Clear Form

APPLICATION FOR MEDICAL STAFF MEMBERSHIP

& PHYSICIAN CREDENTIALING FORMS

INSTRUCTIONS: For consideration of surgical privileges at this healthcare facility, please complete all attached forms (which are listed below in Step 3) and sign and date using blue or black ink. If a form or a particular section of a form is not applicable to you or your specialty, write "N/A", and then sign and date the form regardless. **ALL FORMS AND FORM SECTIONS MUST BE COMPLETED IN THEIR ENTIRETY and ALL SIGNATURE FIELDS SIGNED and DATED.**

STEP 1

Enter name of physician being credentialed.

M.D. ☐
D.O. ☐
DPM ☐

FIRST NAME | MIDDLE NAME | LAST NAME

STEP 2

Enter healthcare facility name and location address.

FACILITY NAME

LOCATION ADDRESS OF FACILITY & CITY, STATE AND ZIP

STEP 3

Complete the following forms:

- ❒ Application for Medical Staff Membership
- ❒ Request for Privileges
- ❒ Orientation Checklist
- ❒ Annual In-Service Module
- ❒ Non-Disclosure / Confidentiality Agreement
- ❒ Conflict of Interest Disclosure
- ❒ Corporate Compliance Plan Review
- ❒ Authorization for Background Check
- ❒ Acknowledgment of Duty to Report Patient Abuse
- ❒ Annual Health Attestation
- ❒ Influenza Vaccination Declination, if applicable
- ❒ HEP B Immunization Consent / Refusal, if applicable
- ❒ HIV Test Informed Consent / Refusal, if applicable

STEP 4

Provide copies of the following documents:

- ❒ Curriculum Vitae
- ❒ Physician & Surgeon License
- ❒ DEA License
- ❒ Board Certification Credentials
- ❒ ACLS CPR Certificate
- ❒ Government-issued photo ID
- ❒ List of Prior Delineated Privileges
- ❒ Evidence of PPD test or chest x-ray
- ❒ Evidence of current flu vaccination, or decline.
- ❒ Evidence of HEP B vaccination, or decline.
- ❒ Evidence of HIV test, or decline.
- ❒ Evidence of Medical Malpractice Insurance
- ❒ Explanations and other documents relating to self-disclosures, if applicable.

STEP 5

Return your completed application with accompanying forms and all requested documents to the attention of the Administrative Director at the address above, or email a high-resolution scan to your contact directly at the email address provided to you. Please note that Incomplete applications with unclear or poorly rendered document copies will be summarily returned for your resubmission. We look forward to receiving and processing your completed application.

Thank you for your interest in providing services at our facility. Please do not hesitate to contact our office if you have any questions regarding the enclosed forms or our credentialing procedures.

Medical Staff Administration

as of 01/2022, you must also include Covid 19 Vaccine Proof + Boosters

Application for Appointment to Medical Staff

This application is submitted to: _____, herein, this Healthcare Organization[1]

I. 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. **Current copies of the following documents must be submitted with this application:**

- State Medical License(s)
- DEA Certificate
- Board Certification (if applicable)
- Face Sheet of Professional Liability Policy or Certification
- Curriculum Vitae
- ECFMG (if applicable)

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known? Name (s):		
Home Mailing Address:	City:	
	State:	ZIP:
Home Telephone Number: ( ) Home Fax Number: ( )	E-Mail Address: Pager Number: ( )	
Birth Date: Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include copy of Alien Registration Card).	
Social Security #:	Gender[2]: ☐ Male ☐ Female	
Specialty:	Race/Ethnicity[2] (voluntary):	
Subspecialties:		

III. PRACTICE INFORMATION

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:	

[1] As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

[2] This information will be used for consumer information purposes only.

Secondary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Tertiary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Other Medical Interests in Practice, Research, etc.:		

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

College or University Name:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State:	ZIP:

V. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference This Section Number and Title)

Medical School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State & Country:	ZIP:
Medical/Professional School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State & Country:	ZIP:

POSTGRADUATE TRAINING AND EXPERIENCE

VI. INTERNSHIP/PGYI (Attach additional sheets if necessary. Reference This Section Number and Title)

Institution:	Program Director:	
Mailing Address:	City:	
	State & Country:	ZIP:
Type of Internship:		
Specialty:	From (mm/yy):	To (mm/yy):

VII. RESIDENCIES/FELLOWSHIPS (Attach additional sheets if necessary. Reference This Section Number and Title)

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education in chronological order, giving name, address, city and ZIP code, and dates. Include **all** programs you attended, whether or not completed.

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training (eg. residency, etc.):	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? ☐Yes ☐No (If "No," please explain on separate sheet.)			

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? ☐Yes ☐No (If "No," please explain on separate sheet.)			

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? ☐Yes ☐No (If "No," please explain on separate sheet.)			

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 state medical board that issued your license.
- 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

Name of Issuing Board:	Specialty:	Date Certified/Recertified**:**	Expiration Date (if any):

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.)
(Attach additional sheets if necessary. Reference This Section Number and Title)

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

X. MEDICAL LICENSURE/REGISTRATIONS (Remember to attach copies of documents)

State Medical License Number:	Issue Date:	Expiration Date:
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Date Issued: Valid Through:
Medicare UPIN/National Physician Identifier (NPI):		MediCal/Medicaid Number:

XI. ALL OTHER STATE MEDICAL LICENSES. List All Medical Licenses Now or Previously Held.
(Attach additional sheets if necessary. Reference This Section Number and Title)

State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:

XII. PROFESSIONAL LIABILITY (Remember to attach copy of professional liability policy or certification face sheet)

Current Insurance Carrier:	Policy Number:	Original effective date:	
Mailing Address:		City:	
		State:	ZIP:
Per Claim Amount $	Aggregate Amount: $	Expiration Date:	

Please explain any surcharges to your professional liability coverage on a separate sheet. Reference This Section Number and Title.

Please list all of your professional liability carriers within the past seven years, other than the one listed above:

Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:

Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:

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 affiliations (A) and have had previous hospital privileges (B) during the past ten years. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

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

Name and Mailing Address of Primary Admitting Hospital:	City:	
	State:	ZIP:
Department/Status (active, provisional, courtesy, etc.):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status:	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status:	Appointment Date:	

If you do not have hospital privileges, please explain on Addendum A.

B. PREVIOUS AFFILIATIONS During Last Ten Years. (Attach additional sheets if necessary. Reference This Section Number and Title)

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

XIV. 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 Reference:	Specialty:	Telephone Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number: ( )	
Mailing Address:		City:	
		State:	ZIP:

XV. WORK HISTORY (Attach additional sheets if necessary. Reference This Section Number and Title)

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

Current Practice:	Contact Name:	Telephone Number: ( )	
		Fax Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		

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.

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? Yes ☐ No ☐

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? Yes ☐ No ☐

C. Have your clinical privileges, membership, contractual participation 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? Yes ☐ No ☐

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? Yes ☐ No ☐

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? Yes ☐ No ☐

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? Yes ☐ No ☐

G. Have you been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)? Yes ☐ No ☐

H. Have you ever been convicted of any crime (other than a minor traffic violation)? Yes ☐ No ☐

I. Do you presently use any drugs illegally? Yes ☐ No ☐

J. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending? Yes ☐ No ☐

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? Yes ☐ No ☐

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? Yes ☐ No ☐

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 application or termination of my privileges, employment or physician participation agreement.

Print Name Here: _____

Physician Signature _____ Date _____

(Stamped Signature Is Not Acceptable)

INFORMATION RELEASE/ACKNOWLEDGMENTS

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 application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. 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[3] 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 participation 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, relevant business and professions codes, 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 nonrenewal of my license to practice medicine in the state of issuance; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal 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 state of issuance taken or pending, including but 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 stating and reporting the adverse action to the Medical Board of the state of issuance, including a Section 805 report with the Medical Board of California, if applicable, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my 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 application 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 and current dates are required on pages 8 and 9.

Print Name Here _____

Physician Signature _____ Date _____
(Stamped Signature Is Not Acceptable)

[3] The intent of this release is to apply at a minimum, protections comparable to those available in California to any action, regardless of where such action is brought.

Professional Liability Action Explanation

This Addendum is submitted to _____ herein, this Healthcare Organization [1].

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 seven (7) 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.

I. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Street Address:	City:	
	State:	ZIP:

II. CASE INFORMATION

City, County and State where lawsuit filed:	Court case number, if known:		
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suit Filed:	Sex of patient:	Age of patient:

Location of Incident:
☐ Hospital ☐ My office ☐ Other doctor's office ☐ Surgery Center
☐ Other, (please specify)

Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consultant, etc.):

Allegation:

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, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

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.

Name _____ Phone Number ( )

Name _____ Phone Number ( )

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

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. 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 attorneys 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)

Section A	**CONFIDENTIAL QUESTIONS -- HEALTH HISTORY**	
1. Do you have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others? **If yes, please describe any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise.**	☐ YES	☐ NO
2. Are you a certified Worker's Compensation provider? **If yes, please attach a copy of your certificate.**	☐ YES	☐ NO
3. Are you a reservist? If yes, what branch of the military? _____ Anticipated date of separation from reserve duty? _____	☐ YES	☐ NO
4. Medicaid/Medi-Cal #: _____		

I attest to the fact all of the information submitted by me in this document are true and correct to the best of my knowledge and belief. I fully understand that any significant misstatement in, or omission from the application may constitute cause for denial of participation or cause for summary dismissal.

_____ _____

Provider Name **Date**

_____

Signature

ADDENDUM TO APPLICATION FOR MEDICAL STAFF PRIVILGES

NOTICE TO PRACTITIONERS OF CREDENTIALING RIGHTS/RESPONSIBILITIES

I. Right of Review

As an applicant for credentialing/re-credentialing, you have a right to review non-privileged information obtained for the purpose of evaluating your application. This includes information obtained from outside sources such as liability insurance carriers, Medical Boards, National Practitioner Data Bank. It does not include review of information that is privileged, such as references or recommendations which are protected by law from disclosure.

II. Notification of Discrepancy

You will be notified in writing, by fax or letter, when information obtained by primary sources varies significantly from information provided on your application. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

III. Correction of Erroneous Information

If you believe that erroneous information has been supplied to CalOptima by primary sources, you may correct such information by submitting written notification to the Credentialing Department at the above cited address/fax number. Your notification, via letter or fax, must include a detailed explanation of the discrepancy and must be returned to the address above within fifteen (15) days of notification of discrepancy.

Upon receipt of your notification, CalOptima will re-verify the primary source information under consideration. If the primary source information has changed, an immediate correction will be made to your credentials file. You will be notified of this action. If the primary source information remains inconsistent with your notification, you will be advised of same through letter, fax, or phone. You will be requested to provide proof of correction by the primary source to the Credentialing Department via letter or fax as cited above within ten (10) days. Subsequently, a second re-verification of primary source information will be performed by the Credentialing Department.

Print Name: _____ Date: _____

_____ _____

Signature (Stamped signature is Not Acceptable) (Date)

Physicians, NPs, PAs, 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** ✔ Medical Staff App ✔ Peer References ✔ Request for Privileges ✔ Orientation Checklist ✔ Annual In-Service Module ✔ Confidentiality / HIPAA ✔ Conflict of Interest ✔ 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 ----(flood, earthquake, fire, mud slide) ✔ 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: _____

*you can review the training videos located on the eliteaccreditation.org website and then go to "professional resources", then choose "initial orientation training"

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, generator)
- ☑ 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.

DATE HERE → _____

SIGN HERE → _____

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

*All the training videos above can be viewed by going to the website @ https://www.eliteaccreditation.org/initial-orientation-training

NON-DISCLOSURE / CONFIDENTIALITY AGREEMENT

I have read and understand the policies of _____ (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: _____

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 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/Reporting/Report-Abuse. In addition, an internal report must be made to your supervisor or Medical Director. 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: _____

AUTHORIZATION FOR RELEASE OF INFORMATION FOR EMPLOYMENT PURPOSES

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

Health Attestation Form

INSTRUCTIONS: 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 conditions 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: _____, 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).

* **COVID 19 VACCINE + BOOSTERS MUST BE PROVIDED, PROOF YOU ARE VACCINATED**

ATTESTATION

I, _____ 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: _____

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 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):

_____

_____

_____

In the event of occupational exposure to HIV or other infectious materials while working at this facility you are required to notify the Medical Director immediately and be tested for HIV, regardless to whether you have, or have not, previously consented to such a test (workers compensation laws protect the employer from litigation should it be necessary to perform such a test in this manner). If you refuse to test for HIV upon occupational exposure, then you are waiving your right to claim any medical condition that should arise from that incident hereto.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____