925A

SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

FROM: Riverside County Regional Medical Center

SUBMITTAL DATE:
November 10, 2011

SUBJECT: Medical Staff Appointments, Reappointments and Clinical Privileges

RECOMMENDED MOTION:

1. Request approval by the Board of Supervisors of appointments, reappointments, and clinical privileges.
2. Request approval by the Board of Supervisors of the attached California Participating Physician Application.

BACKGROUND: The Medical Executive Committee on November 10, 2011, recommended to refer the following items to the Board of Supervisors for review and action:

A. Approval of Medical Staff Appointments and Clinical Privileges:

1. Agapian, John, MD — General Surgery
2. Arif, Muhammad, MD — Family Medicine

Douglas N Bagley
Douglas D. Bagley, Hospital Director

Departmental Concurrence

FINANCIAL DATA	**Current F.Y. Total Cost:**	$ 0	**In Current Year Budget:**	Yes
	Current F.Y. Net County Cost:	$ 0	**Budget Adjustment:**	No
	Annual Net County Cost FY:	$ 0	**For Fiscal Year:**	11/12

SOURCE OF FUNDS:

Positions To Be Deleted Per A-30 ☐

Requires 4/5 Vote ☐

C.E.O. RECOMMENDATION: APPROVE

BY: Debra Cournoyer
Debra Cournoyer

County Executive Office Signature

☐ Policy ☐ Policy
☐ Consent ☐ Consent
☒ Consent ☒ Consent

Dep't Recomm.: Per Exec. Ofc.:

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Ashley, seconded by Supervisor Benoit and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes: Buster, Tavaglione, Stone, Benoit and Ashley
Nays: None
Absent: None
Date: November 22, 2011
xc: RCRMC

Kecia Harper-Ihem
Clerk of the Board
By: Deputy

Prev. Agn. Ref.: | **District:** 5 | **Agenda Number:** 2.11

ATTACHMENTS FILED
WITH THE CLERK OF THE BOARD

3.	Azizi, Faramarz, MD	Pathology
4.	Febre, Aprille D., MD	Pediatrics
5.	Green, Harry M., OD	Optometry
6.	Hadley, David A., MD	Urology
7.	Huang, Aaron, DO	Anesthesiology
8.	Jones, William G., MD	Radiology
9.	Ko, Edmund Y., MD	Urology
10.	Lavery, Adrian P., MD	Neonatology
11.	Leenheer, Rebecca S., MD	Ophthalmology
12.	Luke, Janiene D., MD	Dermatology
13.	Nguyen, Tam M., MD	Psychiatry
14.	Nguyen, Truclinh T., DO	Internal Medicine
15.	Scapa, Victor I., MD	Otolaryngology
16.	Siccama, Melissa D., MD	Pediatrics
17.	Smith Damien L., MD	Urology
18.	Solomon, Tabitha E., MD	Neonatology
19.	Vasquez, Herbert A., MD	Neonatology
20.	Vetsa, Madhavi, MD	Gastroenterology
21.	Walsh, Catherine A., MD	Plastic Surgery
22.	Wood, Terry D., MD	Ophthalmology

B. Approval of Reappointments: (11/30/2011 – 11/30/13) – Attachment

C. Additional Privileges:

1. Rao, Ravindra, MD — Pediatrics
   - Moderate Sedation

The Physician Application submitted for approval replaces the existing application in order to comply with current regulatory credentialing guidelines of the Joint Commission and Centers for Medicare and Medicaid Services (CMS).

D. California Participating Physician Application: - Attachment

Riverside County Regional Medical Center
Medical Staff Reappointments

The Credentials Committee is submitting the following reappointment recommendations for review and action. The RCRMC Medical Staff member has met the reappointment standards and requirements set forth in the Medical Staff Bylaws, Rules and Regulations.

Department	Name	Title	Status	Reappointment Period		Recommendation
Medicine						
	Paresh C. Giri	MD	Active	12/1/2011	11/30/2013	Renewal, current staff category and privileges as delineated.
	Shuja Rasool	MD	Active	12/1/2011	11/30/2013	Renewal, current staff category and privileges as delineated.
Obstetrics/Gynecolology						
	Guillermo Valenzuela	MD	Active	11/30/2011	11/30/2013	Renewal, current staff category and privileges as delineated.
Ophthalmology						
	Laura A. Tesley	MD	Active	12/1/2011	11/30/2013	Renewal, current staff category and privileges as delineated.
Psychiatry						
	Jerry L. Dennis	MD	Active	11/30/2011	11/30/2013	Renewal, current staff category and privileges as delineated.
Radiology						
	Juanito S. Villanueva, Jr.	MD	Active	12/1/2011	11/30/2013	Renewal, current staff category and privileges as delineated.
	Alix Vincent	MD	Active	12/1/2011	11/30/2013	Renewal, current staff category and privileges as delineated.
Surgery						
	Michael E. Hill	MD	Active	11/30/2011	11/30/2013	Renewal, current staff category and privileges as delineated.
	Miguel Krishnan	DO	Active	12/1/2011	11/30/2013	Renewal, current staff category and privileges as delineated.
	Frank R. Rogers	MD	Active	11/30/2011	11/30/2013	Renewal, current staff category and privileges as delineated.

California Participating Physician Application

I. INSTRUCTIONS:

This form should be typed. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please refer to cover page for a list of the required documents to be submitted with this application.

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known? Name (s):		
Home Mailing Address:	City:	
	State:	ZIP:
Home Telephone Number: ( ) Fax Number: ( ) Cell Number: ( )	Email address:	
Birth Date: Birth Place (City/State/Country):	Citizenship (If not a US citizen, please provide a copy of Alien Registration Card)::	
Social Security #	Gender: ☐ Male ☐ Female	
Specialty:		
Subspecialties:	Driver's License Number/State:	

III. PRACTICE INFORMATION

Practice Name (if applicable):	Department Name (if hospital based):	
Primary Office Mailing Address:	City:	
	State:	ZIP:
Telephone Number: ( )	Fax Number: ( )	
Office Manager/Administrator:	Telephone Number: ( )	

III. PRACTICE INFORMATION continued

Office Manager Email address:	Fax Number: ( )	
Website Address (if applicable):	Email Address:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Secondary Office Street Address:	City:	
	State:	ZIP:

Office Manager/Administrator:	Telephone Number: ( )
Office Manager Email address:	Fax Number: ( )
Website Address (if applicable):	Email Address:
Name Affiliated with Tax ID Number:	Federal Tax ID Number:
Tertiary Office Mailing Address:	City:
	State: ZIP:
Office Manager/Administrator:	Telephone Number: ( )
Office Manager Email address:	Fax Number: ( )
Website Address (if applicable):	Email Address:
Name Affiliated with Tax ID Number:	Federal Tax ID Number:
Medicare UPIN:	NPI #

IV. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary.)

Medical School/Professional:	Mailing Address:		Degree Received:
City:	State:	ZIP:	Date of Graduation:
Registrar's Office:	Website (if applicable):		

POSTGRADUATE TRAINING AND EXPERIENCE

V. INTERNSHIP/PGY-I

Institution:			Program Director:
Mailing Address:	City:		
	State:		ZIP:
Phone: ( ) Fax: ( ):	Website (if applicable):		
Type of Internship:	From: (mm/yyyy)		To:(mm/yyyy)

Did you successfully complete the program? ☐ Yes ☐ No (If "No," please explain on separate sheet.)

VI. RESIDENCIES/FELLOWSHIPS

Include residencies, fellowships, and postgraduate education in chronological order, giving name, address, city and ZIP code, and dates. Use separate sheet if necessary.

Institution:	Program Director:

Mailing Address:	City:		
	State:	ZIP:	
Phone: ( ) Fax: ( ):	Website (if applicable):		
Type of Training (e.g. residency, etc.):	Specialty:	From: (mm/yyyy)	To: (mm/yyyy)
Did you successfully complete the program? ☐ Yes ☐ No (If "No," please explain on separate sheet.)			
Institution:	Program Director:		
Mailing Address:	City:		
	State:	ZIP:	
Phone: ( ) Fax: ( ):	Website (if applicable):		
Type of Training (e.g. residency, etc.)	Specialty	From: (mm/yyyy)	To: (mm/yyyy)
Did you successfully complete the program? ☐ Yes ☐ No (If "No," please explain on separate sheet.):			
Institution:	Program Director:		
Type of Training (e.g. fellowship, etc.)	Specialty:	From: (mm/yyyy)	To: (mm/yyyy)
Did you successfully complete the program? ☐ Yes ☐ No (If "No," please explain on separate sheet.)			

VII. MEDICAL LICENSURE

California State Medical License Number:	Expiration Date:
Drug Enforcement Administration (DEA) Registration Number: **Schedules:**	Expiration Date:
Controlled Dangerous Substances Certificate (CDS) (if applicable):	Expiration Date:
ECFMG Number (applicable to foreign medical graduates):	Date Issued:
National Physician Identifier (NPI): MediCal/Medicaid Number:	PPIN:

VIII. ALL OTHER STATE MEDICAL LICENSES

State:	License Number: Issue Date:	Expiration Date:
State:	License Number: Issue Date:	Expiration Date:

State:	License Number: Issue Date:	Expiration Date:
State:	License Number: Issue Date:	Expiration Date:
State:	License Number: Issue Date:	Expiration Date:

IX. OTHER CERTIFICATIONS (e.g., FLUOROSCOPY, RADIOGRAPHY, ACLS/BLS/PALS, ETC.)

Please include copy of certificate.

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

X. BOARD CERTIFICATION(S)

Include certifications by board(s) which are duly organized and recognized by:

- **a member board of the American Board of Medical Specialties**
- **a member board of the American Osteopathic Association**
- **a board or association with equivalent requirements approved by the Medical Board of California**
- **a board or association with an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty.**

Name of Issuing Board	Certificate Number	Date Certified/Recertified	Expiration Date (if any)

Have you applied for board certification other than those indicated above? Yes ☐ No ☐

If so, list board(s) and date(s):

XI. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in reverse chronological order (with the current affiliation{s} first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B). This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s).

A. CURRENT AFFILIATIONS

If you do not have hospital privileges, please explain (physicians without hospital privileges must provide written plan for continuity of care).

Name and Address of Primary Admitting Hospital:	Department:
Status (active, provisional, courtesy, temporary, etc.):	From (mm/yr); To (mm/yr):
Website (if applicable):	Verify Online: Yes ☐ No ☐
Name and Address of Secondary Admitting Hospital:	Department:
Status:	From (mm/yr); To (mm/yr):

Website (if applicable):	Verify Online: Yes ☐ No ☐
Name and Address of Other Institutions:	Department:
Status:	From (mm/yr); To (mm/yr):
Website (if applicable):	Verify Online: Yes ☐ No ☐

B. PREVIOUS HOSPITAL AND OTHER INSTITUTION AFFILIATIONS

1. Name and Address of Affiliation:		Department: Status:
From: (mm/yyyy)	To: (mm/yyyy)	Reason for Leaving:
Website (if applicable):		Verify Online: Yes ☐ No ☐
2. Name and Address of Affiliation:		Department: Status:
From: (mm/yyyy)	To: (mm/yyyy)	Reason for Leaving:
Website (if applicable):		Verify Online: Yes ☐ No ☐
3. Name and Address of Affiliation:		Department: Status:
From: (mm/yyyy)	To: (mm/yyyy)	Reason for Leaving:
Website (if applicable):		Verify Online: Yes ☐ No ☐
4. Name and Address of Affiliation:		Department: Status:
From: (mm/yyyy)	To: (mm/yyyy)	Reason for Leaving:
Website (if applicable):		Verify Online: Yes ☐ No ☐
5. Name and Address of Affiliation:		Department: Status:
From: (mm/yyyy)	To: (mm/yyyy)	Reason for Leaving:
Website (if applicable):		Verify Online: Yes ☐ No ☐

XII. SUPPLEMENTAL PEER REFERENCES

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations. **At least one reference must be from someone with the same credentials, for example, a MD must list a reference from another MD or a DPM must list one reference from another DPM.**

Name of Reference:	Title:	Telephone Number: ( )

		Fax Number: ( )
Mailing Address:	City:	State:
Email address:		Zip:
Name of Reference:	Title:	Telephone Number: ( ) Fax Number: ( )
Mailing Address:	City:	State:
Email address:		Zip:
Name of Reference:	Title:	Telephone Number: ( ) Fax Number: ( )
Mailing Address:	City:	State:
Email address:		Zip:

XIII. WORK HISTORY

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be completed. Curriculum vitae is not sufficient. Please explain any gaps on a separate page.

Current Practice: Website (if applicable):	Contact Name:		Telephone Number: ( ) Fax Number: ( ) Position Held:		
Mailing Address:	City:	State:	ZIP:	From: (mm/yyyy)	To: (mm/yyyy)
Name of Practice/Employer: Website (if applicable):	Contact Name:		Telephone Number: ( ) Fax Number: ( ) Position Held:		
Mailing Address:	City:	State:	ZIP:	From: (mm/yyyy)	To: (mm/yyyy)
Name of Practice/Employer: Website (if applicable):	Contact Name:		Telephone Number: ( ) Fax Number: ( ) Position Held:		
Mailing Address:	City:	State:	ZIP:	From: (mm/yyyy)	To: (mm/yyyy)

XIV. PROFESSIONAL LIABILITY

Please list all of your professional liability carriers for the past seven years. If more space is needed, attach additional sheet(s).

Name of Carrier:	Mailing Address:	From: (mm/yyyy)	To: (mm/yyyy)
Policy #	City:	State:	ZIP:
Website (if applicable):		Phone: ( )	Fax: ( )

Tail Coverage: ☐ Yes ☐ No		Email address:	
Name of Carrier:	Mailing Address:	From: (mm/yyyy)	To: (mm/yyyy)
Policy #	City:	State:	ZIP:
Website (if applicable):		Phone: ( )	Fax: ( )
Tail Coverage: ☐ Yes ☐ No		Email address:	
Name of Carrier:	Mailing Address:	From: (mm/yyyy)	To: (mm/yyyy)
Policy #	City:	State:	ZIP:
Website (if applicable):		Phone: ( )	Fax: ( )
Tail Coverage: ☐ Yes ☐ No		Email address:	

XV. ATTESTATION QUESTIONS

Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "Yes", please provide full details on a separate sheet of paper.

. Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, suspended, revoked, not renewed, or subject to probationary conditions, or have you been fined or received a letter of reprimand or is such action pending?	oYes	o No
2. Have you ever been 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, by Medicare, Medicaid, or any federal program or is any such action pending?	oYes	o No
3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical ff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with federal programs), 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?	oYes	o No
4. 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), 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?	oYes	o No
5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?	oYes	o No
6. Have you ever been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed?	oYes	o No
7. a. Have you ever been convicted of, or plead guilty to a criminal offense (i.e. felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense??	oYes	o No
b. Are any such actions pending?	oYes	o No
8. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending? This would include dismissed claims.	oYes	o No
9. Has your professional liability insurance ever been terminated, not 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?	oYes	o No
10. Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations?	oYes	o No
11. Within the last two years, have you been dependent upon alcohol or drugs?	oYes	o No
12. Within the last two years, have you been in treatment for alcohol or drug abuse or dependency?	oYes	o No
13. Within the last two years, has your membership, privileges, participation or affiliation with any health care organization (e.g., a hospital or HMO), been terminated, suspended, or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs?	oYes	o No

I hereby affirm that the information submitted in this Section, Attestation Questions, and any addendums thereto (including my curriculum vitae if attached) is current, correct, complete, and true to the best of my knowledge and belief and is furnished in good faith. I understand that material, omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Applicant Signature(Stamped Signature in Not Acceptable)	Printed Name	Date

INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations {IPAs}, health plans, health maintenance organizations {HMOs}, preferred provider organizations {PPOs}, other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, 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 "Health care Organizations,") for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of peer records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including, but not limited to, California Business and Professions Code Section 809 et seq., if applicable.

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.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal or my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, within five (5) days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me, by the Medical Board of California taken or pending, including, but not limited to, any accusation filed, temporary restraining order or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization, which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding any minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I pledge to provide continuous care for my patients.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is current, correct, complete, and true to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

A photocopy of this document shall be as effective as the original

Print Name Here: _____ Date: _____

Signature: _____
(A Stamped Signature is Not Acceptable)

Addenda Submitting (Please check the following):

☐ Addendum A – Professional Liability Action Explanations

This application and Addenda A was created and are endorsed by:

- American Medical Group Association – (310/430-1191 x 223)
- California Association of Health Plans – 916/552-2910)
- California Healthcare Association – (916/552-7574)
- California Medical Association – (415/882-5166)
- National IPA Coalition – (510/267-1999)
- The Medical Quality Commission – (310/936-1100 x230)

Individual healthcare organizations may request additional pr attach supplements to this form. They are not part of the California Participating Physician Reapplication nor have they been endorsed by the above organizations. Any questions about supplements should be addressed to the healthcare organization from which it was provided.