

UCSF MEDICAL CENTER *and*
LANGLEY PORTER PSYCHIATRIC HOSPITALS AND CLINICS (LPPH&C)
MEDICAL STAFF MEMBERSHIP APPLICATION
(for MDs, DOs, DPMs, DDSs, DMDs, licensed clinical psychologists)

ALL requested information is required. **INCOMPLETE APPLICATIONS WILL BE RETURNED**
If more space is needed than provided, attach additional sheets and reference question being answered.

Before submitting your application, please be sure you have completed the following:

- Obtained the UCSF Medical Staff Bylaws and Rules and Regulations from the weblink:
<http://www.ucsfmedicalcenter.org/medstaffoffice/MedStaffBylawsRulesRegs.htm>
- FULLY completed, signed and dated Medical Staff Application Form. ALL ANSWERS MUST BE SUPPLIED.
- ALL FAX and telephone numbers requested are accurately listed
- Documentation/Attestation of continuing education (CME) during the past two years
- Sign and Date the Confidentiality of Patient, Employee and University Business Information
- Sign and Date the Authorization, Release, and Confidentiality Statement
- Completed, signed and dated Department Privilege form(s)
- REQUIRED:** TB clearance from UCSF Employee Health. *** YOU MUST CALL (415) 885-7580 for TB clearance

In addition, please be sure to include copies of the following (as applicable to your scope of practice):

- ALL** Professional licenses in California and all other states (**past and current**) **OR** copy of 2113 Cert. with request letters
- Other Certificates/Permits applicable to your practice at this Healthcare Organization
- DEA Certificate, if applicable, (**Otherwise, attest to non-use on p. 4 of application**)
- Fluoroscopy/X-ray Operator, Supervisor Certificate, if applicable (**Otherwise, attest to non-use on page 4 of application**)
- ECFMG certificate (international medical graduates only)
- Board Certification
- Current Certificate of Insurance for **ALL** non-UCSF Professional Liability Insurance policies **since beginning of clinical practice**
- CV in **mm/yy format** for all training, work history. **All time gaps, medical school forward. Are fully explained**
- Clear, current photograph
- RETAIN A COPY OF ENTIRE PACKET FOR YOUR RECORDS AND FUTURE USE**

***** ALL FAX AND PHONE NUMBERS ARE REQUIRED.**

INCOMPLETE APPLICATIONS CANNOT BE PROCESSED AND WILL BE RETURNED FOR COMPLETION.

Forward your fully completed application packet with all attachments to the Chief(s)/Chair(s) of the Department(s) to which you are applying. Contact that department to ensure the Chief/Chair has signed your application and privileges and your packet has been submitted to the Medical Staff Office.

Please immediately notify Medical Staff Services of any changes to information in this application.
If you have any questions, please contact the Medical Staff Services office at (415) 885-7268.

V. BOARD CERTIFICATION

Include board(s) duly organized/recognized by the American Board of Medical Specialties (ABMS) or by the American Osteopathic Association (AOA); or a board or association with an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved post-graduate training that provides complete training in that specialty or subspecialty.

	Specialty Name	Cert. Year	Recert. Date (mm/yy)	Exp. Date (mm/yy)
Primary Specialty				
Specialty 2				
Specialty 3				

Have you applied for board certification other than those indicated above? Yes No. If yes, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for certification.

Have you ever been examined by any specialty board, but failed to pass the examination? Yes No. If yes, please attach full details.

VI. HOSPITAL / MEDICAL CENTER / FREE STANDING CLINIC AFFILIATIONS & PENDING APPLICATIONS

List in **reverse chronological order** (current affiliation[s] first) **all** institutions where you have current/past affiliations and indicate if any are your "Primary" hospital affiliation. Must include Clinical Dept. Chief's Name, Tel & Fax #.

A. **CURRENT** or pending Hospital / Medical Center / Free Standing Clinic affiliations **other than** UCSF / Langley Porter:

TYPE "NONE" IF NO CURRENT AFFILIATIONS:

Institution:	Dept. Name & Your Status (attending, active, courtesy, etc.):		
Address:	City:	State:	Zip:
Medical Staff Office Tel & Fax#	Clin. Dept. Chief's Name & Tel#:		
Appointment Date:(mm/yyyy) <input type="checkbox"/> Pending Primary Hosp. Affiliation? <input type="checkbox"/> yes <input type="checkbox"/> no	Clin. Dept. Chief's Fax #:		

Institution:	Dept. Name & Your Status (attending, active, courtesy, etc.):		
Address:	City:	State:	Zip:
Medical Staff Office Tel & Fax#	Clin. Dept.Chief's Name & Tel#:		
Appointment Date:(mm/yyy) <input type="checkbox"/> Pending Primary Hosp. Affiliation? <input type="checkbox"/> yes <input type="checkbox"/> no	Clin. Dept. Chief's Fax #:		

B. **PREVIOUS: HOSPITAL / MEDICAL CENTER / FREE STANDING CLINIC AFFILIATIONS** – List all previous affiliations since beginning of **attending** activity (ie, where you served in a **NON-TRAINEE** capacity)

TYPE "NONE" IF NO PREVIOUS AFFILIATIONS: (Attach additional pages as necessary.)

Institution:	Department Name & Your Status (attending, active, courtesy, etc.):		
Address/City/State/Zip	Medical Staff Office Tel# & Fax#		
From Date:(mm/yy)	Thru Date:(mm/yy)	Clin. Dept Chief's Name & Tel#	
Reason for leaving:		Clin. Dept. Chief's Fax #:	
Institution:	Department Name & Your Status (attending, active, courtesy, etc.):		
Address/City/State/Zip	Medical Staff Office Tel & Fax#		
From Date:(mm/yy)	Thru Date:(mm/yy)	Clin. Dept. Chief's Name & Tel#:	
Reason for leaving:		Clin. Dept. Chief's Fax #:	

VII. MEDICAL/PROFESSIONAL EDUCATION: ALL information MUST be included. Attach additional pages as necessary.

Medical or Professional School:			
Address:		City, State, ZIP:	
Registrar's Tel #:	Registrar's Fax#:	Degree Received:	Date Received: (mm/yy)
Medical/Professional School:			
Address:		City, State, ZIP:	
Registrar's Tel #:	Registrar's Fax#:	Degree Received:	Date Received: (mm/yy)

VIII. TRAINING: ALL information MUST be included. Attach additional pages as necessary.

INTERNSHIP (PGY1)			
Institution:			
Mailing Address:	City:	State:	Zip:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please explain on separate sheet.)			
Program Director's Name:	Director's Tel#:	Director's Fax#:	

RESIDENCIES / FELLOWSHIPS: ALL information MUST be included. Attach additional pages as necessary.

Institution:			
Mailing Address:	City:	State:	Zip:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please explain on separate sheet.)			
Program Director's Name:	Director's Tel#:	Director's Fax#:	

Institution:			
Mailing Address:	City:	State:	Zip:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please explain on separate sheet.)			
Program Director's Name:	Director's Tel#:	Director's Fax#:	

Institution:			
Mailing Address:	City:	State:	Zip:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please explain on separate sheet.)			
Program Director's Name:	Director's Tel#:	Director's Fax#:	

IX. PROFESSIONAL LICENSURE & CERTIFICATES (all present & all past) Submit copy of CA licenses. (attach additional pages as necessary)

ID Type	ID Number	Issue Date mm/dd/yy	Expiration Date mm/dd/yy	State:
California State License				
Out of State License (Current and ALL Prior)				
Out of State License (Current and ALL Prior)				
ECFMG Number (foreign graduates)				
other Certificates (Current and ALL Prior)				
NPI				
General Anesthesia Permit DDS/DMD (Current and ALL Prior)				
Out of State CDS Certificates (Current and ALL Prior)				
DEA Number OR <input type="checkbox"/> I do not prescribe drugs requiring a DEA Certificate	<input type="checkbox"/> Pending			
X-ray Operator/Supervisor Fluoroscopy Certificate Number OR <input type="checkbox"/> I do not use/supervise use of fluoro/x-ray equipment	<input type="checkbox"/> Pending			

***Must submit** if you will use or supervise the use of this equipment. **Specialties required to submit when Fluoroscopy privileges are requested:** Anesthesia, Dent/Oral Max, Cardiology, Gastroenterology, NeuroSurgery, Orthopedics, Ob/Gyn, Otolaryngology, Pediatrics, Pulmonary, Radiation Oncology, Radiology, Surgery or Urology.

X. PROFESSIONAL LIABILITY: (attach additional pages as necessary; All Info must be completed)

A. CURRENT PROFESSIONAL LIABILITY INSURANCE CARRIER

Ins. Co. 1:	Policy #:	Tel#:
Mailing Address, City, State, Zip:		Fax#:
Per claim amount:	Aggregate amount:	BEGIN & Expiration Date: (mm/yy to mm/yy)

Does your professional liability insurance extend to all privileges you requested? Yes No

Exclusions:

Ins. Co. 2:	Policy #:	Tel#:
Mailing Address, City, State, Zip:		Fax#:
Per claim amount:	Aggregate amount:	BEGIN & Expiration Date: (mm/yy to mm/yy)

Does your professional liability insurance extend to all privileges you requested? Yes No

Exclusions:

B. PRIOR PROFESSIONAL LIABILITY INSURANCE CARRIER (ALL carriers since beginning clinical practice as an attending)

Ins. Co. 1:	Policy #:	Tel#:
Mailing Address, City, State, Zip:		Fax#:
Per claim amount:	Aggregate amount:	BEGIN & Expiration Date: (mm/yy to mm/yy)

Does your professional liability insurance extend to all privileges you requested? Yes No

Exclusions:

XIII. PROFESSIONAL LIABILITY ACTION INFORMATION: (TYPE "NONE" IF NO ACTIONS)

Please complete this form for pending or settled professional liability action(s) filed and served, or any payment made on your behalf. All questions must be answered completely. ***If you have additional pending or settled professional liability action, please submit additional pages with answers to the following questions.**

Date of Alleged Incident: mm/yy	Date Suit Filed: mm/yy	Patient Gender:	Age:
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Location of Incident:

Your relationship to Patient (Attending Phys., Surg., Asst., Consultant, etc.)

Allegation:

Liability Carrier when Incident Occurred:

Additional Named Defendant(s):

CLAIM STATUS: DISMISSED

<input type="checkbox"/> OPEN. If open, amount being sought:	<input type="checkbox"/> CLOSED. If closed, indicate method of closing: <input type="checkbox"/> Judgment <input type="checkbox"/> Settlement
Date:	Amount of settlement or judgment: \$

Summarize below, detailing the circumstances of any and all actions. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. Include 1) condition and diagnosis at the time of incident; 2) dates and description of treatment rendered; and (3) condition of patient subsequent to treatment.

Summary of details (required):

XIV. CME REPORTING FORM:

COMPLETE THIS FORM OR PROVIDE DOCUMENTATION OF YOUR CME ACTIVITY FOR THE PAST 2 YEARS. Minimum Requirements: **Physicians** - 50 hours Category I in past TWO years; **Dentists** - 50 hrs/25 of which must be Category I in past 2 yrs. Clin. Psychologists 36 hr in past 2 yrs. *List Activities sponsored by an accredited provider (formal courses, seminars etc. attended)*

Dates	Accredited Sponsor	Course Title	Cat I Hours
TOTAL for immediate past 2 years:			

XV. ANNUAL PPD TEST REQUIRED by State of California and UCSF Medical Staff Bylaws

YOUR MEDICAL STAFF APPOINTMENT CANNOT BE APPROVED WITHOUT TB CLEARANCE.

Call Employee Health Services (415) 885-7580 or go to website for more information:

<http://www.occupationalhealthprogram.ucsf.edu/>

XVI. ATTESTATION QUESTIONS		
Please answer the following questions . ALL "YES," ANSWERS REQUIRE FULL DETAILS ON A SEPARATE SHEET.		
Professional Liability Insurance		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has any medical malpractice judgment been entered against you, or have you been named or the subject of allegations, in any professional liability case(s)/arbitrations?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has any settlement been made in any professional liability case in which you or your insurance carrier had to or agreed to make a monetary payment?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you aware of any liability cases or allegations currently pending/under investigation against you?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has any policy been canceled, or has any professional liability insurer refused to renew your policy or placed limitations on the scope of your coverage?	
<i>Please note that members of this Healthcare Organization shall report to this Healthcare Organization the disposition (including settlement) and/or final judgement in professional liability cases in which they are involved, within thirty (30) days of disposition and/or final judgement.</i>		
Physical and Mental Health		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently have, or have you had, a problem associated with the use or misuse of drugs or controlled substances of any kind (whether obtained by prescription or otherwise), or alcohol? If yes, on a separate sheet please give a full explanation, including, without limitation, frequency and amount of use, the time period in which you engaged in such use, and the date last used.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any reason you cannot safely perform all the essential mental and physical functions related to the specific clinical privileges you are requesting or required by your agreement with the medical staff bylaws of the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance, and without posing a significant health and safety risk to others? If yes, on a separate sheet, please describe the essential function(s) and state the reason why you may not be able to safely perform it.	
Disciplinary and/or Voluntary actions: <i>Voluntarily *** or involuntarily, have any of the following ever been, or are currently being, denied, revoked, suspended, relinquished, withdrawn, reduced, limited, placed on probation, not renewed, or currently pending/under investigation?</i>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Clinical license in any jurisdiction;	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other professional registration/license;	
<input type="checkbox"/> Yes <input type="checkbox"/> No	DEA Certificate of registration or any applicable narcotic registration in any jurisdiction;	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Academic appointment, faculty position or trainee/student status in any training/clinical education program;	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Membership on any hospital medical staff;	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Clinical privileges, prerogatives/rights on any medical staff;	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Board Certification;	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other type of professional sanction;	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been subject to any disciplinary action in any health care organization, professional organization or medical society, or is any such action pending;	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has any monitoring requirement been imposed;	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you resigned or taken a leave of absence in order to avoid possible revocation, suspension, or reduction of privileges at any hospital or institution;	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have there been any, or are there any, misdemeanor or felony criminal convictions against you, or charges pending against you, including those under the Criminal Control Act;	
*** For the purposes of answering these questions, a "Voluntary" termination is considered a disciplinary action when the relinquishment is done to avoid an adverse action, preclude an investigation, or is done while the licensee is under investigation related to professional conduct. You do not need to report resignations for reasons of relocation or change of activity.		
Compliance with Laws Related to Patient Care		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are there any pending or completed administrative agency, government, or court cases, decisions or judgments involving allegations that you failed to comply with laws, statutes, regulations, or other legal requirements that may be applicable to the practice of your profession or to your rendition of service to patients;	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are there any prior or pending government agency or third party payer proceedings or litigation challenging or sanctioning your patient admission, treatment, discharge, charging, collection, or utilization practices, including, but not limited to, Medicare and Medicaid fraud and abuse proceedings or convictions?	

By my signature below, I acknowledge and agree that I will promptly and fully report all information to the Medical Staff Office of each Healthcare Organization to which I am applying in the event any of the answers above change, or if any situation arises which affects my ability to treat patients, after I have signed and dated this form, while my application is pending, and, if I am granted membership and/or clinical privileges, while I maintain membership and/or clinical privileges.

PRINT NAME

SIGNATURE

DATE

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

STATEMENT OF POLICY

It is the legal and ethical responsibility of all UCSF faculty and staff employees, house staff, students, volunteers and contractors to use personal and confidential patient, employee and University business information (referred to here collectively as “confidential information”) in accordance with the law and University policy, and to preserve and protect the privacy rights of the subject of the information as they perform their University duties. Medical Information including Protected Health Information (PHI) is maintained to serve the patient, health care providers, health care research and to conform to regulatory requirements.

Laws controlling the privacy of, access to and maintenance of confidential information include, but are not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), the California Information Practices Act (IPA), the California Confidentiality of Medical Information Act (COMIA), and the Lanterman-Petris-Short Act (LPS). These and other laws apply whether the information is held in electronic or any other form, and whether the information is used or disclosed orally or in writing.

University policies that control the way confidential information may be used include, but are not limited to, the following: UCSF Medical Center Policy 05.01.04 & 05.02.01, LPPI Policy, UCSF Policy 650-16 Minimum Security Standards, UC Personnel Policies PPSM 80, APM 160, applicable union agreement provisions, UC Business and Finance Bulletin RMP 8, and as summarized below.

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

The term “medical information” includes the following whether stored externally or on campus; whether electronically stored or transmitted patient information: medical and psychiatric records, including paper printouts, photos, videotapes, diagnostic and therapeutic reports, x-rays, scans, laboratory and pathology samples; patient business records, such as bills for service or insurance information; visual observation of patients receiving medical care or accessing services; verbal information provided by or about a patient.

ACKNOWLEDGEMENT OF RESPONSIBILITY: I understand and acknowledge that: It is my legal and ethical responsibility as an authorized user to preserve and protect the privacy, confidentiality and security of all medical records, proprietary and other confidential information relating to UCSF, its patients, activities and affiliates, in accordance with the law and University policy.

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

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

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

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

I understand that it is my responsibility to follow safe computing guidelines. To this end, I agree not to share my Login or User ID and/or password with a faculty member, employee, house staff, student, volunteer, contractor, or any other person and that any access to UCSF electronic information systems (including mobile devices) made using my Login or User ID and password is my responsibility. If I believe someone else has used my Login or User ID and/or password, I will immediately report the use to the appropriate Information Technology Department and request a new password.

I understand that my User ID(s) constitutes my signature and I will be responsible for all entries made under my User ID(s). I agree to always log off of shared workstations.

I understand that under provisions of the California CONFIDENTIALITY OF MEDICAL INFORMATION ACT (CIVIL CODE SECTION 56) and/or the Federal HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996, and/or any of the University’s policies and procedures related to confidential information or of any state or federal laws or regulations governing a patient’s right to privacy, intentional and/or malicious release of protected health information or involuntary violation of confidentiality may subject me to legal and/or disciplinary action up to and including immediate termination from my employment/professional relationship with UCSF, fines and imprisonment. Violation of Local, State or Federal statutes may carry the additional consequence of prosecution under the law. In addition I understand that I may be personally liable for harm resulting from my breach of this Agreement.

I have **read and agree to abide** by the above STATEMENT OF POLICY AND ACKNOWLEDGEMENT OF RESPONSIBILITY:

PRINT NAME

SIGNATURE

DATE

AUTHORIZATION, RELEASE, AND CONFIDENTIALITY STATEMENT

I fully understand that any significant omissions, misstatements or misrepresentations in this application, or during the application process, constitute cause for denial of this application, or for termination or suspension of my membership and/or clinical privileges at this healthcare organization. I affirm that the information submitted in or appended to this application is complete, true and current to the best of my knowledge and belief and is furnished in good faith. In making this application for appointment to this Healthcare Organization, I acknowledge that I have received the pertinent Bylaws, Rules and Regulations and policies and procedures (herein "Bylaws"): <http://www.ucsfmedicalcenter.org/medstaffoffice/MedStaffBylawsRulesRegs.htm> Further, I agree to be bound by the terms thereof and to uphold the Bylaws if I am granted membership, employment or participation (herein "membership"), and/or clinical privileges. I further agree to be bound by the terms of the Bylaws without regard to whether or not I am granted membership and/or clinical privileges in all matters relating to the consideration of my application for appointment to this Healthcare Organization. I further agree to comply with all applicable federal laws and laws of the State of California, as well as government regulations, in addition to specific department and/or service rules and regulations.

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

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

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

I understand and agree that I, as an applicant for membership and/or clinical privileges, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. By my signature below, I acknowledge and agree that I will promptly and fully report all information to the Medical Staff Office of each Healthcare Organization to which I am applying in the event any information contained herein changes, or if any situation arises which affects my ability to treat patients, after I have signed and dated this form, while my application is pending, and, if I am granted membership and/or clinical privileges, while I maintain membership and/or clinical privileges.

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

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

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

PRINT NAME

SIGNATURE

DATE