RIVERSIDE – SAN BERNARDINO COUNTY INDIAN HEALTH, INC.
11980 Mt Vernon Ave
Grand Terrace, California 92313
(909) 864-1097
(909) 503-1225 Fax

APPLICATION FOR CLINICAL STAFF EMPLOYMENT

An Equal Opportunity Employer

NOTICE OF EQUAL OPPORTUNITY EMPLOYER

Applicants are considered for all positions without regard to race, color, religion, sex, national origin, age, marital or veteran status or the presence of non-job related medical conditions or handicap.

NOTICE OF GENERAL SALARY RATINGS

Riverside-San Bernardino County Indian Health, Inc. is not a federal government agency. Reference to the General Salary Schedule Ratings (GS-) are equivalencies for the purpose of establishing and identifying wage scale only. This position does not entitle the incumbent to accrue any benefits from any federal benefits program.

NOTICE OF INDIAN PREFERENCE FOR EMPLOYMENT

You are also advised that this organization will be required to give preference in employment and training to qualified Indian candidates (Title 25 U.S.C. 472 and 473) and the Public Law 93-638 provided the applicant has submitted appropriate verification of Indian preference for employment. (Form BIA – 4432)

NOTICE OF DRUG-FREE WORKPLACE ACT REQUIREMENTS

Riverside-San Bernardino County Indian Health, Inc. is required to implement the Drug-Free Workplace Act of 1988, 45 CFR Part 76, and subpart F. As such, it is unlawful for employees to manufacture, distribute, dispense, possess, or use a controlled substance on the job site. Employees who are reasonably suspected of violating this act may be subject to drug testing as a condition of employment. Employer required fitness examinations shall include drug testing as evidence of employee and employer compliance with the Drug-Free Workplace Act.

NOTICE OF IMMIGRATION REFORM AND CONTROL ACT REQUIREMENTS

The Immigration Reform and Control Act of 1986, a Federal law, prevents us from hiring people who cannot prove they are either U.S. Citizens or are non-citizens whom the law permits to work here.

If we decide to hire you, you must show us one of the following original documents to provide your citizenship or legal right to work; an original Social Security Number Card; a Birth Certificate; a U.S. Passport; a Certificate of United States Citizenship, an INS Citizen identification Document; an INS Employment Authorization Document; a Native American Tribal Document.

You must also show one of the following documents to prove your identity; a state-issued Driver's License, ID Card, or Canadian Driver's License; a U.S. Passport; a U.S. Military ID Card; a Voter's Registration Card; a School Identification Card bearing a photograph of you; a U.S. Military Card, Draft Record, U.S. Coast Guard Merchant Mariner Card, or Military Dependent's ID card; an identification card issued by a federal, state or local government agency or entity; a Native American Tribal Document.

THE INDIAN CHILD PROTECTION AND FAMILY VIOLENCE PREVENTION ACT

The Indian Child Protection and Family violence Prevention Act (the "Act"), Public Law (P.L.) 101-630, 104 Stat 4544, 25 U.S.C. 3202-3211, are regulations that prescribe minimum standards of character and suitability of employment criteria for individuals whose duties and responsibilities involve regular contact with, or control over, Indian children.

There will be a background investigation check and finger printing process on all individuals who will come in contact with children or have control over Indian children. The minimum standards of character will have been met only after individuals in positions involving regular contact with or control over Indian children have been the subject of a satisfactory background investigation. This process will ensure that at no time have the individuals been found guilty of or entered a plea of nolo contendere or guilty to an offense under Federal, State, or tribal law involving crimes of violence; sexual assault, molestation, exploitation, contacts, or prostitution; or crimes against persons. The Act requires that tribes or tribal organizations that receive funds under the Indian Self-Determination and Education Assistance Act, P.L. 93-638, employ individuals in positions involving regular contact with or control over Indian children only if the individuals meet standards of character no less stringent than those prescribed for the government.

I understand and acknowledge receipt of the above information regarding Notice of Equal Opportunity Employment, salary, benefits, the requirements of Indian Preference, the Drug-Free workplace Act of 1988, the legal right to work, both a background check and the procedure of finger printing of myself. I also understand and acknowledge that results from the background investigation will be shared with me.

Signature: _____ Date: _____

APPLICANT DATA RECORD

Applicants are considered for all positions, and employees are treated during employment without regard to race, color, religion, sex, sexual orientation, national origin, age, marital or veteran status, medical conditions or disability.

EMPLOYMENT INQUIRY & RELEASE FORM

FULL NAME _____ _____ _____
LAST **FIRST** **MIDDLE**

SOCIAL SECURITY NO. _____ - _____ - _____ **DRIVERS LICENSE NO. / STATE** _____
(optional)

In connection with my employment or contract for services with you, I understand that investigative background inquires, including a fingerprint check, are to be made on myself. In accordance with my right to privacy, I have been advised that the information described below is required to assist the same in making an employment determination concerning me and that execution of this form is voluntary.

It is understood that all information / data obtained will be supplied to me in the form of an investigative report and that this report will not be used in violation of any federal or state law. Furthermore, if adverse action is to be taken based on this report, I will be notified, and a copy, along with a summary of the consumer's rights will be provided to me, at my request, by the entity supplying the information.

I hereby authorize any qualified agent bearing this document, or a copy thereof, to obtain information from all personnel, educational institutions, government agencies, companies, corporations, reporting agencies, law enforcement agencies or individuals, relating to my past activities, to supply any and all information concerning my background, and release same from any liability resulting from providing such information. The information received may include, but is not limited to academic, job performance, attendance, personal history, driving history, disciplinary and conviction records.

I understand that the information released is for consideration of my employment application and possibility for the purpose of determining my qualifications for future assignments.

I further hereby release any individual associated with the compilation of such information to include record custodians, directors, mro's, doctors, officers, agents, employees, if authorized representatives, from any and all liability for damages of whatever kind of nature, which may at any time accrue to me on account of (1) reliance by such persons on the information submitted in my employment application; (2) reliance by such persons on the information obtained pursuant to this authorization; (3) compliance with, or any attempt to comply with, this authorization; and (4) termination of my employment based on information obtained after commencement thereof pursuant to validity of this authorization.

I hereby certify that all the statements and answers set forth on the application form and documents signed are true and complete to the best of my knowledge, and I understand that if subsequent to employment, any of such statements and/or answers are found false or that information has been omitted, such false statements or omissions will be just cause for the termination of my employment.

I acknowledge and agree that I am executing this AUTHORIZATION FOR RELEASE OF INFORMATION voluntarily and have the right to receive a copy of it upon my written request.

It is hereby understood that in order to be considered for employment I must first pass a Pre-employment Urine Drug Screen. This test will be paid for by the employer and conducted at Riverside-San Bernardino County Indian Health, Inc. I also understand and authorize all testing results to be released to this company and/or its agents.

Under California Law, you have the right to receive a copy of your report I would like a copy of my report. (Check one)
YES ☐ NO ☐

_____ _____
SIGNATURE OF APPLICANT **DATE**

_____ _____ _____ _____
ADDRESS **CITY** **STATE** **ZIP**

RIVERSIDE – SAN BERNARDINO COUNTY INDIAN HEALTH, INC.
11555½ Potrero Road
Banning, CA 92220
(909) 849-4761
(909) 849-5612 Fax
An Equal Opportunity Employer

APPLICATION FOR CLINICAL STAFF EMPLOYMENT

PERSONAL INFORMATION

PLEASE PRINT

Position(s) applied for: _____

FULL NAME _____ (LAST) _____ (FIRST) _____ (MIDDLE)

SOCIAL SECURITY NO. ___ - ___ - ___ **DRIVERS LICENSE NO. / STATE** _____

DATE OF BIRTH _____ **PLACE OF BIRTH** _____

Home Address _____ (CITY) _____ (STATE) _____ (ZIP) _____

Home Phone _____ **Business Phone** _____ **Email Address** _____

Are you authorized to work in the USA? YES ☐ NO ☐

Citizenship _____

If employed and under 18, can you furnish a work permit? YES ☐ NO ☐

Have you filed an application here before? YES ☐ NO ☐

Have you ever been employed here before? If so, when _____ YES ☐ NO ☐

Can you travel if the job requires it? YES ☐ NO ☐

Are you available to work nights and weekends if required? YES ☐ NO ☐

Are you employed now: YES ☐ NO ☐

Are you on a lay-off and subject to recall? YES ☐ NO ☐

May we contact your previous/current employer? YES ☐ NO ☐

Are you a member of the Reserves, and subject to recall? YES ☐ NO ☐

To your knowledge, are you an immediate relative of any member of the Board of Directors of Riverside-San Bernardino County Indian Health, Inc.? YES ☐ NO ☐

Have you been convicted of or plead guilty to or no contest (no lo contender) to an offense involving crimes of violence? YES ☐ NO ☐

If yes, please explain _____

Referred by ☐ Advertisement ☐ Friend ☐ Relative ☐ Employment Agency ☐ Walk-In ☐ Other

Date you can start _____

List professional, trade, business or civic activities and offices held. (Exclude those which indicate race, color, religion, sex or national origin):

Are you a Native American / Alaskan Native? YES ☐ NO ☐

Can you perform the essential functions of this job with or without accommodations? YES ☐ NO ☐

REASONABLE ACCOMMODATIONS: This agency provides reasonable accommodations to applicants with disabilities. If you need a reasonable accommodation for any part of the application and hiring process, please notify us.

_____

Signature

1 Education Record

High School Name		Graduation Date	Degree
Address	City, State	Zip Code	Phone

Business or Technical School Name		Dates Attended (mo/yr)	Degree / Major
Address	City, State	Zip Code	Phone

Undergraduate College Name		Dates Attended (mo/yr)	Degree / Major
Address	City, State	Zip Code	Phone

Graduate School Name		Dates Attended (mo/yr)	Degree / Major
Address	City, State	Zip Code	Phone

2 Premedical Education

College or University Name		Graduation Date (Month/Year)	Degree, Subject
Address	City, State	Zip Code	Phone

3 Professional Education

College or University Name		Graduation Date (Month/Year)	Degree, Subject
Address	City, State	Zip Code	Phone

Practice Name		Graduation Date (Month/Year)	Degree, Subject
Address	City, State	Zip Code	Phone

4 Post-Graduate Training *(specify Internships, Residencies, Fellowships)*

INTERNSHIP INSTITUTION / HOSPITAL NAME			Dates of Service
Address	City, State	Zip Code	Phone

RESIDENCY INSTITUTION / HOSPITAL NAME			Dates of Service
Address	City, State	Zip Code	Phone

ADDITIONAL RESIDENCY INSTITUTION / HOSPITAL NAME			Dates of Service
Address	City, State	Zip Code	Phone

FELLOWSHIP INSTITUTION / HOSPITAL NAME			Dates of Service
Address	City, State	Zip Code	Phone

5 Chronological Order of Previous Practice

Practice Name		Status		Dates
Address	City, State	Zip Code	Phone	

Practice Name		Status		Dates
Address	City, State	Zip Code	Phone	

Practice Name		Status		Dates
Address	City, State	Zip Code	Phone	

6 Hospital Affiliations

Hospital Name		Status		Dates
Address	City, State	Zip Code	Phone	

Hospital Name		Status		Dates
Address	City, State	Zip Code	Phone	

Hospital Name		Status		Dates
Address	City, State	Zip Code	Phone	

7 Membership in Professional Society / Academy

Name of Society / Academy		Membership Status		Dates
Address	City, State	Zip Code	Phone	

Name of Society / Academy		Membership Status		Dates
Address	City, State	Zip Code	Phone	

8 American Board Certification *(list dates of expiration)*

Board			Expires
Address	City, State	Zip Code	Phone

Board			Expires
Address	City, State	Zip Code	Phone

Boards Taken Results Pending	Date Taken
If not Boarded, State Current Status	

9 Licensing

California Board License Number	Expiration Date
ECFMG Certificate Number (if applicable)	Date Passed

Medicare UPIN	National Physician Identifier	Medical UPIN	Medicaid UPIN

List all other State Medical Licenses *(past / present)*

State	License Number	Expiration Date
State	License Number	Expiration Date

10 Drug Enforcement Administration Registration

DEA Number	Expiration Date

11 Other Certification

CPR Certification	Expiration Date
ACLS	Expiration Date
Other	Expiration Date

12 Liability Insurance

Carrier Name	Policy Number		Expiration Date
Address	City, State	Zip Code	Phone

13 Professional References

Name	Relationship		
Address	City, State	Zip Code	Phone

Name	Relationship		
Address	City, State	Zip Code	Phone

Name	Relationship		
Address	City, State	Zip Code	Phone

14 Employment Experience

Start with your present or last job. Include military Service Assignments and Volunteer Activities. Exclude organization names which indicate race, color, religion, sex or national origin.

Employer Name	Supervisor		
Address	City, State	Zip Code	Phone
Dates Employed From	To	Hourly Rate / Salary	
Work Performed			
Reason for Leaving			

Employer Name	Supervisor		
Address	City, State	Zip Code	Phone
Dates Employed From	To	Hourly Rate / Salary	
Work Performed			
Reason for Leaving			

Employment Experience (continued)

Employer Name _____ Supervisor _____

Address _____ City, State _____ Zip Code _____ Phone _____

Dates Employed From _____ To _____ Hourly Rate / Salary _____

Work Performed _____

Reason for Leaving _____

IF YOU NEED ADDITIONAL SPACE, PLEASE CONTINUE ON A SEPARATE SHEET OF PAPER

15 Special Skills and Qualifications

Summarize any special skills and qualifications that you have acquired from employment or other experience:

If your answer to any of the following four questions is "YES", please provide full details on a separate sheet of paper.

A	Has your clinical license to practice ever been limited, suspended, or revoked in any jurisdiction, or is any such action pending?	YES ☐ NO ☐
B	Have your privileges at any health care organization ever been suspended, diminished, revoked, or not reviewed, or is any such action pending?	YES ☐ NO ☐
C	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization, or is any such action pending?	YES ☐ NO ☐
D	Have any judgments or settlements been made against you in professional liability cases, or are such cases pending?	YES ☐ NO ☐

RIVERSIDE – SAN BERNARDINO COUNTY

INDIAN HEALTH, INC.

I understand that the Program is responsible for the evaluation of my professional competence and qualifications, and has the obligation to inquire into my professional training, experience, professional conduct and judgment, and to make appropriate recommendations to the governing body of this Program.

By filing an application for employment and privileges, and in connection with this application, I agree to be bound by the policies of the Program, and the bylaws, rules and regulations of the professional staff, as adopted by the board and the applicable laws of the State of California.

I agree that it is my duty and ethical responsibility as an individual and as an employee of this Program to cooperate with and assist the Program in evaluating not only my professional qualifications but also those of my colleagues. I agree to appear before the Executive Director, Clinical Services Director and Committees for interview or inquiry at reasonable times and places. I consent to the communication of information and documents between this professional staff and other professional staffs, schools, training programs, societies, professional associations, professional liability insurance companies, national practitioner data bank, and licensing authorities in the jurisdiction in which I have trained, resided, or practiced, for the evaluation of my professional training, experience, character, conduct and judgment.

I release from any liability all individuals and organizations who provide information in good faith and without malice concerning my competence, ethical conduct, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged information.

Evaluation and inquires into my professional competence and qualifications shall be accomplished in a professional manner. I hereby affirm that the information furnished by me is true to the best of my knowledge and is furnished in good faith. I understand that willful and substantial omissions or misrepresentations may result in denial, modification, or revocation of my privileges or termination of employment.

Applicant's Printed Name	Applicant's Signature	Date

Riverside-San Bernardino County Indian Health, Inc.
Clinical Staff
Privileging Authorization

Name _____ Position _____

Department _____ Clinical Specialty _____

☐ This is a request for ***initial and/or renewal*** of privileges

☐ This is a request for ***adding*** a new privilege

The Privileging Authorization form must be accompanied or preceded by completed application for clinical staff appointment / reappointment.

I. Privileging by Category

(put a check mark on your clinical specialty category in which you are applying for privileging)

Requested	Clinical Specialty	Approved	Denied
	Cardiology: Ambulatory office-based non-invasive cardiology which is within the physician's California license, competence and scope of our Program's contract.		
	TeleCardiology: To provide ambulatory office-based non-invasive cardiology by way of digital or video transmission from originating site (RSBICHI) to a distant site (provider site) and is within the physician's California license, competence and scope of our Program's contract.		
	Clinical Psychiatry: General ambulatory psychiatric care of adult, adolescent and child patients, including diagnosing and treating. Clinical outpatient counseling services for individual adults and children, family, group and couples therapy, as well as educational and preventive care activities. All practice must be within the generally accepted psychiatric treatment and assessment procedures and standards of care for office based practice. Telehealth operation and utilization to provide health care services which may include telemedicine by way of digital or video transmission from an originating site (RSBCIHI) to a distant site. All practice must be within their license scope of practice, competency and follow treatment standards and ethical procedures and guidelines of the Board of Psychiatry and comply with the scope of work as defined by the Program.		
	TeleClinical Psychiatry: To provide general ambulatory psychiatric care of adult, adolescent and child patients, including diagnosing and treating. Clinical outpatient counseling services for individual adults and children, family, group and couples therapy, as well as educational and preventive care activities. All practice must be within the generally accepted psychiatric treatment and assessment procedures and standards of care for office based practice by way of digital or video transmission from originating site (RSBICHI) to a distant site (provider site). All practice must be within their license scope of practice, competency and follow treatment standards and ethical procedures and guidelines of the Board of Psychiatry and comply with the scope of work as defined by the Program (originating site) to a distant site.		

Clinical Privileging……..2

Requested	Clinical Specialty	Approved	Denied
	Clinical Psychology: General ambulatory psychological assessments, psychometric measurements and interpretations, SDM IV diagnosis and clinical outpatient counseling services for individual adults and children, family, group and couples therapy. Crisis intervention, on-call services, case consultation and supervision of cases will be a function of clinical psychologist. Educational and preventive care activities will also be provided. Telehealth operation and utilization to provide health care services which may include telemedicine by way of digital or video transmission from an originating site (RSBCIHI) to a distant site. All behavior and treatment provided must be within the practice of their license, competency and follow treatment standards and ethical procedures and guidelines of the Board of Psychology and comply with the scope of work as defined by the Program.		
	TeleClinical Psychology: To provide general ambulatory psychological assessments, psychometric measurements and interpretations, DSM IV diagnosis and clinical outpatient counseling services for individual adults and children, family, group and couples therapy. Crisis intervention, on-call services, case consultation and supervision of cases will be a function of clinical psychologist. Educational and preventive care activities will also be provided by way of digital or video transmission from originating site (RSBICHI) to a distant site (provider site). All behavior and treatment provided must be within the practice of their license, competency and follow treatment standards and ethical procedures and guidelines of the Board of Psychology and comply with the scope of work as defined by the Program.		
	Dermatology: Ambulatory office-based dermatology which is within the physician's California license, competence, and scope of our Program's contract.		
	Endocrinology: Ambulatory office-based endocrinology which is within the physician's California license, competence, and scope of our Program's contract.		
	TeleEndocrinology: To provide ambulatory office-based endocrinology by way of digital or video transmission from originating site (RSBICHI) to a distant site (provider site) which is within the physician's California license, competence, and scope of our Program's contract.		
	Family Practice: General ambulatory primary care of adult, pediatric, and pregnant patients, history, physical exams, diagnosing and treating disease, prescribing medications, therapeutic injections and aspirations of superficial structures and joint spaces, immunizations, ordering and interpreting clinical laboratory data, basic suturing, shave biopsies, and excisions of cutaneous lesions, and management of the well, acute and chronic disease patients, and provide basic health education of patients. Telehealth operation and utilization to provide health care services which may include telemedicine by way of digital or video transmission from an originating site (RSBCIHI) to a distant site. All practices must be within the generally accepted family practice procedures and standards of care for office based practice and be within their California license, competence, and scope of work as defined by the Program.		
	Family Nurse Practitioner: General ambulatory primary care of adult, pediatric, and pregnant patients; history, physical exams, diagnosing and treating disease independently as per the Program's Nurse Practitioner Clinical Guidelines, and joint management with a physician or referral of patients to physicians who are outside the scope of the practice guidelines; prescribing medications as allowed by ones Furnishing License, immunizations, ordering and interpreting clinical laboratory data, management of the well, acute and chronic disease patients, and provide basic health education of patients. Telehealth operation and utilization to provide health care services which may include telemedicine by way of digital or video transmission from an originating site (RSBCIHI) to a distant site. All clinical activities must be within the Family Nurse Practitioner's California License, level of competence, and scope of work as defined by the Program.		

Clinical Privileging……..3

Requested	Clinical Specialty	Approved	Denied
	Gastroenterology: Ambulatory office-based gastroenterology which is within the physician's California license, competence, and scope of our Program's contract.		
	TeleGastroenterology: To provide ambulatory office-based gastroenterology by way of digital or video transmission from originating site (RSBICHI) to a distant site (provider site) which is within the physician's California license, competence, and scope of our Program's contract.		
	General Dentistry: General dental history, oral exams, diagnosis, and treatment of teeth and gums; oral radiographic interpretation, treatment of dental caries, simple surgical extractions, endodontic procedures, design and placement of dental prosthesis both fixed and removable; periodontal procedures including oral prophylaxis, fluoride application, root planning and subgingival curettage, and dressings; prescription of analgesics, antibiotics and antifungals, steroids, and administration of local anesthetics and oral nerve blocks. Telehealth operation and utilization to provide health care services which may include telemedicine by way of digital or video transmission from an originating site (RSBCIHI) to a distant site. All clinical activities must be within the Dentist's California License, level of competence, and scope of work as defined by the Program.		
	General Practice: General ambulatory primary care of adult, pediatric, and pregnant patients; history, physical exams, diagnosing and treating disease, prescribing medications, therapeutic injections and aspirations of superficial structures and joint spaces, immunizations, ordering and interpreting clinical laboratory data, basic suturing, shave biopsies, and excisions of cutaneous lesions, and management of the well, acute and chronic disease patients, and provide basic health education of patients. Telehealth operation and utilization to provide health care services which may include telemedicine by way of digital or video transmission from an originating site (RSBCIHI) to a distant site. All practices must be generally accepted practice procedures and standards of care for office based practice and be within one's California license, competence, and scope of work as defined by the Program.		
	Internal Medicine: General and specialized ambulatory care primarily of adult patients with specific attention to internal organ system pathophysiology, history, physical exams, diagnosing and treating disease, prescribing medications, therapeutic injections and aspirations of superficial structures and joint spaces, immunizations, ordering and interpreting clinical laboratory data, basic suturing, shave biopsies, and excisions of cutaneous lesions, and management of the well, acute and chronic disease patients and provide basic health education of patients. Telehealth operation and utilization to provide health care services which may include telemedicine by way of digital or video transmission from an originating site (RSBCIHI) to a distant site. All procedures and treatments must be within the generally accepted internal medicine protocols and standards of care for office based practice and be within one's California license, competence, and scope of work as defined by the program.		
	Laboratory Medicine: Clinical laboratory direction for a CLIA or COLA moderate to high complexity laboratory. Supervision of quality control and interpretative standards for laboratory results.		
	Nephrology: Ambulatory office-based nephrology which is within the physician's California license, competence, and scope of our Program's contract.		
	TeleNephrology: To provide ambulatory office-based nephrology by way of digital or video transmission from originating site (RSBICHI) to a distant site (provider site) which is within the physician's California license, competence, and scope of our Program's contract		
	Neurology: Ambulatory office-based neurology which is within the physician's California license, competence, and scope of our Program's contract.		

Clinical Privileging……..4

Requested	Clinical Specialty	Approved	Denied
	TeleNeurology: To provide ambulatory office-based neurology by way of digital or video transmission from originating site (RSBICHI) to a distant site (provider site) which is within the physician's California license, competence, and scope of our Program's contract.		
	Obstetrics and Gynecology: Ambulatory office-based OB-GYN and Telehealth operation and utilization to provide health care services which may include telemedicine by way of digital or video transmission from an originating site (RSBCIHI) to a distant site. All clinical activities must be within the physician's California license, competence, and scope of our Program's contract.		
	Obstetrics and Gynecology Nurse Practitioner: General ambulatory primary care of adult or adolescent female patients, and pregnant patients; history, physical exams, diagnosing and treating disease independently as per the Program's Nurse Practitioner Clinical Guidelines, and joint management with a physician or referral of patients to physicians who are outside the scope of the practice guidelines; prescribing medications as allowed by ones Furnishing License, immunizations, ordering and interpreting clinical laboratory data, management of the well, acute and chronic disease patients, and provide basic family planning and health education of patients. Telehealth operation and utilization to provide health care services which may include telemedicine by way of digital or video transmission from an originating site (RSBCIHI) to a distant site. All clinical activities must be within the Family Nurse Practitioner's California License, level of competence, and scope of work as defined by the program. General adult or pediatric care for routine illness may be provided as needed and if within the practitioner's competence.		
	Optometry: Comprehensive optometric care of adult and pediatric patients including general health history, visual acuity measurement, pupil and binocular status assessment, refraction, anterior and posterior segment assessment, visual field, optical coherence and retinal tomographer interpretation, intraocular pressure and pachymeter testing and assessment, contact lens evaluation, goniocopy, diagnosing and treatment of any ocular disease within the scope of licensure within the Board of Optometry, California. Telehealth operation and utilization to provide health care services which may include telemedicine by way of digital or video transmission from an originating site (RSBCIHI) to a distant site. Optometrist's therapeutically licensed in glaucoma in accordance with California, is permitted to treat primary open angle glaucoma, pigmentary, pseudoexfoliation and stabilize acute angle. Additionally, pharmacological appropriate agents, orally and topically within the scope may be used for treatment and assessment, minor surface procedures such as foreign body removal is permitted following CA state law. Appropriate Lab work and X –ray orders are permitted for consideration of certain systemic and ocular involvement. Prescribing controlled substances are permitted within DEA guidelines for optometry.		
	Pediatrics: General ambulatory primary care of pediatric patients; history, physical exams, diagnosing and treating disease, prescribing medications, therapeutic injections and aspirations of superficial structures and joint spaces, immunizations, ordering and interpreting clinical laboratory data, basic suturing, shave biopsies, and excisions of cutaneous lesions, and management of the well, acute, chronic disease, developmental, and congenital problems of children as well as provide basic health education to patients and their parents/guardians. All protocols must be within the generally accepted pediatric practice procedures and standards of care for office based practice and be within their California license, competence, and scope of work as defined by the Program. General adult care for routine illness may be provided as needed and if within the practitioner's competence.		

Clinical Privileging……..5

Requested	Clinical Specialty	Approved	Denied
	Ophthalmology: Comprehensive Ophthalmologic care of adults and pediatric patients including general health history, measurement of visual acuity and intraocular pressure, assessment of pupils and binocular status, assessment of the anterior and posterior segment, appropriate visual field testing and interpretation proper assessment and treatment plan of any ocular diagnosis. Health education of the patient, pharmacological eye care, interpretation of retinal diagnostic imaging to include OCT (Optical Coherence Tomography) and fluorescein angiography, intravenous injection of fluorescein dye and/or ICG (Indocyanine green) dye and intraocular injections of pharmacologic agents.		
	Pain Management: Evaluation and management of patients requiring pain intervention. Privileges include to evaluate, diagnose, consult perform history and physical exam, and provide treatment to patients presenting with a condition requiring pain management local anesthetics and nerve blocks. Telehealth operation and utilization to provide health care services which may include telemedicine by way of digital or video transmission from an originating site (RSBCIHI) to a distant site. All clinical treatment and management must be within the physician's California license, competence, and scope of our Program's contract.		
	Pediatric Nurse Practitioner: General ambulatory pediatric patients; history, physical exams, diagnosing and treating disease independently as per the Program's Nurse Practitioner Clinical Guidelines, and joint management with a physician or referral of patients to physicians who are outside the scope of the practice guidelines; prescribing medications as allowed by ones Furnishing License, immunizations, ordering and interpreting clinical laboratory data, management of the well, acute, chronic disease, developmental, and congenital problems of children as well as provide basic health education to patients and their parents/guardians. Telehealth operation and utilization to provide health care services which may include telemedicine by way of digital or video transmission from an originating site (RSBCIHI) to a distant site. All clinical activities must be within the Family Nurse Practitioner's California License, level of competence, and scope of work as defined by the Program. General adult care for routine illness may be provided as needed and if within the practitioner's competence.		
	Pediatrics: General ambulatory primary care of pediatric patients; history, physical exams, diagnosing and treating disease, prescribing medications, therapeutic injections and aspirations of superficial structures and joint spaces, immunizations, ordering and interpreting clinical laboratory data, basic suturing, shave biopsies, and excisions of cutaneous lesions, and management of the well, acute, chronic disease, developmental, and congenital problems of children as well as provide basic health education to patients and their parents/guardians. Knowledge Telehealth operation and utilization to provide health care services which may include telemedicine by way of digital or video transmission from an originating site (RSBCIHI) to a distant site. All protocols must be within the generally accepted pediatric practice procedures and standards of care for office based practice and be within their California license, competence, and scope of work as defined by the Program. General adult care for routine illness may be provided as needed and if within the practitioner's competence.		

Clinical Privileging……..6

Requested	Clinical Specialty	Approved	Denied
	Pediatric Nurse Practitioner: General ambulatory pediatric patients; history, physical exams, diagnosing and treating disease independently as per the Program's Nurse Practitioner Clinical Guidelines, and joint management with a physician or referral of patients to physicians who are outside the scope of the practice guidelines; prescribing medications as allowed by ones Furnishing License, immunizations, ordering and interpreting clinical laboratory data, management of the well, acute, chronic disease, developmental, and congenital problems of children as well as provide basic health education to patients and their parents/guardians. Telehealth operation and utilization to provide health care services which may include telemedicine by way of digital or video transmission from an originating site (RSBCIHI) to a distant site. All clinical activities must be within the Family Nurse Practitioner's California License, level of competence, and scope of work as defined by the Program. General adult care for routine illness may be provided as needed and if within the practitioner's competence.		
	Podiatry: Ambulatory office-based podiatry practice limited to the history, physical exam, diagnosis, and treatment of the feet. Minor office-based surgery, wound care, prescription of foot prosthetics and shoe orthotics, administration of local anesthetics, local nerve blocks of the foot or digits, prescription of analgesics, anti-inflammatories, and antibiotics for treatment of foot related illness. Telehealth operation and utilization to provide health care services which may include telemedicine by way of digital or video transmission from an originating site (RSBCIHI) to a distant site. Practice is within the physician's California license, competence, and scope of our Program's contract.		
	Preventive Medicine: General Preventive Medicine with an emphasis on either public health or occupational medicine. Primary care emphasis on clinical patient education, exercise, nutritional modification, lifestyle management and risk factor reduction for disease reduction and health promotion. Telehealth operation and utilization to provide health care services which may include telemedicine by way of digital or video transmission from an originating site (RSBCIHI) to a distant site. Ambulatory office-based Clinical Preventive Medicine which is within the physician's California license, competence, and scope of our Program's contract.		
	Pulmonology: Ambulatory office-based pulmonology which is within the physician's California license, competence, and scope of our Program's contract.		
	Rheumatology: Ambulatory office-based rheumatology which is within the physician's California license, competence, and scope of our Program's contract.		
	Licensed Clinical Social Worker: The scope of practice for a LCSW is to provide general ambulatory clinical outpatient counseling services for individual adults, children, family, group, and couples therapy. Including DSM IV diagnosis, treatment planning and case management. Psychosocial evaluations may be requested for general assistance grant and for placement in hospital and residential care. Crisis intervention and on-call services will be a function of LCSW services. Educational and preventive care activities will also be provided. Telehealth operation and utilization to provide health care services which may include telemedicine by way of digital or video transmission from an originating site (RSBCIHI) to a distant site. All behavior and treatment provided must be within the practice of their license, competency, and follow treatment standards and ethical procedures and guidelines of the Board of Behavioral Science and comply with the scope of work as defined by the Program.		

Clinical Privileging……..7

Requested	Clinical Specialty	Approved	Denied
	Chiropractic: Ambulatory office-based chiropractic diagnosis and treatment for treatment of patients with musculoskeletal problems. Manual therapy and physical therapy modalities are utilized. Practitioner is to remain within his/her scope of practice, competence, California professional license, and within the scope of the Program's contract.		

II. Privileging by Procedure

(Put a check mark on your clinical specialty category in which you are applying for privileging)

Requested	Procedure, Treatment, or Intervention	Approved	Denied
	Acupuncture		
	Cardiology: Advanced EKG Interpretation		
	Cardiology: Defibrillation of the heart		
	Cardiology: Exercise Stress Test EKG readings		
	Cardiology: Holter Monitor EKG Interpretation		
	Exercise Stress Testing (Treadmill or Bicycle) and Interpretation ***(At Soboba***)		
	General: Addiction and Withdrawal Treatment		
	General: Allergy Testing and Desensitization Treatment		
	General: Aspiration and Injection of Joint Space		
	General: Audiometry		
	General: Blood Pressure Monitoring with Sphygmomanometer		
	General: Closed Reduction and Setting of Minor Fractures		
	General: Complete or partial avulsion of toe nails		
	General: Glaucoma Screening with an NCT, Goldmann or tonopen		
	General: Extended Ophthalmoscopy using a binocular indirect ophthalmoscope		
	General: Slit lamp using a 73D or 90D lens		
	General: Gonioscopy using a goniolens		
	General: Incision and Drainage of minor wounds or abscesses		
	General: Lumbar Puncture		
	General: Minor Wound Closure and Suturing		
	General: Phlebotomy		
	General: Preliminary Reading of Abdominal X-rays ***(At Soboba)***		
	General: Preliminary Reading of Chest X-rays		
	General: Preliminary Reading of Extremity X-rays		
	General: Preliminary Reading of Fetal Ultrasound		
	General: Removal of Cutaneous Cysts		
	General: Removal of Moles (Nevi)		
	General: Skin Biopsies and Excision of Cutaneous Lesions		
	General: Slit Lamp Eye Examination		
	General: Splinting of Strains and Sprains		
	General: Trigger Point Injection		
	General: Tympanometry		
	General: Urethral Catheterization		
	General: Vasectomy		
	GI: Flexible Sigmoidoscopy ***(At Soboba)***		
	Manual Therapy: High Velocity Maneuvers		
	Manual Therapy: Low Velocity Maneuvers		
	Nutrition: Nutrition Analysis		
	Nutrition: Skin fold measurement of Body Fat		

Clinical Privileging……..8

Requested	Procedure, Treatment, or Intervention	Approved	Denied
	OB-GYN: Cervical Cryotherapy		
	OB-GYN: Colposcopy		
	OB-GYN: Endometrial Biopsies		
	OB-GYN: Fit and Prescribe Diaphragms		
	OB-GYN: Insertion and Removal of IUD's		
	OB-GYN: Placement and Removal of Norplant		
	OB-GYN: Provide Post-Partum Care		
	OB-GYN: Provide Prenatal Care		
	Psychology: Biofeedback Therapy		
	Psychology: Hypnosis		
	Pulmonary: Basic Spirometric Testing and Interpretation		
	Pain Management: Carpal Tunnel Blocks		
	Pain Management: Joint Injections		
	Pain Management: Occipital Nerve Blocks		
	Pulmonary: Lung volume and Diffusion Testing Interpretation		
	Respiratory: Management of Obstructed Airway		
	Respiratory: Nasotracheal Suctioning		
	Respiratory: Tracheal Intubation		
	Supervise: Medical Students		
	Supervise: Nurse Practitioners		
	Supervise: Other Allied Health Practitioners		
	Supervise: Resident Physicians		
	Wound Care: Skin Biopsy		
	Wound Care: Laceration repair		
	Wound Care: Removal Soft Tissue Mass – i.e. Ganglion, Subcutaneous Cyst.		
	Wound Care: Nail Avulsion – Partial or Total		
	Wound Care: Nail Matrixectomy – Partial or Total		
	Wound Care: Interdigital Neuroma Excision		
	Wound Care: Exostectomy		
	Wound Care: Debridement of Wound – Superfiscial / Deep		
	Wound Care: Debridement / Curratage of Bone		
	Wound Care: Incision of Drainage		
	Wound Care: Hammertoe Correction / Arthropasty		
	Wound Care: Plantar Fascia Release		
	Wound Care: Phalangectomy – Partial / Total		
	Wound Care: Tenotomy		
	Wound Care: Foreign Body Removal		
	Wound Care: Bunionectomy		
	Wound Care: Metatarsal Head Resection		
	Wound Care: Metatarsal Osteotomy		

Applicant's Signature **Date**

III. Approvals

The signatures below indicate the completion of the privileging process and grant the above clinical privileges to the staff member for the following category:

_____ Limited Privileges – practitioner to operate under supervision of staff within the scope of privileges indicated above and as specified below.

- ☐ For a period not to exceed six (6) months.
- ☐ For the period of the assignment.
- ☐ For a certain number of cases (as specified).

_____ Full Privileges – practitioner to operate independently within the scope of privileges indicated above.

_____ Privileges not recommended

Comments _____

_____

_____

_____

_____ _____

Clinical Department Director / Advisor **Date**

_____ _____

Chairperson, Executive Clinical Staff Committee **Date**

_____ _____

Executive Director **Date**

RIVERSIDE – SAN BERNARDINO COUNTY

INDIAN HEALTH, INC.

CLINICAL APPLICANT'S ATTESTATION

I. Mental Health Statement

I, _____, certify that I have no mental or physical condition(s) which could affect my ability to, or would require an accommodation in order for me to exercise the clinical privileges requested.

II. Drug & Alcohol (Substance Abuse) Statement

Riverside-San Bernardino county Indian Health, Inc.'s (RSBCIHI) Drug and Alcohol (Substance Abuse) Policy strictly abides by the Drug Free Workplace Act of 1988, 56 CFR Part 75, Subpart F. In addition, RSBCIHI must be notified within five (5) calendar days of any criminal drug statute conviction for violation occurring in the workplace.

As such, it is unlawful for any employee/contractor to manufacture, distribute, dispense, possess, or use a controlled substance on the job site. Employees / contractors who are reasonably suspected of violating this act may be subject to drug / alcohol testing, as a condition or continuation of employment / contract.

I understand that as a prerequisite for employment, and as evidence of compliance with the Drug Free Workplace Act of 1988, I will be required to submit to drug/alcohol testing and to attend the Program's Drug Free Workplace Orientation.

I understand failure to submit or to agree to submit to drug / alcohol testing, or a positive result, may deny appointment, contract to RSBCIHI.

III. Liability Insurance and Malpractice Information:

If you answered "yes" to any of the following questions, please provide a details explanation on a separate sheet of paper. Make certain to number the separate sheet(s) of paper to correspond to the question being answered. Include the name, docket number of the case, the nature and date of the claim, the judgment or outcome, and damages or settlement awarded.

Since your last appointment:	YES	NO
1. Have you had any change(s) in your license to practice in any State	☐	☐
2. Have you been charged or convicted of any misdemeanor or felony charges?	☐	☐

Yes No

3. Has your narcotic registration certificate been called into question, suspended, or revoked? ☐ ☐

4. Have you been the subject of professional disciplinary charges, hearings, or dispositions in the state(s) in which you are licensed to practice? ☐ ☐

5. Have you been granted staff privileges at any other health facilities? ☐ ☐
   If so, please provide the name(s), address(es), dates, and privileges granted at these facilities.
   _____
   _____

6. Have been the subject of staff privileges inquiries or action at any other facilities? ☐ ☐

7. Have you taken or been granted a leave of absence with respect to your clinical staff privileges at any health facility? ☐ ☐
   If yes, for how long? Dates: _____

8. Have you voluntarily resigned from the clinical staff of a health care facility? ☐ ☐

9. Have your privileges been curtailed, suspended, revoked, or changed in any health care facility? ☐ ☐

10. Have you voluntarily relinquished your DEA or other privileged clinical activity? ☐ ☐

11. Has your specialty board status changed? ☐ ☐

12. Please indicate whether you are able to perform the essential functions of the profession for which you are seeking privileges with or without reasonable accommodation. ☐ ☐

13. Have you changed professional liability insurance carrier and/or the extent of liability insurance coverage since your last appointment to the clinical staff? ☐ ☐

14. Have you been named as a party in any professional liability lawsuits since your last applied for appointment to the medical staff? ☐ ☐

15. Have you or your professional corporation been involved in any settlements or judgments of professional liability lawsuits since your last applied for appointment to the medical staff. ☐ ☐

16. Since you last appointment to the clinical staff, has your professional liability carrier excluded any practices or procedures form stated coverage? ☐ ☐

Applicant's Printed Name	Applicant's Signature	Date

RIVERSIDE – SAN BERNARDINO COUNTY

INDIAN HEALTH, INC.

RELEASE OF INFORMATION

I authorized Riverside-San Bernardino County Indian Health, Inc. (RSBCIHI) to obtain written documentation concerning my current clinical staff status, clinical privileges and appointment and reappointment dates from any hospital and other health care institutions, which I am associated.

I release RSBICHI and RSBCIHI's representative from any liability for their acts performed in good faith and without malice in evaluating my credentials and qualifications. Further I release all individuals and organizations which provide information to RSBCIHI regarding my professional competence, ethics, character, and other qualifications or affiliations from any liability provided they act in good faith, and without malice.

I understand that any misleading statement made by me or on my behalf concerning my professional qualifications may result in termination of my participation in RSBCIHI provider network.

I understand that RSBCIHI may provide information it obtains under this Release of Information to those health care organizations with which I am affiliated.

I further understand that all information disclosed to pursuant to this Release of Information shall be confidential and not disclosed to anyone unless as provided herein or in accordance with California law.

A copy of this waiver will be provided to me upon request. A photocopy of this Release of Information shall be considered as valid as the original.

Name (please print or type)	Signature	Date

Note: This Release of Information is for the sole and confidential use of RSBCIHI's Clinical Staff Credentials Verification Policy / Executive Clinical Staff Committee / Peer Review Committee / Quality Assurance

RIVERSIDE – SAN BERNARDINO COUNTY

INDIAN HEALTH, INC.

STATEMENT OF CONFIDENTIALITY

I, _____ am an employee / contractor / volunteer of Riverside-San Bernardino County Indian Health, Inc., and state the following:

It is the legal and ethical duty of each employee / contractor / volunteer to safeguard client / patient / employee confidentiality within the constraints of Program Policy and constraints of existing law.

It is the policy of riverside-San Bernardino County Indian Health, Inc., to consider all client / patient information and employee / employer information as confidential and to allow access only to those persons or agencies who "need to know" or who are granted access by law. Employees / Contractors / volunteers are directed to practice prudence and restraint in verbal communications and handling of records.

I have been provided orientation, within the scope of service, by a personnel representative and my supervisor regarding confidentiality. I understand and shall comply with the policy. The Program Administration Manual, Section 3: Personnel Administration, Part 3-7: Employee Conduct and Responsibilities, 5.0 Confidential Information. The Medical Records Manual, Section 5: Confidentiality of Records, Part 5-1 Confidentiality and Security of Records, and 5-2: Confidentiality of Patient Information.

Employee	Date
Personnel Representative	Date
Supervisor	Date