OLIVE VIEW-UCLA MEDICAL CENTER
Medical Administration

INTEROFFICE MEMORANDUM

DATE: _____

TO: Medical Staff Office

FROM: _____

_____

RE: **2025/2026 HOUSE STAFF MEMBER CHECKLIST**

The attached HOUSE STAFF INFORMATION SHEET is for:

LAST	FIRST	M.I.
Department:	Specialty:	
C#:		
County Title (Select One) ☐ Intern w/o Comp (9439) ☐ Resident w/o Comp (9440) ☐ Phys. Post Grad. 1st Yr. (5408) ☐ Phys. Post Grad. 2nd-7th Yr. (5411)		

This APPLICABLE DOCUMENTATION MUST ACCOMPANY this form:

House Staff Information Sheet	☐ Attached	
Copy of Medical School Diploma	☐ Attached	
Copy of E.C.F.M.G. Certificate (Foreign Graduate Physician Only)	☐ Attached	☐ Not Applicable

OLIVE VIEW-UCLA MEDICAL CENTER

HOUSE STAFF **INFORMATION SHEET**

(Please complete BOTH SIDES of this form)

Are you currently in an ACGME (Accreditation Council for Graduate Medical Education) Program?

□ Yes (If "yes," proceed with this information sheet)

□ No (If "no," stop. Complete a PSA {Professional Staff Association} Application)

Last, First, Middle

Print or type full name, including suffix (e.g., Jr., Sr.) and maiden name if applicable

ACADEMIC YEAR 2025/2026

Home Address

City State Zip

Telephone Number ( )	Beeper/Pager Number ( )	E-mail address:

- I hold the following valid State of California License:
  - □ Physician and Surgeon Number: _____ Expiration Date: _____ / _____ / _____
  - □ Postgraduate Training Lic. Number: _____ Expiration Date: _____ / _____ / _____
  - □ D.O. Number: _____ Expiration Date: _____ / _____ / _____
  - □ D.D.S. Number: _____ Expiration Date: _____ / _____ / _____
- I hold the following Drug Enforcement Administration Certificate (□ I do not possess a DEA Certificate):
  Number: _____ Expiration Date: _____ / _____ / _____
- Attached is a coy of my E.C.F.M.G. Certificate (□ Not Applicable):
  Number: _____ Date Issued: ____ / ____ / ____ Expiration Date: _____ / _____ / _____
- Ethnicity:_____ Languages Spoken:_____
- My Social Security Number is: _____--_____--_____. • Please indicate: □ Male □ Female
- My NPI Number is _____ (10 digits)
- My Date of Birth is: **_____ / _____ / _____,** and Place of Birth: **_____**
  (City and State/Country)

AMERICAN BOARD OF MEDICAL SPECIALTIES CERTIFICATION(S).

Attach copies of all board certifications. Indicate here if **not presently** Board Certified: □

American Board Name	Expected Date of Examination	Date Certified (Mo / Yr)	Date Recertified (To be Recertified) (Mo / Yr)
(1)			
(2)			

MEDICAL EDUCATION List the name(s) of all medical/osteopathic school(s) attended, city and state, beginning and ending dates, degree received and the date the degree was received. **(Attach a copy of your ECFMG certificate if you received your medical education outside of the United States)**

Name of School	Address Complete Street, City, State, Zip Code	From	TO (mm/dd/yy)	Degree Received
(1)			___ / ___ / ___	
(2)				

POSTGRADUATE TRAINING AND EXPERIENCE

INTERNSHIP/PGY1 Attach additional sheets if necessary.

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

RESIDENCIES/FELLOWSHIPS Include residencies, fellowships, preceptorships in chronological order, giving name, address, city and ZIP code, and dates. Include **all** programs you attended, whether or not completed. (Attach additional sheets if necessary).

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

ATTESTATION QUESTIONS: Please read and answer each question carefully. Any discrepancies or inaccuracies may be used to reject the application, or to revoke membership upon discovery of the discrepancy or inaccuracy. Please answer the following questions "yes" or "no." If your answer to question A is "no," or if your answer to B through O is "yes," please provide full details on separate sheet.

(A) 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
(B) 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 to 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
(C) 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
(D) 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
(E) Have your clinical privileges at any hospital or other health care 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 voluntarily or involuntarily suspended, restricted, limited, reduced or relinquished?	☐ Yes ☐ No
(F) 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), private payer (including those that contract with public programs), 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
(G) Has your Medical Staff membership, contractual affiliation or employment with any hospital or other health care 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 voluntarily withdrawn or terminated?	☐ Yes ☐ No
(H) Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?	☐ Yes ☐ No
(I) 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
(J) 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
(K) Have you ever been convicted of any crime (other than a minor traffic violation)?	☐ Yes ☐ No
(L) Do you presently use any drugs illegally?	☐ Yes ☐ No
(M) In the last five (5) years, have you had a history of chemical dependency or substance abuse that might adversely affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?	☐ Yes ☐ No
(N) Have any judgments been entered against you, or settlements been agreed to by you, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending? (if yes, please explain on a separate sheet of paper)	☐ Yes ☐ No
(O) Has your professional liability insurance ever been terminated, no 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

DATE: _____ SIGNATURE: _____

LOS ANGELES COUNTY **DEPARTMENT OF HEALTH SERVICES**

OLIVE VIEW-UCLA MEDICAL CENTER

STATEMENT OF CONFIDENTIALITY

OF PEER REVIEW/QUALITY IMPROVEMENT ACTIVITIES
OF THE PROFESSIONAL STAFF ASSOCIATION,
COMMITTEES, DEPARTMENTS AND DIVISIONS

All information discussed, distributed, and prepared for peer review/quality improvement activities shall be deemed confidential, including but not limited to all material related to the performance of medical review, participation in a risk prevention program, or investigation/discussion of any safety or quality of care issues.

The Medical Director shall determine the persons or entities outside the respective committees or activities that are legally entitled to access this information. All minutes, files, and correspondence shall be kept secured in a designated area and distributed only as directed by the Medical Director.

CONFIDENTIALITY AGREEMENT:

As a member or a guest of peer review/quality improvement activities at Olive View-UCLA Medical Center, I agree to respect and maintain the confidentiality of all discussions, deliberations, records and other information generated in connection with these activities, and to make no voluntary disclosures of such information except to persons authorized to receive it by the Medical Director.

I further understand that the organization is entitled to undertake action as is deemed appropriate to ensure that this confidentiality is maintained, including action necessitated by any breach or threatened breach of this agreement.

Print full name _____

Signature _____ Date _____

Health Services
LOS ANGELES COUNTY

NEW PROVIDER ORIENTATION ATTESTATION
MANDATORY TRAINING

Background:

The County of Los Angeles, Department of Health Services (DHS), is contracted with Health Plans to operate as a Participating Provider Group (PPG) and to provide Hospital services. Through this collaboration, DHS and the Health Plans provide and/or arrange for healthcare services for DHS assigned members. Pursuant to the agreements, DHS providers are required to review and understand the following information.

In addition to the DHS New Orientation packet, Health Plan's websites provide additional resources and opportunities for provider education. Information related to DHS' contracts with Health Plan's is available on DHS' SharePoint in the section at https://lacounty.sharepoint.com/sites/dhs-pophealth/SitePages/LearnHome.aspx

For more information about the Health Plan's programs, please visit their websites as follows:
L.A. Care: http://www.lacare.org/providers
Health Net: https://www.healthnet.com/portal/provider/home.ndo

Information available includes but is not limited to:

- DHS Provider Agreement with Managed Care Health Plans
- Health Plan's Provider Manual and Guidelines
- Health Plan's Member Handbooks
- Health Plan's Operations Manual
- Interpreter Services
- Provider Update
- I.C.E. Better Communication, Better Care: Provider Tools to Care for Diverse Populations
- Member's Rights and Responsibilities
- Quality Improvement Programs
- Preventive Health Guidelines
- Access Standards

ADDITIONAL TRAINING: Screening, Brief Intervention, and Referral to Treatment (SBIRT)
New DHS providers will be automatically enrolled into the Screening, Brief Intervention, and Referral to Treatment (SBIRT) training onto the Learning Net. This training is highly encouraged if you work with patients who are at risk for substance use disorders. Upon completion of this training, you will receive 4.0 CME units. The training is in accordance with the DHCS All Plan Letter (APL) 17-016 Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care. This APL explains the obligations of Medi-Cal managed care health plans (MCPs) to provide Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care. The SBIRT training will fulfill the requirements of this APL. Below is the link to the State DHCS All Plan Letter.
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-014.pdf

I acknowledge that I have read, reviewed and understand the above information. If I have questions or concerns, I will contact my Director for clarification.

Provider Name (First Name, Middle Initial, Last Name): _____

_____ _____
Signature Employee/Contract Number:

Date: _____

DISTRIBUTION OF HOUSE STAFF INFORMATION

The MEDICAL STAFF OFFICE receives the following:

Original copy of House Staff Information Sheet
Copy of Medical School Diploma
Copy of E.C.F.M.G. Certificate (Foreign Graduated Physicians Only)

Your DEPARTMENT FILES should retain the following:

Original Copy of House Staff Information Sheet
Copy of Medical School Diploma
Copy of E.C.F.M.G. Certificate (Foreign Graduated Physicians Only)