ANTELOPE VALLEY
HOSPITAL
A facility of Antelope Valley Healthcare District
1600 West Avenue J • Lancaster, CA 93534 • (661) 949-5000
www.avhospital.org

Dear Doctor:

Thank you for your interest in becoming a member of the Medical Staff of the Antelope Valley Hospital. Please see the following Application Policy from the Credentials Policy and Procedure Manual.

1.1 It is the policy of this hospital to provide applications for appointment to the Medical Staff to licensed medical and osteopathic physicians, dentists, oral surgeons, and podiatrists who are able to:☑

- ☐ 1.1-1 have a current, unrestricted license to practice in California and have never had a license to practice revoked or suspended by any state licensing agency
- ☐ 1.1-2 have current, valid professional liability insurance coverage in a form and in amounts required by the Board of Directors;
- ☐ 1.1-3 where applicable to their practice, have a current, unrestricted DEA license;
- ☐ 1.1-4 have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medical, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;
- ☐ 1.1-5 have never been, and are not currently excluded or precluded from participation in Medicare, Medical or other federal or state governmental health care program
- ☐ 1.1-6 have never been convicted of, or entered a plea of guilty or no contest to any felony or misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence (federal or in any state);
- ☐ 1.1-7 agree to adhere to the Hospital's Code of Conduct;
- ☐ 1.1-8 agree to participate in, and comply with, the Hospital's computerized physician order entry (CPOE) system;
- ☐ 1.1-9 not be applying to a specialty which is subject to an exclusive contract(s) (unless the applicant is a member of the group holding the exclusive contract(s));
- ☐ 1.1-10 have successfully completed (or be in the last six (6) months of):
  (a) a residency program approved by the Accreditation Council for Graduate Medical Education ("ACGME") or the American Osteopathic Association ("AOA") in a specialty in which the applicant seeks clinical privileges; or
  (b) a dental or an oral and maxilla facial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"); or
  (c) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association
- ☐ 1.1-11 be eligible/certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties ("ABMS") or the American Osteopathic Association "(AOA"), the American Association of Oral and Maxillofacial Surgery, or other board as applicable to their specialty.
- ☐ 1.1-12 demonstrate recent active clinical practice in the individual's primary specialty during at least two of the last four years, at least a portion of which must have been in an acute hospital setting; and
- ☐ 1.1.13 explain in writing their plans for office location and their plans for utilizing this hospital.

If you meet the above listed eligibility requirements, please attest by signing below and returning with the required documentation.

Upon completion and review of the enclosed application request, information release form and other listed required documents, eligible applicants will be provided a full application packet. If you require any further information, please call our office at (661) 949-5545.

Sincerely,

Medical Staff Services

I attest that I have read, understood and meet the above listed eligibility for application requirements.

_____ _____
Signed Date

_____
Print Name

Enclosures: Medical Staff Application Request
Authorization for Release of Information

Medical Staff Application Request

Last Name	First Name	Middle Name	Suffix	Sal	Degree/Title

Other Last Name	Other First Name	Other Middle Name	Suffix	Sal	Other Degrees/Titles

Specialty		**Sub-Specialty**	
Social Security Number:		**DEA Number**	
ECFMG Number		**Medical Board of CA License Number**	
Primary Office Address:		**Phone:**	
		Cell Phone:	
Birthdate:		**EMAIL:**	

In chronological order list all hospitals in which you have held clinical privileges during the previous four years (Please see the requirements listed in 1.1-12 Credentials Policy and Procedure Manual, as referenced on the previous page)

Type:	☐ *Hospital* ☐ *Office* ☐ *Clinic* ☐ *Other*_____			**Status:**	*Position:*
Hospital:					
From: (mm/dd/yyyy)		**To:** (mm/dd/yyyy)		**Dept.**	
Address:		**Phone 1:**		**Ext:**	
		FAX:			
City:		**State:**		**Zip:**	

Type:	☐ *Hospital* ☐ *Office* ☐ *Clinic* ☐ *Other*_____			**Status:**	*Position:*
Hospital:					
From: (mm/dd/yyyy)		**To:** (mm/dd/yyyy)		**Dept.**	
Address:		**Phone 1:**		**Ext:**	
		FAX:			
City:		**State:**		**Zip:**	

Please attach copies of:☑

- ☐ **Board Certification or letter indicating your admissibility to take the board examination**
- ☐ **Proof of your Professional Liability Insurance**
- ☐ **Clear copy of a current photo ID- Driver's License or Passport**
- ☐ **Current CV**

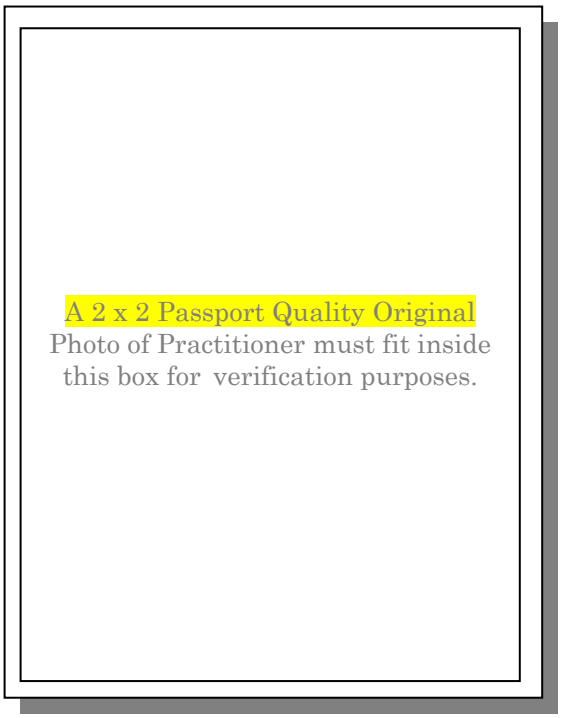
I attest that I have provided the requested documentation, and that the information above is true and correct.

_____ Signed

_____ Date

_____ Print Name

I. AUTHORIZATION FOR RELEASE OF INFORMATION



I understand that Antelope Valley Hospital has the obligation to evaluate my professional competence and qualifications, and to inquire into my professional training experience, professional conduct and judgment, in order to make a decision on my application for continued membership to the medical staff of the hospital.

By completing an application for appointment, I acknowledge that I am familiar with the principles of medical ethics of the professional association applicable to my training and licensure and agree to be bound by the terms thereof in all matters relating to the consideration of my application without regard to whether or not I am granted medical staff membership. I agree to be bound by Medical Staff Bylaws, Rules and Regulations.

I agree that it is my duty and ethical responsibility as an individual practitioner and as an applicant or medical staff member to cooperate with and assist Antelope Valley Hospital in evaluating not only my professional qualifications but also those of my colleagues. I agree to appear before hospital officers and committees for interviews or inquiries at reasonable times and places. I consent to the communication of information and documents between any Antelope Valley Hospital and other hospital medical staffs, medical schools, professional liability insurance carriers, training programs, medical licensing authorities in jurisdictions in which I have trained, resided, or practiced, or the evaluation of my professional training, experience, character, conduct, claims history, and judgment. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records.

I release from liability Antelope Valley Hospital, all representatives of Antelope Valley Hospital, the Antelope Valley Hospital medical staff, for their acts performed in connection with evaluating my application and my credentials and qualifications, so long as such entities and representatives act without malice, have made a reasonable effort to obtain the facts of the matter as to which they act, and act in reasonable belief that the action taken is warranted by the facts known to them after the reasonable effort to obtain facts. I hereby release from liability any and all individuals and organizations that provide information to Antelope Valley Hospital or the Antelope Valley Hospital medical staff, so long as the communication is intended to aid in the evaluation of my qualifications, fitness, character, or insurability as a practitioner.

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.

I certify that the information submitted is complete and correct to the best of my knowledge. I hereby affirm the information furnished by me in this application is true to the best of my knowledge and is furnished in good faith. I understand that substantial omissions or misrepresentation may result in denial, modification or revocation of my medical staff membership. I agree to immediately notify the Medical Staff Office and the Chief of Staff if any of my attestations in Section XV of this application change during the period of application processing.

_____ _____

Signature *(Stamped Signature Is Not Acceptable)* Date

_____

PRINT NAME LEGIBLY