



MEDICAL BOARD OF CALIFORNIA Central Complaint Unit



LICENSE VERIFICATION SYSTEM (LVS) – SUBSCRIPTION SERVICE REQUEST <i>For New Subscriptions, Renewals, Cancellations, or Change(s)</i>	
Subscription Service Request is: <small>(Check one)</small>	New <input type="checkbox"/> Renewal <input type="checkbox"/> Cancellation <input type="checkbox"/> Change(s) <input type="checkbox"/>
Current Subscription: <small>(For Renewals, Cancellations or Changes)</small>	Period Covered From: _____ Facility Login: _____
	Period Covered To: _____ Password: _____
Name of Organization:	_____
Type of Facility: <small>(Enter one of the numbers listed on page 2)</small>	Hospital: <input type="checkbox"/> HMO: <input type="checkbox"/> IPA: <input type="checkbox"/> Medicare Certified/Accredited <input type="checkbox"/> Outpatient Surgery Setting: <input type="checkbox"/> Other: <input type="checkbox"/>
Mailing Address:	Department: _____
	Street Address: _____
	City/State/Zip: _____
Contact Person:	Name: _____ Title: _____
	Telephone: _____ FAX: _____
	E-mail Address: _____
If Requesting Access to the “805 Report” Information, Please Complete the Following:	
Pursuant to Business and Professions Code section 805.5, prior to granting or renewing staff privileges to any physician, any health care facility licensed by DPH or health care services plan or medical care foundation or the medical staff of the institution, a facility certified to participate in the federal Medicare Program as an ambulatory surgical center, or an accredited outpatient surgery setting shall request a report from the Medical Board as to whether the applying physician has been denied staff privileges or had those privileges removed or restricted. This is not considered public information and cannot be disclosed to clients other than those legally entitled to request that information.	
If licensed by the Department of Public Health, enter the seven digit license number and provide a copy of the license.	_____
If licensed by the Department of Managed Health Care, enter the license/plan number.	_____
If accredited by an approved accreditation agency or Medicare certified, enter the accreditation or certification number.	_____
Organization, if other than indicated above, you are authorizing to act as your agent to request 805 information:	Name: _____
	Street Address: _____
	City/State/Zip: _____
	Telephone: _____
I certify under the penalty of perjury under the laws of the State of California, that the information I have provided is true and correct.	
Signature _____	Date _____
Title _____	Telephone Number _____
Return completed form to:	
Medical Board of California License Verification System 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 ATTENTION MARCO ARMAS	

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Type of Facility List – Page 2

The facilities and organizations authorized by Health and Safety Code Section 1200 to request 805 reports are listed below.

Licensed by the Department of Public Health:

1. General acute care hospital
2. Acute psychiatric hospital
3. Skilled nursing facility
4. Intermediate care facility
5. Intermediate care facility/developmentally disabled rehabilitative
6. Special hospital
7. Intermediate care facility/developmentally disabled
8. Intermediate care facility/developmentally disabled-nursing
9. Congregated living health facility-A
10. Congregated living health facility-B
11. Correctional treatment center

Licensed by the Department of Managed Healthcare:

12. Health Care Service Plan
13. Medical Care Foundation

Accredited by a Medical Board of California Approved Accreditation Agency

14. Accredited Outpatient Surgery Setting

Centers for Medicare & Medicaid Services

15. Medicare Certified