

Indicate if applicant will be:

- ☐ Onsite only
(Physically Present at VPH)
- ☐ Offsite only
(Telemedicine / Remote)
- ☐ HYBRID
(BOTH Onsite *and* Offsite)

Request for Application for:

- ☐ Physician (MD/DO)
- ☐ Podiatrist (DPM)
- ☐ Dentist (DDS/DMD)
- ☐ Certified Registered Nurse
Anesthetist (CRNA)

Applicant Information

Last Name

NPI

First Name

Primary Specialty

Middle Name

Office Telephone

Email

Mobile Phone

By my signature below, I acknowledge that I have read and understand the following qualifications for membership (Medical Staff Bylaw 2.2):

Current licensure, adequate experience, education and training, current professional competence in the exercise of the privileges which they seek, demonstrate good judgment and current adequate physical and mental health status related to the privileges requested, and pass a background check, so as to demonstrate to the satisfaction of the Medical Staff and Board of Directors that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care.

Maintain in force individual professional liability insurance covering the exercise of all requested clinical privileges, in not less than the amounts specified in the Rules and Regulations or Policies and Procedures. Limits of coverage may not be shared between individuals. Professional liability insurance must be held with an insurance carrier approved by the California State Insurance Commissioner to conduct business in the State of California, or the practitioner may demonstrate membership in a physician's cooperative as defined in Section 1280.7 of the California Insurance Code.

Eligible to participate in federal health care programs.

Applicant Signature

Date

(continued next page)

Request for Application continued (page 2)

If you wish to authorize a delegate (office manager or assistant) to help you complete your online electronic application, complete this section:

Delegate Information

Delegate Email

Delegate First Name

Delegate Last Name

Delegate Office Telephone (if different from applicant)

Applicant Attestation Regarding Authorization for Delegate

By my signature below, I hereby authorize the above-named delegate to access the Valley Presbyterian Hospital online application (MD-App) to enter data and submit documentation to support my application for membership and practice prerogatives. I understand that I will need to review the data and documents and attest to their accuracy before I submit them for consideration, and that I am solely and fully responsible for the information I submit.

I also acknowledge that I have voluntarily provided the above information and that I have carefully read and understand this Authorization for Delegate. I understand and agree that a facsimile, PDF, or photocopy of this Authorization shall be as effective as the original.

Applicant Name (print)

Applicant Signature

Date

Reason for Application

Briefly articulate *why* you are applying to VPH; include details like *who* you will be practicing with and *how* you will utilize the facility.

Coverage (N/A for CRNAs)

Name of current member of the Medical Staff who will cover your practice when you are unable to provide care for your patients ^A

Commitment to Timely Completion of Application

I acknowledge by my signature below that if I am unable to complete the electronic application within 30 days of receipt, it will be automatically closed, and an additional application processing fee will be required to re-start the application.

Applicant Name (print)

Applicant Signature

Date

(continued next page)

Ensure the application process is as efficient as possible ...

Be prepared to upload / transfer a PDF or JPG of the following items into the “Required Documents” section of the electronic application:

- Up-to-date Curriculum Vitae
- Activity report (from the hospital you are most active at or training program [if completed within past 12 months]) listing diagnoses and procedures performed during the past two years
- Copy of your current DEA certification
Ensure that a local office or practice is listed (per Federal Title 21, Section 1301.12) and/or that it does not state “exempt” on the certificate
- Copy of your current malpractice liability insurance certificate
- Current color photograph (from the immediate-past 12 months)
- If you will care for maternal patients, you will be required to submit documentation of completion of training in implicit bias and racial disparities that complies with California Senate Bill 464 (Dignity in Pregnancy and Childbirth Act)
- If you are a surgeon, you will be required to complete an Operating Room Fire Safety module and exam
- Your specialty *may* require that you submit at least six hours of stroke-related education from the past 24 months
- If you will care for newborn infants, you must submit documentation of completion of three hours of breastfeeding education
- Orthopaedic Surgeons, Podiatrists, and Urologists are required to maintain a fluoroscopy permit
- Certain privileges require completion of a Moderate Sedation module and exam

Please return all pages to Medical Staff Services via fax 818.904.3774 or email medstaff@valleypres.org

^A If you do not have a current sponsor or current member of the Medical Staff who will agree to provide coverage, you must speak with either the Chief of Staff or applicable Department Chairperson prior to submitting this pre-application.