description of professional services rendered:

8. Condition of patient subsequent to professional services, (dates of follow-up visits and outcome of incident) if known:

9. Comments (including any additional education or changes to practice):

Allied Practitioner's Rights

An Allied Practitioner has the right to review information obtained by Surgery Center for the purpose of evaluating his or her credentialing or re-credentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards or the National Practitioner Data Bank), but does not extend to review of information, references or recommendations protected by law from disclosure. A practitioner has the right to request his/her status at this Surgery Center. Upon written request, this facility will provide details of his/her current status in the credentialing or re-credentialing process.

A. **Right of Review:** An Allied Practitioner may request to review such information at any time by sending a written request via letter or fax to the Credentialing Department. The Credentialing Department will notify the practitioner within 72 hours of the date and time when such information will be available for review at Surgery Center location.

B. **Notification of Discrepancy:** Allied Practitioners will be notified in writing, via letter or fax, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of a practitioner's malpractice claim history, actions taken against a practitioner's license/ certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/ her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

C. **Correction of Erroneous Information:** If an Allied Practitioner believes erroneous information has been supplied to Surgery Center by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit written notice via letter or fax, along with an explanation that details the nature of the error and its corrections, to the Manager/Supervisor of Credentialing. Notification to the practitioner of a discrepancy as provided in Section B.), above, or within 24 hours of a practitioner's review of his/her credentialing file as provided in Section C.), above.

Upon receipt of notification from the Allied Practitioner, the Credentialing Department will re-verify the primary source information in dispute. If the primary source information has changed, corrections will be applied immediately to the practitioner's credentialing file. The practitioner will then be dutifully notified in writing via post, courier or facsimile that such correction(s) have been made to his or her file. If upon re-review the primary source information remains inconsistent with the practitioner's notification, the Credentialing Department will notify the practitioner via letter or fax. The practitioner may then provide proof of correction by the primary source body to Surgery Center's Credentialing Department via letter or fax within 10 business days. The Credentialing Department will re-verify primary source information if such documentation is provided.

If after 10 business days the primary source information remains in dispute, the Allied Practitioner will be subject to action, up to and including administrative denial/termination.

Allied Practitioners should submit correspondence regarding practitioner rights to the email/postal address or fax number provided by his or her Surgery Center contact person.

>>> HIGHLIGHT AND REPLACE THIS TEXT WITH THE NAME OF YOUR FACILITY <<<
>>> HIGHLIGHT AND REPLACE THIS TEXT WITH THE ADDRESS OF YOUR FACILITY <<<

ORIENTATION CHECKLIST

ORIENTATION ITEMS FOR REVIEW	DATE COMPLETED	ORIENTATION BY	EMPLOYEE INITIALS
1. FACILITY OVERVIEW ☑ Organization Mission Statement, Vision Statement and its goals ☑ Organizational Chart ☑ Corporate Compliance Program ☑ Introduction to Facility Personnel ☑ Tour of Facility ☑ Introduction to Work Stations ☑ Equipment Management ☑ Storage, handling and access to supplies, medical gasses and pharmaceuticals			
2. HUMAN RESOURCE POLICIES ☑ Quality Management Plan ☑ Incident reporting (aka Adverse Event) ☑ Staff grievance and complaints policy **FORMS STAFF MEMBER COMPLETES** ☑ Employment Application ☑ Employer References ☑ Job Descriptions ☑ Competency Assessments ☑ Performance Evaluations ☑ Orientation Checklist ☑ Annual In-Service Module ☑ Confidentiality Agt/HIPAA ☑ Conflict of Interest ☑ Employment Verification ☑ Health Status Attestation ☑ Flu, HEP-B, HIV Consents **DOCUMENTS STAFF MEMBER PROVIDES** ☑ Curriculum Vitae/Resume ☑ Valid, unexpired professional licenses and other credentials for inspection & photocopy ☑ Valid, unexpired CPR certificate (ACLS/BLS) ☑ Valid, unexpired US Passport, or government-issued photo ID in conjunction with a Social Security Card, or other acceptable form of photo ID listed on page 9 of Form I-9 ☑ PPD/CXR TB Results; Immun. Record			
3. ENVIRONMENT OF CARE EMERGENCY PREPAREDNESS ☑ Life & Fire Safety ☑ Emergency Evacuation ☑ Actions in Unsafe Situations ☑ Emergency Management Plan			
4. INFECTION PREVENTION AND CONTROL PRACTICES ☑ Universal Precautions ☑ Influenza Vaccination Program ☑ OSHA Bloodborne Pathogens ☑ Sharps Injury Prevention ☑ Hand Hygiene ☑ Personal Protection Equipment (PPE) ☑ Identifying, handling, and disposing of hazardous or infectious materials.			
5. PATIENT CARE ☑ Ethical aspects of patient care. ☑ Patient care services this facility provides. ☑ Patient safety. ☑ Patient confidentiality, privacy, and HIPAA requirements. ☑ Patient rights and responsibilities. ☑ Advance Directives. ☑ Responsibility to report patient abuse and neglect.			

The above facility policies and procedures have been reviewed with me. I understand it is my responsibility to direct any questions regarding the foregoing to my manager or to Human Resources personnel for further clarification.

Print Employee Name: _____

Employee Signature: _____ Date: _____

Supervisor / HR Signature: _____ Date: _____

>>> HIGHLIGHT AND REPLACE THIS TEXT WITH THE NAME OF YOUR FACILITY <<<
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ANNUAL IN-SERVICE MODULE

1. INFECTION CONTROL

I have received and reviewed the following Infection Control Policies:

- ☑ Standard Precautions
- ☑ Traffic in the OR
- ☑ Hand hygiene
- ☑ Infection/incident reporting
- ☑ Hazard/Sharps safety training
- ☑ TB exposure control
- ☑ Surgical scrub attire
- ☑ Health screening
- ☑ Annual Influenza Vaccine
- ☑ Bloodborne pathogens

I understand that infection control is a vital part of patient care in the outpatient setting. I acknowledge I have received copies of this facility's infection control policies, and have subsequently familiarized myself with the information contained therein. I acknowledge I have also received training on specific safety protocols and procedures that I am to follow pursuant to Infection Control Committee directives and guidelines established by the Centers for Disease Control (CDC). I promise to participate in all safety improvement programs implemented during the course of my tenure, including observation of handwashing frequencies and scrubbing techniques (as is applicable to my job description), and will participate in annual flu vaccination directives using recommended CDC flu vaccines that protect against the latest flu virus strains.

INITIAL HERE _____

2. EMERGENCY PREPAREDNESS

I have received and reviewed the following surgery center Emergency Preparedness policies:

- ☑ Alarms (nurse call, fire, med gas)
- ☑ Fire safety/emergency procedures
- ☑ Use of fire extinguishers
- ☑ Patient emergency: O^2 Fire in the O.R.
- ☑ Patient emergency: Malignant Hyperthermia
- ☑ MDV[1] vs. SDV[2] usage
- ☑ Disaster Preparedness
- ☑ Evacuation procedures, routes
- ☑ Emergency Codes (Blue, Red, etc.)
- ☑ Incapacitated Surgeon
- ☑ Incapacitated Anesthesia
- ☑ QAPI Plan and Program for the facility

I have received copies of this facility's emergency policies and have been oriented to them. I agree that I will participate in any emergency drills that may occur and will accept the responsibilities assigned to me as a physician or other staff member during these drills and in the event of any actual emergency occurrence.

INITIAL HERE _____

3. PAIN MANAGEMENT

I have received and reviewed the following Pain Management policies:

- ☑ Reporting
- ☑ Assessment
- ☑ Patient Evaluation

I understand that respecting patients' reports of pain is a vital part of the delivery of quality care. I have reviewed this facility's policies regarding pain management and agree to follow their intent while working as an employee, independent contractor or physician/medical staff member at this facility.

INITIAL HERE _____

4. ADDITIONAL POLICIES TO REVIEW

I attest that I have received training and instructional materials regarding:

- ☑ Timeout
- ☑ High Alert, Sounds/Looks-like
- ☑ Hazard Communication
- ☑ Privacy/Confidentiality
- ☑ Cultural Sensitivity
- ☑ Medical Staff Bylaws
- ☑ Discharge Policies
- ☑ HIPAA

I have reviewed the above additional policies and agree to abide by them.

INITIAL HERE _____

I, _____, attest that I have reviewed this facility's policies on Infection Control, Emergency Preparedness, Pain Management, and others listed above that address patient care, workplace safety, and regulatory compliance. I promise to review these policies annually hereafter for changes to patient care protocols and procedures that may have occurred during the previous year.

To be signed annually by healthcare worker on the anniversary of his or her date of hire or contract:

SIGN HERE → _____ DATE HERE → - - 2017

SIGN HERE → _____ DATE HERE → - - 2018

SIGN HERE → _____ DATE HERE → - - 2019

SIGN HERE → _____ DATE HERE → - - 2020

[1] MDV:Multi-dose vials; [2] SDV: Single-dose vials

NON-DISCLOSURE / CONFIDENTIALITY AGREEMENT

I have read and understand the policies of **>>> HIGHLIGHT AND REPLACE THIS TEXT WITH** (herein "Facility") regarding the privacy of individually identifiable health information (or protected health information ("PHI")), pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Also, I acknowledge that I have received training concerning the use, disclosure, storage and destruction of PHI as required by HIPAA, and that I have read and understand the material outlined in the HIPAA Training Handbook(s) provided by Facility.

I further understand that through my affiliation with Facility I may be exposed to information considered beyond the purview of HIPAA that is confidential, sensitive, personal, intimate, private or propriety in nature regarding patients, contractors, employees and other third-party entities with whom Facility has a fiduciary affiliation or relationship (such information and PHI shall collectively be referred to as "PHI" herein).

In consideration of my employment with and/or compensation from Facility, I hereby agree that I will not at any time—either during or after my employment or affiliation with Facility—use, access or disclose PHI in any manner to any person or entity, internally or externally, except as is required and permitted in the course of my duties and responsibilities with Facility as permitted under their privacy policies and procedures as adopted and amended from time to time or as permitted under HIPAA. I understand that this prohibition includes, but is not limited to, disclosing any information about the identity of the patients with whom I work or any information about them, including their medical and other personal information, to family, friends, other patients, vendors, or co-workers, unless such person is lawfully authorized to receive such information. I agree to document uses and disclosure of PHI as required by HIPAA and to return or destroy all PHI associated with patients or Facility upon the termination of my services. I agree that I will immediately report to Facility any impermissible PHI use or disclosure. I understand that my person access code, user ID, access key, password and similar access information will be kept confidential at all times. I understand that I will not remove from Facility any devices or media unless instructed or authorized to do so. I agree to return all means of access to PHI upon termination of my employment with Facility.

I understand and acknowledge my responsibility to apply the policies and procedures of Facility. I understand that unauthorized use or disclosure of PHI will result in disciplinary action, up to and including the termination of employment or affiliation with Facility and could result in the imposition of civil and criminal penalties under applicable laws, as well as professional disciplinary action. I understand that my obligations will survive the termination of my employment or end of my affiliation with Facility, regardless of the reason for such termination. I understand that my obligations extend to any PHI that I may acquire during the course of my employment or affiliation with Facility, whether in oral, written or electronic form and regardless of the manner in which access was obtained. I understand that I should contact an administrative officer of Facility if I have any questions, comments or concerns about the training I received or my obligations under this agreement.

Healthcare worker name: _____

Healthcare worker signature: _____ Date: _____

CONFLICT OF INTEREST DISCLOSURE

A conflict of interest occurs when the leadership or staff enters into a relationship with another organization or individual(s) which, in its content or process may adversely affect or have the appearance of adversely affecting the staff's commitment to the facility and to the culture of safety and quality.

Conflicts of interest may include, but shall not be limited to, relationships, associations or business dealings with vendors, suppliers, other healthcare organizations or individuals.

A conflict of interest may take overt or covert forms, and can represent many situations. However, it is generally understood that a conflict of interest constitutes a situation when the organization as a whole or individual representatives of the organization, has competing professional or personal obligations or personal or financial interests that would make it difficult for the organization or the individual(s) to fairly fulfill the mission, vision, values and goals of the institution.

In general, conflicts of interest relate to the potential for self-gain typically, but not always, of a fiscal nature. Potential for self-gain can serve to undermine the judgment or objectivity of licensed independent practitioners (LIPs), administrators, employees, consultants and designated contractors such that their mission and dedication to the values and activities of this healthcare institution are compromised.

The goal of the Conflict of Interest Policy is to ensure that the mission and responsibility to the residents and community served by this facility are not harmed by any professional, ownership, contractual or other relationships. This policy aims to preserve the integrity of decision making, and to ensure that directors and staff act in the best interests of the organization.

Members of this facility's patient care team and staff are required to disclose all professional and personal relationships, and/or interests, from which any financial or personal profit and/or gain may be directly or indirectly derived, or that otherwise conflict, or have the potential to conflict, with this facility's responsibilities to patients and their families, its public service mission, and its adherence to ethical business practices.

Please select either YES or NO and sign where indicated below.

☐ **YES, I may have conflicts of interest to disclose.**

Please describe below any relationships, positions, or circumstances in which you are involved in which you believe could contribute to a Conflict of Interest arising:

_____

_____

☐ **NO, I have no conflicts of interest to disclose at this time.**

I hereby certify that the information set forth above is true and complete to the best of my knowledge. I have reviewed, and agree to abide by, the Policy of Conflict of Interest of this facility, which is currently in effect.

Print Name: _____ Date: _____

Signature: _____

CORPORATE COMPLIANCE PLAN
REVIEW & TRAINING ATTESTATION

I ATTEST TO, AND AM IN AGREEMENT WITH, THE FOLLOWING STATEMENTS:

1. I have reviewed this facility's policies and procedures relating to Medicare/Medical fraud and abuse.
2. I have received and read a copy of this facility's Corporate Compliance Plan and the Code of Conduct and an explanation of the federal False Claims Act.
3. I have completed this facility's Corporate Compliance Plan training program (in conjunction with the Health Insurance Portability and Accountability Act (HIPAA) Compliance Plan).
4. I understand that I have a continuing responsibility to comply with the Code of Conduct and participate fully in this facility's ongoing Corporate Compliance Plan in its entirety.
5. I understand that my failure to comply with this facility's Code of Conduct policies and procedures and its Corporate Compliance Plan, or to observe the Health Insurance Portability and Accountability Act (HIPAA) or abide by government law and regulation pertaining to healthcare fraud and abuse, including my responsibility to report possible violations, may result in disciplinary action, up to and including termination.

Signature: _____ Date: _____

Print Name: _____

>>> HIGHLIGHT AND REPLACE THIS TEXT WITH THE NAME OF YOUR FACILITY <<<
>>> HIGHLIGHT AND REPLACE THIS TEXT WITH THE ADDRESS OF YOUR FACILITY <<<

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT SUSPECTED ABUSE OF DEPENDENT ADULTS AND ELDERS

California law requires certain people to report known or suspected dependent adult or elder abuse or neglect. You have been identified as one of those people who may be a "mandated reporter." Mandated reporters are individuals who have "assumed full or intermittent responsibility for the care or custody of an elder or dependent adult," as well as health care practitioners, clergy members, and law enforcement personnel. [W&I § 15630(a)]

DEPENDENT ADULTS AND ELDERS

A dependent adult is a California resident aged 18-64 who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights. These include persons with physical or developmental disabilities or whose physical or mental abilities have diminished with age. [W&I 15610.23] Elders are California residents age 65 or older. [W&I15610.27]

WHEN REPORTING ABUSE IS REQUIRED

A mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be dependent adult or elder abuse or neglect, or who is told by a dependent adult or elder that he or she has experienced abuse or neglect, or reasonably suspects abuse or neglect, must report this information by telephone immediately or as soon as practically possible, and by written report within two (2) working days. [W&I 15630(b)]

ABUSE THAT MUST BE REPORTED

- Physical abuse [W&I § 15610.63]
- Neglect [W&I § 15610.57]
- Financial abuse [W&I § 15610.30(a)]
- Abandonment [W&I § 15610.65]
- Isolation [W&I § 15610.43]
- Abduction [W&I § 15610.06]

WHERE TO CALL IN AND SEND THE WRITTEN ABUSE REPORT

If the abuse occurred in a long-term care facility or residential facility serving adults or elders or an adult day program, you must report to either local law enforcement or the local long-term care ombudsman. [W&I § 15630(b)(1)(A)]. Otherwise, you must report to local law enforcement (including Campus Police) or county adult protective services. [W&I § 15630(b)(1)(C)] Forms for submitting written reports may be found online at http://www.cdss.ca.gov/agedblinddisabled/PG1298.htm. In addition, an internal report must be made to your supervisor or to the University Compliance Hotline. This internal report may be made anonymously.

PENALTY FOR FAILURE TO REPORT ABUSE

Failure to make a mandatory report may result in fines ranging from $1000-$5000 and imprisonment for 6 months to 1 year, depending on the circumstances. [W&I § 15630(h)]

ACKNOWLEDGEMENT OF RESPONSIBILITY

I acknowledge my responsibility to report known or suspected dependent adult or elder abuse or neglect in compliance with California Welfare and Institutions Code W&I § 15630.

Signature: _____ **Date:** _____

Print Name: _____

For your reference, a copy of California's Welfare & Institutions Code W&I § 15630 may be obtained from the Facility Administrator.

AUTHORIZATION FOR RELEASE OF INFORMATION FOR EMPLOYMENT PURPOSES

<< ENTER FACILITY NAME HERE >>

The position for which you are being considered requires that you consent to a criminal background check as a condition of employment. As such, and with your signature at the bottom of this page, you hereby authorize Employer and its designated agents and representatives to conduct at its discretion a comprehensive review of your background through a consumer report and/or investigative consumer report generated by an employee background screening company ("Screening Company") of Employer's choosing for purposes of employment, which include hiring, promoting, reassigning or retaining an employee. You acknowledge the scope of the consumer report and/or investigative consumer report may include, but is not limited to, the following areas: names and dates of previous and current employment; work experience; Bureau of Workers Compensation/Claims; criminal history records (from local, state, federal, international and other law enforcement agencies' records); sexual offender lists; wants and warrants records; motor vehicle records; military records; education verification; license verification; credit history; civil cases; OIG/GSA; USA PATRIOT Act/OFAC; any sanction lists, FBI finger printing and drug testing. You further acknowledge you have received a copy of "A Summary of Your Rights Under the Fair Reporting Act" prescribed by the Federal Trade Commission and that questions regarding your rights and this form, if any, have been satisfactorily answered. Employer will supply to you a copy of the completed consumer report and/or investigative consumer report if information contained in these reports leads to an adverse decision or action taken against you as it relates to your employment status or potential employment.

Please complete the following information as it is required by law enforcement agencies and other entities for identification purposes when checking records. It is confidential and will not be used for any other purpose.

Identifying Information

Full legal name (first middle last): _____ Position(s) Applied for: _____

Other names used in the past 7 years: _____

Current address: _____

Most recent previous address: _____

Other addresses used in the past 7 years: _____

Phone No: _____ Alt Phone No: _____ Social Sec No: _____

Date of Birth: _____ Driver's Lic No: _____ State of Issue: _____

Email Address: _____ Gender: Male ☐ Female ☐

Disclosure of Criminal Offenses

Have you ever been convicted of a criminal offense or are pending criminal charges currently filed against you? (This refers only to felonies and misdemeanors; you do not need to include non-criminal traffic violations or municipal ordinance violations): Yes ☐ No ☐

If "yes", please provide details: _____

Authorization and Release

I, _____, authorize the complete release of records or data pertaining to me, which an individual, company, firm, corporation, or public agency may have in its posession. I authorize the full release of the information described above, without any reservation, throughout any duration of my employment with Employer. I hereby release Screening Company and its agents, officials, representatives, or assigned agencies, including officers, employees, or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may at any time, result to me, my heirs, family or associates because of compliance with this authorization for release form. I certify that all information provided herein and on my résumé and/or job application or other attachments is, to the best of my knowledge, true, correct and complete. Any false statements provided on this form and/or my résumé or job application will be considered just cause to deny or rescind employment offerings made to me by Employer, or to terminate my existing employment at any time. This authorization and consent shall be valid in original, fax, or copy form.

_____ _____

Signature Date

>>> HIGHLIGHT AND REPLACE THIS TEXT WITH THE NAME OF YOUR FACILITY <<<
>>> HIGHLIGHT AND REPLACE THIS TEXT WITH THE ADDRESS OF YOUR FACILITY <<<

HEALTH ATTESTATION FORM

Print Staff Member name: _____

Please explain any "yes" answers in the space provided on this form or by attaching a separate sheet. This form is confidential and will be kept in your credentials file.

Do you presently have any physical or mental condition that may affect your ability to perform clinical or professional duties? If yes, please explain: _____	☐ Yes ☐ No
Within the past five years, have you been treated in an inpatient or outpatient facility or have you missed work due to any physical or mental condition that may affect your ability to perform clinical or professional duties? If yes, please explain: _____	☐ Yes ☐ No
Do you presently suffer from an addiction to drugs, alcohol, or other chemical substances that may affect your ability to perform clinical or professional duties? If yes, please explain: _____	☐ Yes ☐ No
Within the past five years, have you been treated in an inpatient or outpatient facility or have you missed work due to an addiction to drugs, alcohol, or other chemical substances? If yes, please explain: _____	☐ Yes ☐ No
Are you currently taking any medications that may affect your ability to perform clinical or professional duties? If yes, please explain: _____	☐ Yes ☐ No
Do you have any communicable diseases? If yes, please explain: _____	☐ Yes ☐ No
Please provide the date of your most recent physical exam: _____ Performed by: _____	

Please provide dates for the following vaccinations/tests and attach supporting documentation:

- Annual TB Screening: PPD_____ (Result_____) or Chest X-ray_____ (Result_____)
- Annual Influenza: _____, and/or check here ☐ to decline (complete Influenza Declination and attach).
- Hepatitis B (initial attestation only): ____ ____ ____, or check here ☐ to decline (complete HEP B Declination and attach)
- HIV Test (initial attestation only): _____, or check here ☐ to decline (complete HIV Test Declination and attach).

I (please print full name) _____ attest that I am in good health and have no physical or mental conditions that may affect my ability to perform clinical or professional duties. I also attest that I have no current addictions to drugs, alcohol, or any other recreational chemical substances. I understand that I may not hold [name of health center] responsible for any physical or mental conditions or addictions that I have or have not disclosed.

Staff Member signature: _____ Date: _____

** PPD tests are only good for one year, if you've had the test within the past 12 months, then a copy of that test with whomever gave it to you can be used for this requirement. If you've previously tested positive then a chest x-ray every two years is required. You do not need a chest x-ray if you've never tested positive. Flu Vaccines are valid for one year only. Only direct-patient caregivers need to have a PPD test on an annual basis. If you do not come into contact with patients, then there is no need or requirement for you to comply to the annual PPD (TB) testing.

SEASONAL INFLUENZA VACCINATION PROGRAM

Please select either YES or NO and sign where indicated below.

☐ YES, I will participate in the Influenza Vaccination Program.

I choose to participate in this healthcare facility's seasonal influenza vaccination program. I understand I am responsible for procuring my own vaccination and agree to provide evidence of having been vaccinated for inclusion in my employee health record. I further agree to reaffirm my participation in this program annually.

☐ NO, I will not participate in the Influenza Vaccination Program.

This healthcare facility recommends that I participate in its Influenza Vaccination Program to protect the patients I serve, in part, because of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread it to others and they can become seriously ill, even if my symptoms are mild or non-existent.
- The strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year.

After reviewing information given to me regarding my occupational risk to the Influenza virus and measures to safeguard against infection, including seasonal vaccination, I choose not to participate in this healthcare facility's Influenza Vaccination Program. I understand the consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, my coworkers, my family, and my community. Knowing these facts, I still choose not to participate in the Influenza Vaccination Program at this time for the following reason:

- ☐ I am allergic to components of the vaccine (specify): _____
- ☐ I don't believe in vaccines.
- ☐ I won't take the vaccine because of side effects.
- ☐ I never get influenza.
- ☐ I have had Guillen Barre or other medical problems that preclude me from receiving the vaccine.
- ☐ I got severe influenza-like symptoms from the influenza vaccine and won't get it again.
- ☐ Other (specify): _____

I have read and fully understand the information on this page.

Signature: _____ Date: _____

Print Name: _____

>>> HIGHLIGHT AND REPLACE THIS TEXT WITH THE NAME OF YOUR FACILITY <<<
>>> HIGHLIGHT AND REPLACE THIS TEXT WITH THE ADDRESS OF YOUR FACILITY <<<

HEPATITIS B IMMUNIZATION CONSENT/REFUSAL

Please select either YES or NO and sign where indicated below.

☐ **YES, I want to receive the Hepatitis B vaccine.**

After reviewing information given to me regarding my occupational risk to the Hepatitis B virus and measures to safeguard against infection, I elect to participate in this facility's Hepatitis B Immunization Program. I understand this includes three injections at prescribed intervals over a 6-month period. I understand that there is no guarantee that I will become immune to Hepatitis B and that I might experience adverse side effects as the result of the vaccination. A staff physician has satisfactorily answered all my questions relating to this immunization program.

	Date Given	Lot No.	Administered By	Next Date Due
1st Dose:				
2nd Dose:				
3rd Dose:				

☐ **NO, I don't want to receive the Hepatitis B vaccine.**

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself. However, I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

I am declining the opportunity to receive the Hepatitis B vaccination series for the following reason (check one):

☐ I have previously received the complete Hepatitis B vaccination series (provide immunization record).

☐ Antibody testing has revealed I am immune to Hepatitis B (provide laboratory numerical proof of immunity.)

☐ The vaccine is contraindicated for the following medical reasons:

_____

_____

_____

☐ Other, explain:

_____

_____

_____

Print Name: _____

Signature: _____ Date: _____

HIV Test Informed Consent / Refusal

Please select either YES or NO and sign where indicated below.

☐ **YES. I am informed and I consent to an HIV test.**

I consent to a Human Immunodeficiency Virus (HIV) test and authorize its results to be used to evaluate eligibility for insurance coverage should I be exposed to HIV during my course of work at this facility.

By signing and dating this form, I agree that the HIV antibody test may be performed on samples of my blood, urine, and saliva and that underwriting decisions may be based on the test results. I understand that if my test is returned positive it may result in un-insurability for life, health, or disability insurance for which I may apply in the future.

I have been advised of the implications of the test and have been given an opportunity to ask questions and have my questions answered.

I understand I will receive my test results in person.

OR…

☐ **NO. Though I am informed, I do not consent to an HIV test at this time.**

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk to Human Immunodeficiency Virus (HIV) infection. I also understand that Workers Compensation insurance may be denied to me if I become infected with HIV during the course of my work without having first provided a HIV test result to evaluate insurance coverage eligibility.

I choose not to have the recommended HIV test at this time because:

☐ I don't want blood drawn
☐ I don't want to know my HIV status
☐ Other (please specify):

_____

_____

_____

Print Name: _____

Signature: _____ Date: _____

Form **W-9**
(Rev. November 2017)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number

☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ► **Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*